



DEPARTMENT OF THE NAVY
SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
720 KENNON STREET SE STE 309
WASHINGTON NAVY YARD, DC 20374-5023

IN REPLY REFER TO:
1850
CORB: 003
24 Apr 18

From: Director, Secretary of the Navy Council of Review Boards
To: Ms. Tae Hee (Tamara) Kim, Esq.
Latham & Watkins, LLP
555 Eleventh St, NW Suite 1000
Washington, DC 20004

Subj: CTN2 DANIEL ANDERSON'S REQUEST FOR RECONSIDERATION OF THE
PHYSICAL EVALUATION BOARD'S DENIAL OF A FORMAL PEB HEARING

Ref: (a) Your memo dtd 2 Apr 18
(b) SECNAVINST 1850.4E

Encl: (1) DIRCORB memo dtd 5 Mar 18
(2) DD Form 149

1. Your request on behalf of CTN2 Anderson, as set forth in reference (a), is denied.
2. On 17 January 2017, CTN2 Anderson was found "Fit to Continue on Active Duty." In his Election of Options dated 24 January 2018, he requested a FORMAL PEB hearing to contest his fitness determination. Following re-review of CTN2 Anderson's case by the PEB, and based on the recommendation of the President, PEB, I denied CTN2 Anderson's request for a Formal PEB on 5 March 2018. A copy of my denial letter is provided as enclosure (1).
3. After review of reference (a), CTN2 Anderson's request for a Formal PEB is again denied. His case was processed in accordance with reference (b), which does not provide appeal of the decision to deny a Formal PEB to a service member found fit. I reviewed reference (a), but found the arguments presented and the new information and medical evidence insufficient basis upon which to deviate from regulation by granting further review.
4. Despite my decision, CTN2 Anderson's case may be re-referred to the PEB by appropriate Medical Treatment Facility authorities should they, again, determine his conditions preclude the performance of his duties.
5. CTN2 Anderson's attention is invited to the fact he has the right to petition the Board for Correction of Naval Records (BCNR) if he believes either an error or injustice was committed in his case. Enclosure (2) is provided for your use should you subsequently desire to petition BCNR.


J. A. RIEHL

Copy to: (w/o encl)
President, PEB



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Subj: CTN2 DANIEL ANDERSON'S REQUEST FOR RECONSIDERATION OF THE
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4. Despite my decision, CTN2 Anderson's case may be re-referred to the PEB by appropriate Medical Treatment Facility authorities should they, again, determine his conditions preclude the performance of his duties.
5. CTN2 Anderson's attention is invited to the fact he has the right to petition the Board for Correction of Naval Records (BCNR) if he believes either an error or injustice was committed in his case. Enclosure (2) is provided for your use should you subsequently desire to petition BCNR.


 J. A. RIEHL

Copy to: (w/o encl)
 President, PEB

AR 0002



DEPARTMENT OF THE NAVY
 SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
 720 KENNON STREET SE STE 309
 WASHINGTON NAVY YARD DC 20374-5023

IN REPLY REFER TO
 1850
 PPEB
 01-Mar-18

MEMORANDUM

From: President, Physical Evaluation Board
 To: Director, SECNAVCORB

Subj: REQUEST FOR FORMAL HEARING

Ref: (a) Formal Board Request ICO CTN2 Daniel D. Anderson, USN
 (b) SECNAVINST 1850.4E

1. Reference (a) is forwarded for decision pursuant to reference (b).
2. The Service member was found fit for continued naval service by the Informal Physical Evaluation Board (PEB). Pursuant, a request for a formal hearing was received. I have reviewed the case and recommend the request be denied.

REESERJOHN.DA
 VID.1040792119

Digitally signed by
 REESERJOHN.DAVID.1040792119
 DN: cn=J.D. Reeser, o=U.S. Government,
 email=j.d.reeser@navy.mil, c=US,
 Date: 2018.03.01 13:48:34 -0500

J. D. Reeser

05-Mar-18

From: Director, SECNAVCORB
 To: President, Physical Evaluation Board

1. Your recommendation is approved. The request for a formal hearing as set forth in reference (b) is denied.

RIEHLJEFFREY.AL
 LEN.1041765298

Digitally signed by
 RIEHLJEFFREY.ALLEN.1041765298
 DN: cn=J.A. Riehl, o=U.S. Government, email=j.a.riehl@navy.mil, c=US,
 Date: 2018.03.05 07:48:20 -0500

J. A. Riehl

AR 0003

Volume One

From: Kim, Tamara (DC)
To: jeffrey.riehl@navy.mil
Cc: Daniel Anderson; lakeisha.m.brower.ctr@mail.mil; Esther Leibfarth; Elrod, Eugene (DC)
Subject: CTN2 Daniel Anderson's Request for Reconsideration of the Physical Evaluation Board's Denial of a Formal Hearing
Date: Monday, April 2, 2018 3:10:00 PM
Attachments: Daniel Anderson CORB MEMORANDUM.pdf
Exhibit A.pdf
Exhibit B.pdf
Exhibit C.pdf
Exhibit D.pdf
Exhibit E.pdf
Exhibit F.pdf
Exhibit G.pdf
Exhibit H.pdf
Exhibit I.pdf
Exhibit J.pdf
Exhibit K.PDF
Exhibit L.pdf
Exhibit M.pdf
EXHIBIT N.pdf

Dear Mr. Riehl,

My name is Tamara Kim, and I am an attorney at Latham & Watkins. The National Veterans Legal Services Program has referred CTN2 Daniel Anderson's case to me and Gene Elrod, copied here.

Gene and I are writing to file the attached Memorandum and relevant Exhibits A-N, with the following purposes:

1. To appeal the Physical Evaluation Board's February 22, 2018 denial of CTN2 Anderson's FPEB request for a formal hearing without approval from the Secretary of the Navy Council of Review Boards; and
2. To request that the CORB grant Anderson's request for an FPEB, or directly find Anderson's Generalized Anxiety Disorder and Major Depressive Disorder to be unfitting conditions.

Please let us know if you have any questions.

Warm regards,

Tae Hee (Tamara) Kim

LATHAM & WATKINS LLP
555 Eleventh Street, NW
Suite 1000
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Email: tamara.kim@lw.com
<http://www.lw.com>

From: Kim, Tamara (DC)
To: jeffrey.riehl@navy.mil
Cc: Esther@nvls.org; Daniel Anderson; Elrod, Eugene (DC)
Subject: RE: CTN2 Daniel Anderson's Appeal
Date: Tuesday, April 17, 2018 6:07:26 PM

To: Jeffrey Riehl, CORB

Dear Mr. Riehl,

We are writing to you in our capacity as legal counsel representing CTN2 Daniel Anderson in his appeal of the Physical Evaluation Board's denial of a formal hearing regarding his fitness for duty. On April 2, 2018, on behalf of Mr. Anderson, we filed an appeal of that denial. Please advise us of the status of the appeal. In addition, please copy us on all future communications with Mr. Anderson regarding the appeal.

Thank you.

Respectfully,

Tamara Kim and Gene Elrod
Counsel for Daniel Anderson

Tae Hee (Tamara) Kim

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MEMORANDUM

LATHAM & WATKINS LLP

MEMORANDUM

Date: April 2, 2018

From: Tae Hee (Tamara) Kim, Esq. and Eugene Elrod, Esq., of Latham & Watkins LLP, on behalf of CTN2 Daniel Anderson

To: Director of Secretary of the Navy Council of Review Boards
Attention: Mr. Jeffrey Riehl (jeffrey.riehl@navy.mil)

Subj: CTN2 Daniel Anderson's Request for Reconsideration of the Physical Evaluation Board's Denial of a Formal PEB hearing.

Ref: (a) SECNAVINST 1850.4E

(b) DoDI 1332.18

Encl: Abbreviated Medical Evaluation Board Report dated June 13, 2017 (Exhibit A)

Abbreviated Medical Evaluation Board Report dated December 6, 2017 (Exhibit B)

Consolidated NARSUM (Exhibit C)

Compensation and Pension Exam Report for DBQ PSYCH Mental disorders Exam dated October 26, 2017 (Exhibit D)

Non-Medical Assessment (NMA) dated October 27, 2017 (Exhibit E)

Medical Record created October 30, 2017 at WRNMMC (Exhibit F)

Personal Health Information created on January 24, 2018 from the Military Electronic Health Record (Exhibit G)

Personal Summary of Medical Symptoms by Daniel Anderson (Exhibit H)

Letter from Sherin Paul Psy.D, Clinical Psychologist at WRNMMC (Exhibit I)

IPEB Appeal (Exhibit J)

FPEB Request Denial signed February 22, 2018 (Exhibit K)

SECNAVCORB Memorandum (9 Jul 15) DELEGATION OF AUTHORITY (Exhibit L)

Performance Evaluation signed by Anderson March 27, 2018 (Exhibit M)

Letter to Mr. Jeffrey Riehl, Director of SECNAVCORB (Exhibit N)

April 2, 2018
Page 2

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1. The purposes of this memorandum are:

- to appeal the Physical Evaluation Board's (PEB) February 22, 2018 denial of CTN2 Daniel Anderson's (hereafter "Anderson") Formal PEB (FPEB) request for a formal hearing without approval from the Secretary of the Navy Council of Review Boards (CORB); and
- to request that the CORB grant Anderson's request for an FPEB, or directly find Anderson's Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) to be unfitting conditions.

2. SECNAVIST 1850.4e, Enclosure 4, para 4109, clearly states that the PEB president can grant a request to the FPEB, but only the CORB (upon recommendation of the PEB president) may deny such a request.¹ This denial power cannot be delegated, as SECNAVCORBINST 5216.1G attempted, because the Secretary of the Navy, the CORB's superior Secretary, explicitly withheld such power from the PEB president by specifying in SECNAVIST 1850.4e, Enclosure 4, para 4109 that the PEB President may only "recommend" a denial. This bifurcated appeal process ensures that all sailors will receive due process in that their appeals will not be decided by the same entity that ruled against them initially. Despite this regulation and the safeguards it provides, Anderson's FPEB request was directly denied by the PEB President, Mr. John Reeser, on February 22, 2018, apparently without approval from the CORB. *Exhibit K*. For further analysis of the authority to deny a formal hearing, please see *Exhibit N*.

3. Furthermore, the Navy policy notes that a right to a PEB hearing does not exist when a sailor is found "fit" for duty because the DoDI and SECNAVINST indicate that a "fit" finding is a positive outcome. Every Non-Medical Assessment, including Anderson's, indicates the Service member's actual desired outcome. In this case, Anderson indicated he wanted to found "unfit" for duty. Thus, the PEB is aware that Mr. Anderson desired to be found "unfit" due to the severity of his medical conditions, and that any decision of fitness in his case is a *negative* outcome, not a positive one. Therefore, the rationale that being found "fit" is a positive outcome cannot provide a reasoned basis, *in this case*, for denying Mr. Anderson's formal board hearing.

4. The PEB's denial of Anderson's hearing request not only violated SECNAVIST 1850.4e, Enclosure 4, para 4109, but also ran afoul of the CORB's responsibility pursuant SECNAVIST 1850.4e, Enclosure 1, para 1004c(2) to grant a FPEB hearing in the case of a member found FIT for continued naval service, where necessary to "preclude error or injustice."

5. In Anderson's case, had the proper procedural steps been followed, the CORB would have been permitted to review Anderson's IPEB appeal, *Exhibit J*, prior to the denial of his FPEB hearing request. In that event, we respectfully submit that the CORB would have recognized

¹ According to SECNAVIST 1850.4e, Enclosure 4, para 4109b, the PEB President "may grant a request for a hearing before a Formal PEB or recommend to the DIRNCPB, that the request be denied. The DIRNCPB, upon review of the case may grant the request for a hearing or deny it."

April 2, 2018
Page 3

LATHAM & WATKINS LLP

both the procedural error and the injustice to CTN2 Anderson to find him “fit” for duty without a FPEB hearing.

6. The evidence presented in Anderson’s IPEB appeal makes clear that, pursuant to Appendix 2 of DoDI 1332.18, Anderson’s GAD and MDD make him unfit for duty. Those medical conditions make him “unable reasonably to perform duties of his or her office, grade, rank, or rating . . . ,” represent “a decided medical risk to the health of the member or to the welfare or safety of other members,” and impose “unreasonable requirements on the military to maintain or protect the Service member.”

7. In his IPEB appeal, Anderson demonstrated that, as required by SECNAVINST 1850.4E §3306, the preponderance of the evidence, both medical and non-medical, proves his GAD and MDD are unfitting conditions:

A. Anderson has been in mental health treatment regularly, with weekly visits to his psychiatrist since August of 2012. *Exhibit D, at 5; Exhibit I.* Anderson was hospitalized in 2015 for 30 days at Fort Belvoir for inpatient treatment, and additional inpatient treatment was recently recommended. *Id.*

B. Despite being in treatment for several years and on Limited Duty for over 6 months, Anderson’s MDD and GAD continue to cause significant symptoms and limitations as illustrated by his NARSUM and VA DBQ PSYCH Mental disorders Exam (Psych DBQ) dated September 25, 2017. *Exhibit D.* Specifically, Anderson’s NARSUM dated November 6, 2017 notes that his MDD and GAD, among other diagnoses, fail the medical retention standards of the Navy. Specifically, Anderson’s NARSUM finds his MDD to be duty-limiting because it results in sad mood, feelings of helplessness, feelings of hopelessness, low energy, anhedonia, and chronic suicidal ideation, and that his GAD manifests in worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. *Exhibit C.*

C. Anderson’s GAD and MDD create numerous symptoms that directly limit his ability to serve in the military and to function in the larger world. For example, Anderson’s Psych DBQ states that he has “near-continuous panic or depression affecting the ability to function independently, appropriately and effectively,” “difficulty in adapting to stressful circumstances, including work or a worklike setting,” and “obsessional rituals which interfere with routine activities.” *Exhibit D.*

D. On October 27, 2017, the Commanding Officer of the Cyber Strike Activity Sixty Three completed a Non-Medical Assessment (NMA) in Anderson’s case, confirming the following facts: 1) considering Anderson’s current physical condition, he is not worldwide assignable; and 2) he does not have good potential for continued service in his present physical and mental condition. *Exhibit E, at 2-3.* Anderson’s commander further affirmed her belief that Anderson’s medical conditions render him unfit for military service by personally endorsing the suspension of Anderson’s access to TTS/SCI materials and facilities, stating that his mental health condition “has prompted a review by Department of the Navy Central Adjudication Facility to see if the member can retain

April 2, 2018
Page 4

LATHAM & WATKINS LLP

his current level of security clearance.” This circumstance prevents him from completing regular Cryptologic Networking Technician (CTN2) duties. *Id.* at 3-4.

E. As of March 26, 2018, Anderson’s security clearance remains suspended due to his mental health condition, and there is no indication that it will be reinstated. Because Anderson’s condition, according to his NARSUM, is not likely to improve in the next 12 to 36 months, it appears that he will be disqualified from obtaining the security clearance required to do his job for an indefinite period. *Exhibit C.*

F. Highlighting the errors in the IPEB’s fit-for-duty finding and the PEB’s denial of Anderson’s FPEB request is an Abbreviated Medical Evaluation Board Report, dated December 6, 2017, placing Anderson on a second period of limited duty for his GAD and MDD. Anderson’s second period of limited duty is even more restrictive than his first. *Exhibit B.* The second period of limited duty 1) requires Anderson to remain at Walter Reed for “extensive medical care,” removing him indefinitely from his work as a CTN2; 2) precludes his participation in “late night or overnight duty,” thereby excluding him from shift work that is common for a sailor serving as a CTN2; and 3) prevents him from living on a boat, deploying, and from firing and carrying a weapon. *Id.* Due to these limitations, medical officers concluded that Anderson’s anxiety, depression, and co-morbid medical condition have significantly negatively impacted his ability to function at home and in his social environment. *Id.*

G. On March 16, 2018, and notwithstanding the IPEB’s earlier finding that Anderson is fit for duty, Anderson’s command signed a performance evaluation that concludes that he is “not recommended for retention or advancement.” This recommendation is based largely on the fact that Anderson is in a limited-duty status due to required medical treatment approximately 3-4 days a week. *Exhibit M at 2.*

H. Perhaps most importantly, since the filing of our last memorandum there is new medical evidence that supports a finding that Anderson’s medical conditions render him unfit for duty. Dr. Sherin Paul, Clinical Psychologist at WRNMMC and Anderson’s primary mental health provider, has written a letter to the PEB with information concerning Anderson’s fitness, from a behavioral health perspective, to continue to serve as a CTN2. *Exhibit I.* In Dr. Paul’s professional opinion, Anderson’s GAD and MDD diagnoses, individually and when taken together, leave him unable to perform, safely and reliably, the duties required of a CTN2. *Id.* Moreover, Anderson’s limitations also place at risk secure, classified information and sensitive work product that belong to the Navy. *Id.*

I. Indeed, Dr. Paul’s letter states that, despite his long-term compliance with treatment recommendations, Anderson’s GAD and MOD diagnoses cause him various symptoms that limit his ability to serve in the military, including but not limited to the following: 1) consistent anxiety or depression affecting the ability to function independently, appropriately and effectively; 2) difficulty in adapting to stressful circumstances,

April 2, 2018
Page 5

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including work or a work-like setting; and 3) difficulty developing healthy coping skills to manage life stressors. *Exhibit I.*

J. According to Dr. Paul, the above limitations prevent Anderson from performing either his basic military duties or the duties of his rating. *Id.* As a CTN, Anderson works daily in a stressful position that requires him to produce national intelligence products using complex Information Technology (IT) networks containing secure, classified information. *Id.* Anderson's continued service would place at risk not only his mental health, but also his sensitive work product, as his symptoms will likely continue to interfere negatively with his ability to perform his duties efficiently, effectively, and accurately. *Id.* Therefore, if the PEB were to find Anderson fit for duty and Anderson were to continue service, the Navy would be placing at risk its own secure documentation and information systems. Anderson's psychological conditions are highly likely to result in mistakes, poor judgment, and limited professional and mental functioning at any given time.

K. Contrary to what the PEB claimed in its IPEB response, Anderson's medical records illustrate that his GAD and MDD limit his continued military service. There is no indication that Anderson is limited in his duties because his command does not trust him. In fact, as illustrated by his commander's NMA and Anderson's recent evaluation report, his command documents that his medical conditions cause him to miss 30 hours of work per week, and resulted in his loss of the clearance required to do his job as a CTN. *Exhibit E.*

8. In light of these facts, Anderson respectfully requests that the CORB grant him a formal hearing. At the hearing, we will demonstrate that Anderson's GAD and MDD, individually and taken together, make him unfit for duty. The symptoms of these conditions prevent him from performing, safely and reliably, the duties of his rating and, in fact, even his basic military duties. In the alternative, Anderson requests that the CORB directly overturn the IPEB's decision and find that his GAD and MDD make him unfit for duty.

/s/ Tamara Kim
Tae Hee (Tamara) Kim, Esq.

/s/ Gene Elrod

AR 0014

April 2, 2018
Page 6

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Eugene Elrod, Esq.

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 06-13-2017 Patient Name: Daniel Dennis Merwin Patient SSN: [REDACTED]

Proposed start date for limited duty: 06-14-2017 Proposed end date (≤ 6 months): 12-13-2017

This period of limited duty is for: (Select one)

- ☒ 1st LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary).
- ☐ 2nd LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.
- ☐ 1st LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).
- ☐ 2nd LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).
- ☐ 3rd or subsequent LIMDU periods on Navy and Marine ADSM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").
- ☐ Placement on LIMDU - If the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) <u>Generalized Anxiety Disorder</u>	ICD-9 CM Code	<u>300.02</u>
(2) <u>Major Depressive Disorder, Recurrent, Moderate</u>	ICD-9 CM Code	<u>296.32</u>
(3) <u>IBS-D</u>	ICD-9 CM Code	<u>K58.0</u>

Circumstances of injury/illness:

The patient is a 32-year-old male who presents with anxiety, depression, and co-morbid medical conditions that negatively impact his ability to function at home, work, and in social settings. The GI-confirmed IBS-D is of such severity that it daily interferes with military ADLs.

Treatment plan:

PT referred to IOP (mental health RX). He is on multiple bowel medications and his IBS-D severity requires that he have close proximity to BR facilities at all times.

Limitations from full duty (including whether transfer/TENDU for treatment is indicated, and any PRT limitations):

Ensure access to all medical appointments. Ensure opportunity for 8 consecutive hours of sleep every 24-hour period. The patient should not have access to weapons. The patient should not PCS, deploy, or be placed in austere environments.

PAUL SHERIN 1611836794
Printed MEB Member Name and Signature/Date

[Signature] 16 June 2017
Printed CA Name and Signature/Date
RUSSELL B. CARR
CDR MC USN

SECTION 2: PATIENT INFORMATION TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

[Signature] 14 JUN 17
Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- ☒ Completion of Patient Information Sheet
- ☒ Notification to PSD/Personnel Office
- ☒ LOGB Requested from Parent Command (if LOGB required)
- ☒ Entry into Med2OLTT

- ☒ Briefing to Patient on Limited Duty/MEBs
- ☒ Notification to MTF LIMDU Coordinator
- ☒ Notification to Parent Command

[Signature]
Patient Administration Officer/Medical Boards Official Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEBR Case File, and PERS-4821 or MMSR-4

NAVMED 8100/5 (Rev. 08-2004)
PREVIOUS EDITIONS OBSOLETE

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 12-06-2017 Patient Name: Daniel Dennis Anderson Patient SSN: [REDACTED]

Proposed start date for limited duty: 12-13-2017 Proposed end date (< 6 months): 06-12-2018

This period of limited duty is for: (Select one)

- ☐ 1st LIMDU (< 6 months) Enlisted ADJSM (no referral to service headquarters necessary)
- ☐ 2nd LIMDU (< 6 months) Enlisted ADJSM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period
- ☐ 1st LIMDU (< 6 months) Officer ADJSM (referral to service headquarters necessary)
- ☐ 2nd LIMDU (< 6 months) Officer ADJSM (referral to service headquarters necessary)
- ☐ 3rd or subsequent LIMDU periods on Navy and Marine ADJSM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review")
- ☒ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication

Diagnosis: (1) MDD, Recurrent, Moderate	ICD-9 CM Code	296.32
(2) GAD	ICD-9 CM Code	300.02
(3) IBS-D/P	ICD-9 CM Code	K52

Circumstances of injury/illness:

The patient is a 32-year-old male who has anxiety, depression, and co-morbid medical condition that have significantly negatively impacted his ability to function at home and in his social environment. The GI confirmed IBS-D/P is of such severity that it interferes with military ADL's.

Treatment plan:

Patient to complete IOP through ATS. Patient will follow up on outpatient basis with several appointments including individual/group/OT/Rec therapy & meds.

Limitations from full duty (including whether transfer/TEMU for treatment is indicated, and any PRT limitations):

1) Recommend PCS LimDu to Walter Reed to complete extensive medical care 2) Access to all medical appointments 3) No PT 4) Access to bathrooms 4) No late night or overnight duty, ensure 8-hours of sleep in 24h period 5) No access to weapons 4) No PCS/Not deployable/No austere environments

PAUL SHERIN 1511835794 Digitally signed by PAUL SHERIN, DN: cn=PAUL SHERIN, o=US ARMY, ou=US ARMY, email=PAUL.SHERIN@USARMC.MIL

Printed MEB Member Name and Signature/Date

Edin Todorovic

Printed MEB Member Name and Signature/Date

Printed CA Name and Signature/Date

Edin Todorovic 15 DEC 17

SECTION 2: PATIENT INFORMATION, TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

Daniel Anderson
Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- | | |
|--|---|
| <input type="checkbox"/> Completion of Patient Information Sheet | <input type="checkbox"/> Briefing to Patient on Limited Duty/MEBs |
| <input type="checkbox"/> Notification to PSD/Personnel Office | <input type="checkbox"/> Notification to MTF LIMDU Coordinator |
| <input type="checkbox"/> LODD Requested from Parent Command (if LODD required) | <input type="checkbox"/> Notification to Parent Command |
| <input type="checkbox"/> Entry into MedBOLTT | |

Patient Administration Officer/Medical Boards Officer Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEBR Case File, and PERS-4821 or MMSR-4

NAVMED 8100/5 (Rev. 08-2004)
PREVIOUS EDITIONS OBSOLETE



**DEFENSE HEALTH AGENCY
WALTER REED NATIONAL MILITARY MEDICAL CENTER
WRNMMC CONSOLIDATED NARSUM**

This consolidated NARSUM incorporates specialty consults and review of VA medical records, precluding the need for specialty addenda, and is an Administrative Document, *not* to be used as source documentation for medical decisions.

NAME: ANDERSON, DANIEL DENNIS
SSN/DOB: [REDACTED] 1985
STATUS: PO2/USN
DATE: 06 November 2017

Identification: PO2 Anderson is a 32 y/o USN with 12 years length of service. MOS is CTN. He was referred to the IDES on 21 August 2017 for Irritable bowel syndrome, Generalized anxiety disorder and Major depressive disorder recurrent moderate.

History of Present Illness: Per review of medical records available in AHLTA, ESSENTRIS, and JLV, the following diagnoses are referred to the Navy Central Physical Evaluation Board as duty limiting:

Diagnoses 1-3

1. **Diagnosis 1: Major Depressive Disorder (MDD), Recurrent, Moderate (ICD10: F33.1)**
Diagnosis 2: Generalized Anxiety Disorder (GAD) (ICD 10: F41.1)
Diagnosis 3: Alcohol Use Disorder, Moderate, in early remission (not ratable)

2. **Diagnostic Reasoning:** Per the VA DBQ PSYCH Mental disorders Exam dated 25 September 2017, PO2 Anderson had a history of childhood trauma, had attempted suicide at age 17 which he did not disclose at the time by taking a bottle of aspirin (detail AHLTA Psychiatry Be note dated 04 August 2014), but no history of behavioral health diagnosis or treatment prior to entry into military service in 2005. Per an AHLTA Integrative Health & Wellness Be note dated 16 June 2014, he had anxious mood, irritable bowel, attentional difficulties, nail biting, irritability and insomnia since around age 14. He noted anxiety had also been a problem when he was stationed on a ship in Japan from 2006 to 2009, where he had little down time, worked 12 hour shifts and tried to be the "perfect" worker and he began picking out circular patches of hair in his scalp. In 2014, he was selected for a new job with increased responsibility including leadership and management duties while he noted that he would prefer to do computer work in isolation. He reported at that time that he drank up to 3 drinks, one to two times per week, and would binge, 6 or more drinks once per month or less frequently, but had tried to cut down (AHLTA Psychiatry Be note dated 16 October 2014). He had concerns about his inability to resist daily drinking to manage his, insomnia, anxious ruminations and obsessions despite his growing lack of motivation, worsening mood, and (AHLTA Substance Abuse NY notes dated 17 and 19 March 2015). He had persistent dysphoric mood, intermittent suicidal ideation, irritability, apathy and continued anxiety (AHLTA PSYCHIATRY BE note dated 23 April 2015). He had some benefit to his mood from medication and noted he was more focused and productive but still had anxiety (AHLTA Psychiatry Be note dated 14 May 2015). However, his medication caused excessive sleepiness when the dose was increased and he asked to be tapered off. During times of increased stress, he had anxiety including physical tension, increased heart rate and nausea, and mood swings with suicidal ideation and on one occasion thought about jumping off of a roof related to juggling multiple work responsibilities (AHLTA Psychiatry Be note dated 06 September 2016). In addition, guilt about how he functioned in interpersonal relationships led him to feel suicidal. Though he drank less during active alcohol dependence treatment, he resumed regular drinking of 3 to 4 drinks three to four times per week with binge drinking when he was not working (AHLTA Psychiatry Be note dated 04 January 2017). He stopped taking medication after a change in medication left him feeling flat, but later resumed. However, he noted that his anxiety overwhelmed him and was negatively impacting his ability to be a Sailor (AHLTA Psychiatry Be T-Con note dated 08 June 2017). He had a Command directed safety evaluation after voicing suicidal thoughts and researching methods of suicide on-line, in response to the aftermath of a harassment allegation against him (AHLTA Psychiatry Consult Liaison Be note dated 06 July 2017) which resulted in a loss of rank. When his personal and career circumstances were discussed without his knowledge in front of 150 Service members in an all hands meeting, furthering his

estrangement from Command, he noted increased anxiety and depression with suicidal thoughts of jumping off of a roof (AHLTA Psychiatry Be note dated 06 September 2017). At his most recent follow up, he noted no significant improvement in dysphoric mood, no drinking, and he had continued medication side effects (AHLTA Psychiatry Be note dated 01 November 2017).

3. Treatment History: PO2 Anderson was evaluated for anxiety at Walter Reed National Military Medical Center (WRNMMC) and participated in therapy June to October 2014 but discontinued due to limited impact of visits (AHLTA Substance Abuse at NY note dated 19 March 2015). He self-referred to Substance Abuse Recovery Program Washington Navy Yard in March 2015 for problematic drinking and participated in Level 1 and Continuing Care group therapy until February 2016. He was referred to the Ft. Belvoir Community Residential Treatment Center from 25 March 2015 to 23 April 2015. He was referred to medication management at WRNMMC and Cognitive Behavioral Group therapy for insomnia beginning in 2015. He began Addiction Treatment Services (ATS) at WRNMMC in July 2017 and continued with outpatient individual and group therapy through ATS. He attended the WRNMMC Intensive Outpatient Program from 31 August 2017 to 22 September 2017. He had Transcranial Magnetic Stimulation seven sessions as of 10 October 2017. He continued in behavioral health treatment modalities of individual and occupational therapy and medication management. Medication trials included Escitalopram, Sertraline, and Venlafaxine ER for mood, Melatonin and Ramelteon for insomnia, and Naltrexone for alcohol dependence. Most recent medication included Duloxetine 60mg daily for mood and Eszopiclone 2 mg nightly for insomnia.

4. Symptomatology and Objective Findings: Per the VA DBQ PSYCH Mental disorders Exam dated 25 September 2017, PO2 Anderson had the following symptoms consistent with MDD which included sad mood, feelings of helplessness, feelings of hopelessness, low energy, anhedonia, and chronic suicidal ideation. He had symptoms consistent with GAD which included worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. His symptoms of Alcohol Use Disorder included a maladaptive pattern of alcohol use, excessive use and tolerance, and of interpersonal or occupational problems occurring as a result of use. His most recent mental status was notable for dysphoric mood, full affect, circumstantial thought processes and no suicidal ideation intent or plan (AHLTA Psychiatry Be note dated 01 November 2017).

5. Limitations and Prognosis: The NMA dated 27 October 2017 stated, "The conditions listed in his LIMDU paperwork and the extensive range of medical appointments CTN2 Anderson's medical practitioners have recommended/assigned for his treatment prevent him from conducting his assigned mission for his MOS/Rate."

PO2 Anderson requires ongoing behavioral health treatment at a fixed MTF. He cannot deploy nor carry and fire a weapon from a behavioral health perspective. The prognosis is guarded. It is not likely that the SM will significantly improve sufficiently to be returned to fully duty in the next 12 to 36 months. The above condition is likely to remain stable over the next 12 months.

6. VA DBQ Findings: C&P exams have been reviewed.

Diagnoses 4

1. Diagnosis: Irritable bowel syndrome with diarrhea (ICD10 Code: K58.0)

2. Diagnostic Reasoning: 32 y/o AD male was diagnosed with IBS manifested by chronic intermittent abdominal pain in 2012. He has reported a long history of GI symptoms dating back to childhood, but symptoms have been more disruptive over the past few years. In 2012 he underwent a CT abdomen/pelvis, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was normal. In Sept 2017 anorectal manometry was normal. He has had frequent follow up with GI since 2016. Symptoms include generalized sharp, crampy abdominal pain about every 1-2 days that peaks prior to defecation and is relieved after bowel movements. He typically has 1-2 soft or liquid stools per day, infrequently with urgency. Abdominal pain is worse with intake of insoluble fibers; however, insoluble

PO2 Anderson, Daniel D.

06 November 2017

Page 2

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AR 0022

fibers resolve his liquid stools. Abdominal pain is also worse during physical activity and with increased anxiety/stress. Low FODMAP diet has provided partial relief in frequency of pain and fecal urgency. GI evaluation dated 19Sept17 noted "IBS-D predominant symptoms complicated fecal urgency/soiling, with some element of FODMAP associated osmotic diarrhea. Comprehensive evaluation has otherwise been unremarkable."

3. Treatment History: dietary modification as noted, including low FODMAP and low fructose, peppermint oil 200mg daily for his abdominal cramping, Citrucel, Effexor

4. Symptomatology and Objective Findings: Stools have become more formed over the past few months since starting Effexor and continuing a low FODMAP diet. However, he has ongoing abdominal cramps, which continue to be triggered by physical activity, anxiety, and stress.

5. Limitations and Prognosis: Limited in ability to deploy to austere environment. NMA unavailable at this time.

Continued treatment is unlikely to return Soldier to full duty in 12 months. Condition is stable over 12-36 months. Will require ongoing GI and PCM follow-up and support.

6. VA DBQ Findings: Reviewed and concur.

Diagnoses 5

1. Diagnosis: Obstructive sleep apnea (ICD10 Code: G47.33)

2. Diagnostic Reasoning: Polysomnogram was performed on 04Oct17 at WRNMMC. SM was diagnosed with mild obstructive sleep apnea with AHI of 6/hr. CPAP was recommended.

3. Treatment History: CPAP

4. Symptomatology and Objective Findings: Apnea hypopnea index (AHI) of 7/hr.

5. Limitations and Prognosis: Limited in ability to deploy to austere environment due to need for electricity and fresh water. SM should not engage in any hazardous activities (such as driving) if excessively sleepy. While this condition does not limit his ability to perform his MOS, continued treatment is unlikely to return Soldier to full duty in 12 months. Condition is stable over 12-36 months. SM requires treatment with CPAP.

6. VA DBQ Findings: Reviewed and concur.

Conditions evaluated at the VA DBQ Exam that are not duty limiting, alone or in combination with the SM's other conditions:

- 3. Subjective tinnitus,** with normal hearing bilaterally.
- 4. Disturbance in sensation, cranial nerve V2,** residual OIF orthognathic surgery, improving and not duty limiting.
- 5. Epidermal cysts of the scrotum,** s/p excision.
- 6. Left neck folliculitis,** inactive, no residual scar per VA DBQ examiner.
- 7. Scarring alopecia,** not duty limiting.
- 8. Dry eye syndrome,** not duty limiting.
- 9. Left ankle sprain,** resolved with no residual per VA DBQ examiner.
- 10. Paronychia left hallux,** not duty limiting.
- 11. Right wrist tendinitis,** VA diagnosis, with normal Rom on exam, not duty limiting.
- 12. Right hand 5th proximal phalanx fracture 2008,** well healed without residual per VA DBQ examiner, no pathology found.
- 13. Hemorrhoids,** not duty limiting.

PO2 Anderson, Daniel D.

06 November 2017

Page 3

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AR 0023

14. GERD, managed with PPI.
15. Migraine headaches, onset 2008, treated with Alleve or Excedrin.
16. Allergic rhinitis, not duty limiting.
17. Asthma, not listed as a diagnosis by the VA DBQ examiner, diagnosis confirmed in the medical record. Pulmonary function tests were performed on 17Mar11 and revealed normal spirometry, very mild decrease in TLC, and a normal DLCO. Following the administration of methacholine there was a significant decrease in FEV1 consistent with a positive methacholine challenge. Pulmonary noted "symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. His symptoms are confined to allergen exposure, particularly to cats. Given the mild intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS." Albuterol was last refilled 18May17.

Competency Statement: SM is deemed mentally competent for pay purposes and is capable of cooperating in and understanding the nature of PEB proceedings.

Past Medical History, Social History, Family History and Review of Systems:

Discussed above, otherwise not pertinent.

Discussion: The VA DBQ examiner did not establish a diagnosis related to the following claims, and there is no evidence of impact on duty in available medical records: left wrist condition, anal fissure, and anal spasms. The SM claimed mental health condition to include schizoid effect. Per an AHLTA Psychology Assessment Be note dated 08 February 2017, PO2 Anderson underwent psychological testing which yielded the impression that he had a pattern consistent with Schizoid personality traits but did not formally diagnoses the SM with a personality disorder. Personality traits do not constitute a ratable condition. The SM claimed sleep disturbance to include insomnia which is subsumed under the diagnosis of Major Depressive Disorder, Recurrent, Moderate as diagnosed by the VA and supported by the medical record.

Diagnoses:

1. Major Depressive Disorder (MDD), Recurrent, Moderate (ICD10: F33.1)
2. Generalized Anxiety Disorder (GAD) (ICD 10: F41.1)
3. Irritable bowel syndrome with diarrhea (ICD10 Code: K58.0)
4. Obstructive sleep apnea (ICD10 Code: G47.33)

Recommendations:

The Medical Board recommends that case be referred to the Central Physical Evaluation Board for the above diagnoses. Conditions did not exist prior to entry into the service. This Service Member has received maximum benefit of military medical treatment.

CHAUDHERY.HU

MAJAHAN.13797

38385

Huma Chaudhery, MD
Internist, MEB Division
WRNMMC

MOORE.SHARO

N.K.1522132450

Sharon Moore, MD
Psychiatrist, MEB Division
WRNMMC

PO2 Anderson, Daniel D.

06 November 2017

Page 4

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AR 0024

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1
WASHINGTON.VA.GOV
** FINAL **
Processing time: 54
For DBQ PSYCH Mental disorders Exam

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED]
C-Number: [REDACTED]
DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:
GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]
Bus Phone: [REDACTED]

Entered active service: NOV 1,2005 Last rating exam date:
Released active service: Not specified

Priority of exam: Unknown

Examining provider: 773016
Examined on: SEP 25,2017@09:00

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: SEP 25, 2017@09:00 ENTRY DATE: SEP 25, 2017@11:56:17
AUTHOR: RAVE LANKENAU,MEGAN EXP COSIGNER:
INSTITUTION: WASHINGTON VA MEDICAL CENTER
DIVISION: WASHINGTON VAMC
URGENCY:
STATUS: COMPLETED

Mental Disorders
(other than PTSD and Eating Disorders)
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis; c-file: [REDACTED]
Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?
[X] Yes [] No

SECTION I:

1. Diagnosis

- a. Does the Veteran now have or has he/she ever been diagnosed with a mental disorder(s)?
[X] Yes [] No

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

ICD code: F41.1

If the Veteran currently has one or more mental disorders that conform to DSM-5 criteria, provide all diagnoses:

Mental Disorder Diagnosis #1: Generalized Anxiety Disorder
ICD code: F41.1

Mental Disorder Diagnosis #2: Major Depressive Disorder, Recurrent, Moderate
ICD code: F33.1

Mental Disorder Diagnosis #3: Alcohol Use Disorder, Moderate, in early remission
ICD code: F10.20

b. Medical diagnoses relevant to the understanding or management of the Mental Health Disorder (to include TBI): Irritable Bowel Syndrome, Headaches

2. Differentiation of symptoms

a. Does the Veteran have more than one mental disorder diagnosed?
☒ Yes ☐ No

b. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?
☒ Yes ☐ No ☐ Not applicable (N/A)

If yes, list which symptoms are attributable to each diagnosis and discuss whether there is any clinical association between these diagnoses:

Symptoms of Major Depressive Disorder include chronic suicidal ideation, sad mood, low energy, feelings of helplessness and hopelessness, and anhedonia. Symptoms of Generalized Anxiety Disorder include worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. Symptoms of Alcohol Use Disorder include a maladaptive pattern of substance use, excessive use of alcohol, tolerance, and interpersonal/occupational problems as a result of use.

Continued on next page
VA Form 2507

AR 0027

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 3

C-number: [REDACTED]

Exam Results Continued

- c. Does the Veteran have a diagnosed traumatic brain injury (TBI)?
☐ Yes ☒ No ☐ Not shown in records reviewed

3. Occupational and social impairment

- a. Which of the following best summarizes the Veteran's level of occupational and social impairment with regards to all mental diagnoses? (Check only one)

☒ Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood

- b. For the indicated level of occupational and social impairment, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by each mental disorder?
☐ Yes ☒ No ☐ No other mental disorder has been diagnosed

If no, provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

Symptoms of Major Depressive Disorder and Generalized Anxiety Disorder both significantly contribute to the service member's level of occupational and social impairment, to the extent that it is not possible to tease out how each contributes independently of the other. Symptoms of Alcohol Use Disorder are in early remission.

- c. If a diagnosis of TBI exists, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by the TBI?
☐ Yes ☐ No ☒ No diagnosis of TBI

SECTION II:

Clinical Findings:

1. Evidence Review

Evidence reviewed (check all that apply):

- ☒ VA e-folder (VBMS or Virtual VA)
☒ Other (please identify other evidence reviewed):
 JLV

Continued on next page
 VA Form 2507

AR 0028

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

2. History

a. Relevant Social/Marital/Family history (pre-military, military, and post-military):

The service member grew up in California. His parents divorced when the service member was young and he was raised by his father. He has two sisters with whom he grew up. He also has a half brother and a half sister. He reported that his childhood was unstable; his father was verbally abusive during childhood and "sometimes physically" (abusive).

The service member is single and has never been married. He is not currently dating anyone. No children. Socially, the service member reported that he has one good friend to whom he keeps in touch via text but he has few other social connections. He just started talking to his mother and sisters again this past year, "I've been living in isolation". He is not particularly close with anyone. The service member spends his free time alone, watching TV and doing programming.

b. Relevant Occupational and Educational history (pre-military, military, and post-military):

The service member did not do well in school. He typically got Ds and stated that, "I don't learn that well in school". He denied that he was ever tested for a learning disability. He graduated high school and moved out of state, he tried to go to college and started working. He joined the Navy at age 20.

The service member joined the Navy in November 2005. Rank is E5, rate is cryptologic technician networking. He is currently stationed at Ft. Meade where he has been since August 2012. He has also been stationed in Pensacola, Florida and USS Essex. No combat deployments.

c. Relevant Mental Health history, to include prescribed medications and family mental health (pre-military, military, and post-military):

No history of mental health treatment prior to the period of military service was reported.

The service member first began participating in mental health treatment

Continued on next page
 VA Form 2507

AR 0029

C&P Final Report

Name: ANDERSON, DANIEL DENNIS

Page: 5

For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

in August 2012. He has been in treatment regularly for the last several years. Current medications are Effexor, Rozerem, and Naltrexone. He just completed the Intensive Outpatient Program which he had done for 30 days. He meets with his psychiatrist weekly. He also participates in weekly individual therapy. He was hospitalized in 2015 for 30 days at Ft. Belvoir for inpatient substance abuse treatment. No other psychiatric hospitalizations.

According to the c-file, the service member has been diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder and Alcohol Use Disorder.

- d. Relevant Legal and Behavioral history (pre-military, military, and post-military):

None

- e. Relevant Substance abuse history (pre-military, military, and post-military):

The service member stated that he has been sober for 70 days. Prior to this, he would have approximately 5 ounces of liquor per day and 2 beers daily. He started to drink heavily while he was stationed in Japan. He is currently going to substance abuse treatment at Walter Reed National Military Medical Center.

- f. Other, if any:

None

3. Symptoms

For VA rating purposes, check all symptoms that actively apply to the Veteran's diagnoses:

- ☒ Depressed mood
☒ Anxiety
☒ Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
☒ Chronic sleep impairment

Continued on next page
 VA Form 2507

AR 0030

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- [X] Flattened affect
- [X] Disturbances of motivation and mood
- [X] Difficulty in establishing and maintaining effective work and social relationships
- [X] Difficulty in adapting to stressful circumstances, including work or a worklike setting
- [X] Suicidal ideation
- [X] Obsessional rituals which interfere with routine activities

4. Behavioral observations

The service member reported that he started to have problems with anxiety while on the USS Essex. He stated that he experiences "anticipation anxiety" and he worries about "everything". He is worrying about scheduled appointments, uniform inspections, evaluations, "at the moment, it's been mostly work related". He stated that he picks his hair, he bites his nails, he is often fidgety. He stated that he feels restless, he feels tense and is "stressed out overall". He stated that he worrying 50-70% of the day and he has a hard time controlling the worry.

The service member also endorsed symptoms of depression. He has times when he will sleep most of the day, he will not want to engage in activities. He feels tired, experiences low motivation. He often feels flat and "I try not to think about the things that make me sad...if I do, I start to feel suicidal". He rated his mood at a 3 or 4 on a 10 point scale (with 10 being high). Appetite is low, in part due to medical issues (irritable bowel syndrome). Energy levels are low. He stated that he experiences anhedonia, he has times when he no longer engages in activities but he is trying to do programming more regularly. He reported feelings of helplessness and hopelessness about his life, his future. He stated that he had a time when he felt suicidal, he wondered about the purpose of life, why does he get up every day. He reported ongoing suicidal ideation, but he denied current suicidal plan or intent. He noted that when he is drinking, he experiences more frequent suicidal ideation. He had a suicide attempt at age 16 where he swallowed a bottle of aspirin, but he denied any other suicide attempts.

The service member endorsed sleep disturbances. He has an upcoming sleep study scheduled to rule out sleep apnea. He reported that he typically goes to bed at 10pm; he denied frequent sleep onset problems. Once asleep, the service member wakes up during the night, "there's usually three or four times a night". He might be awake for only "minutes" but he can fall right back asleep. He gets out of bed at 6am. He is bed for 7-8 hours but his sleep is restless. The service member also endorsed mild episodes of sleep paralysis which occur two or three times a week; he stated that it might

Continued on next page
 VA Form 2507

AR 0031

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 7

C-number: [REDACTED]

Exam Results Continued

happen for a few minutes and then he falls right to sleep. He also reported anxiety related nightmares.

5. Other symptoms

Does the Veteran have any other symptoms attributable to mental disorders that are not listed above?
☐ Yes ☒ No

6. Competency

Is the Veteran capable of managing his or her financial affairs?
☒ Yes ☐ No

7. Remarks (including any testing results), if any:

No remarks provided.

Addendum / Clarification
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis; c-file: [REDACTED]

Please utilize this form when responding to VBA requests for either addendums or clarifications of prior VHA examination reports.

Mental health - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?

Continued on next page
VA Form 2507

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 8

C-number: [REDACTED]

Exam Results Continued

☐ Yes ☒ No ☐ N/A

Any changes to his/her health status since DD 2807-1 completed?
☐ Yes ☐ No ☒ N/A

(Proposed) Date of separation from active service: No response provided.

1. Medical record review

Was the Veteran's VA claims file reviewed?
☒ Yes ☐ No

2. Medical history (Review of Systems)

1. Psychiatric:
☒ Yes ☐ No

#1. Claimed Condition: Generalized Anxiety Disorder
Onset: unknown
History: chronic
Prognosis: uncertain

#2. Claimed Condition: Major Depressive Disorder, Recurrent, Moderate
Onset: unknown
History: recurrent
Prognosis: uncertain

#3. Claimed Condition: Mental Health Condition to Include Schizoid
Effect,
Sleep Disturbances to Include Insomnia
Onset: n/a
History:
Prognosis:

#4. Claimed Condition: Sleep Paralysis
Onset: n/a
History:
Prognosis:

(Please follow format if more claims are being addressed)

Continued on next page
VA Form 2507

AR 0033

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 9

C-number: [REDACTED]

Exam Results Continued

PTSD SCREEN PC-PTSD

In your life, have you ever had any experience that was so
 frightening, horrible, or upsetting that, in the past month,
 you:

1. Have had nightmares about it or thought about it when you
 did

not want to?

☐ Yes ☒ No

2. Tried hard not to think about it or went out of your way to
 avoid situations that reminded you of it?

☐ Yes ☒ No

3. Were constantly on guard, watchful, or easily startled?

☐ Yes ☒ No

4. Felt numb or detached from others, activities, or your
 surroundings?

☐ Yes ☒ No

Depression screen: PHQ2

Over the past two weeks, how often have you been bothered by
 any
 of the following problems?

Little interest or pleasure in doing things.
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than
 half
 the days ☒ 3 = Nearly every day

Feeling down, depressed, or hopeless.
☐ 0 = Not at all ☐ 1 = Several days ☒ 2 = More than
 half
 the days ☐ 3 = Nearly every day

Total Point Score: 5

Brief Suicide Risk Assessment

Continued on next page
 VA Form 2507

AR 0034

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 10

C-number: [REDACTED]

Exam Results Continued

- (Perform if score positive on Depression or PTSD screens)

Are you feeling hopeless about the present or future?
☒ Yes ☐ No

Have you had thoughts about taking your life - if yes - when did

you have these thoughts and do you have a plan to take your life?
☒ Yes ☐ No - no current suicidal plan or intent was reported

Have you ever had a suicide attempt?
☒ Yes ☐ No

3. Physical Exam

1. Psychiatric (Specify any personality deviation)
☒ Normal ☐ Abnormal ☐ Not examined

5. Diagnosis:

#1. Claimed condition: Generalized Anxiety Disorder
 Diagnosis/Rationale: Generalized Anxiety Disorder - the service member meets full DSM-5 criteria for this diagnosis

Moderate #2. Claimed condition: Major Depressive Disorder, Recurrent,
 Diagnosis/Rationale: Major Depressive Disorder, Recurrent, Moderate - the service member meets full DSM-5 criteria for this diagnosis

#3. Claimed condition: Mental Health Condition to Include Schizoid Effect,
 Sleep Disturbances to Include Insomnia
 Diagnosis/Rationale: No diagnosos - symptoms of a Mental Health Condition to Include Schizoid Effect, Sleep Disturbances to Include Insomnia can be considered part of the Major Depressive Disorder and Generalized

Continued on next page
 VA Form 2507

C&P Final Report

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

Page: 11

C-number: [REDACTED]

Exam Results Continued

Anxiety Disorder and do not warrant a separate diagnosis

#4. Claimed condition: Sleep Paralysis
Diagnosis/Rationale: No diagnosis - symptoms of Sleep
Paralysis can
be considered part of the Generalized Anxiety Disorder and do not warrant a
separate diagnosis

(for additional Claim/diagnosis, please follow above format)

6. Remarks, if any:

All additional DBQs found to be necessary completed as appropriate at
time
of signing this DBQ?
[X] Yes [] No

/es/ MEGAN K RAVE LANKENAU
PSYCHOLOGIST
Signed: 09/25/2017 11:56

This exam has been reviewed and approved by the examining provider.
VA Form 2507

AR 0036

E



DEPARTMENT OF THE NAVY
CYBER STRIKE ACTIVITY SIXTY THREE
FORT GEORGE G MEADE MARYLAND 20755-6585

1850
Ser N00/017
27 Oct 17

From: Commanding Officer, Cyber Strike Activity SIXTY THREE
To: President, Physical Evaluation Board

Subj: NON-MEDICAL ASSESSMENT (NMA) IN THE CASE OF CTN2 ANDERSON,
DANIEL, XXX-XX- [REDACTED] USN/ACTIVE DUTY

Ref: (a) SECNAVINST 1850.4E, "Department of the Navy (DON) Disability Evaluation Manual," April 30, 2002

1. **PURPOSE:** The Non-Medical Assessment (NMA) is vital to the timely, fair, and transparent determination of whether a Marine or Sailor is Fit (or Unfit) for continued Naval service. The NMA is not a Fitness Report highlighting military character, but is the Commanding Officer's unbiased and accurate comments describing how the medical condition impacts the service member's ability to function within his/her rank and MOS/rating.

a. Part I, the "Questionnaire," collects required facts regarding the service member.

b. Part II, the "Commanding Officer's Comments," is where the PEB relies on the Commanding Officer's comments to explain how the member performs the duties of his/her MOS/Rate with their underlying medical condition(s). The NMA must be signed by the Commanding Officer or acting by direction.

2. **PART I - QUESTIONNAIRE:** The following assessment to assist the PEB in their determination of Fitness/Unfitness in the case of SNM: PO2 ANDERSON, DANIEL, XXX-XX- [REDACTED] USN/ACTIVE DUTY.

a. Service member's MOS/Primary Specialty; Rate/NEC: CTN/0000.

b. Member's current position or assignment: Non-working patient.

c. Is the member currently working outside of his/her specialty because of the medical condition? (Yes ☒ No ☐). If the member is working outside of his/her specialty, could the member perform in his/her rating? (Yes ☐ No ☒.

d. When did the member last pass a "full" PRT/PFT/CFT: March / 2017.

e. Did the member take the most recent PRT/PFT/CFT? (Yes ☐ No ☒ Partial ☐.

• If "No," why didn't the member take the PRT/PFT/CFT? Member's LIMITED DUTY paperwork is being considered for a waiver from PRT.

- If "Partial PRT/PFT/CFT," what events were waived and why? Pending CWG-6 medical waiver review.

f. Member's height and weight: 72in 189lbs. If not within weight standards, what is the member's body fat percentage? N/A.

g. Is the member within weight and body fat standards? (Yes ☒ No ☐). If "No," is the member on an official weight control program? (Yes ☐ No ☐ NA ☒).

h. To your knowledge, is the member fully attending all appointments and complying with all recommended treatments? (Yes ☒ No ☐).

- Has the member complied in the past? (Yes ☒ No ☐).
- If non-compliant, did the appropriate authority advise the member in writing of the medically proper course of treatment, therapy, medication, or restriction? (Yes ☐ No ☐).
- If the member is non-compliant, please explain why. N/A

i. What is the average number of work hours per week that the member's condition required the member to be away from his/her current duties for treatment, evaluation, and/or recuperation? 30 hours.

j. Is the member being processed for separation due to misconduct at a court-martial or administrative separation board proceeding? (Yes ☐ No ☒). [If "Yes," do not submit the case to the PEB until all misconduct proceedings are complete per ref (a) 3203(f)(6) because separation due to misconduct supersedes disability processing. If "No" proceed to paragraph k.]

- If "Yes" to the above, please identify the type of proceeding: ☐ Administrative Separation Board; ☐ Board of Inquiry; ☐ Summary Court-Martial; ☐ Special Court-Martial; or ☐ General Court-Martial and state the expected completion date: _____).
- Has the Commanding Officer notified PERS/MMSR-4 this member is being processed for separation due to misconduct? (Yes ☐ No ☐ NA ☒).
- Does PERS/MMSR-4 request disability processing for this member concurrent to the misconduct proceedings? (Yes ☐ No ☐ NA ☒). (Concurrent Processing requires submission to the ASN (M&RA) for ultimate disposition in accordance with ref (a) 3403(c))

k. What is the member's current length of service and date of entry into active/reserve

- LOS: 11 years / 11 months; ADSD/AFADBD: November / 2005.
- EAOS/EAS: October / 2021.
- Active Duty Years: 11 years / 11 months.
- Reserve Satisfactory Years: N/A.
- Reserve Retirement Eligible (Yes ☐ No ☒).
- Approved Retirement Date (if applicable): N/A.

l. Considering the member's current physical condition, is he/she worldwide assignable? (Yes ☐ No ☒).

m. Does the member have good potential for continued service in his/her present physical and mental condition? (Yes ☐ No ☒). If "No," please explain why not.

Member's medical condition has prompted a review by Department of the Navy Central Adjudication Facility to see if the member can retain his currently level of security clearance, which prevents him from performing the regular duties as a Cryptologic Technician Networks (CTN). Also, the member's current schedule of appointments and required treatment does not allow enough time in the normal course of a week to execute the requirements of his assigned duties.

n. Does the member desire to continue his/her military service; the PEB will not judge the member's request to separate (or remain) as a negative reflection of his/her dedication to serve in the naval service? (Yes ☐ No ☒). (Please personally obtain the member's express desire). The member desires to discontinue his military service.

o. Regarding Permanent Limited Duty (PLD) of active duty members, would you recommend that Naval Personnel Command/Headquarters Marine Corps (MMSR-4) authorize the member's retention on active duty in a Permanent Limited Duty (PLD) status, if found Unfit? (Yes ☐ No ☒).

- Has the member ever served in a PLD status? (Yes ☐ No ☒.
- Do you recommend PLD unconditionally? (Yes ☐ No ☒); or
- Do you recommend PLD only to complete retirement eligibility? (Yes ☐ No ☒ NA ☐); or
- Do you recommend PLD only to complete EAS? (Yes ☐ No ☒ NA ☐.
- If "No" to any of the PLD recommendations above, please explain why.

p. Has the member ever forward deployed in support of Operation Enduring Freedom, Operation Iraqi Freedom, or other Combat Operations? (Yes ☐ No ☒.

q. For Combat Zone determination purposes, did the member's injury occur in a combat-zone tax exclusion area as defined in DoD Financial Management Regulation, Vol. 7A, Chapter 44, Section 440103(a) [Available at <http://www.defenselink.mil/comptroller/fmr/>]? (Yes ☐ No ☒.

- If "Yes," please state where and how the injury or illness occurred. Additionally, please state what document(s) identify the geographic location of the member's injury.

r. For Combat-Related determination purposes, did the cause of the member's injury occur:

- (i) as a direct result of armed conflict, (Yes ☐ No ☒.
- (ii) while engaged in extra hazardous service, (Yes ☐ No ☒.
- (iii) under conditions simulating war; (Yes ☐ No ☒.
- (iv) by an instrumentality of war. (Yes ☐ No ☒.

- If "Yes," to any of the above, please state where and how the injury or illness occurred. Additionally, please state what document(s) identify the cause of the member's injury. N/A

s. Please provide the member's Defense Travel Service (DTS) Agency Program Coordinator's (APC) name Jim Potter; phone: 667-812-2258; and email jepotte@nsa.gov.

3. **PART II – COMMANDING OFFICER'S COMMENTS:** The NMA is a critical element of the Physical Evaluation Board's (PEB) adjudication. The PEB relies on your comments to explain how your Marine/Sailor's medical condition impacts his/her ability to perform the duties of his/her MOS/Rate, and the resulting impact on the command. Please note, the NMA is not an evaluation for promotion, and remains in the member's medical record. To ensure a comprehensive NMA, you must comment on all of the member's referred medical conditions and you are encouraged to comment on any of the member's VA claimed conditions. Please use additional pages as necessary.

a. The Commanding Officer submits the following comments so the PEB can make determination of Fitness/Unfitness for this member: PO2 ANDERSON, DANIEL, XXX-XX-
USN/ACTIVE DUTY.

b. How does the medical condition(s) impact the member's work capacity in relation to his/her MOS/RATE? (MOS/RATE requirements can be found in MCO 1200.17A (4 Jun 09) for Marines; Volume 1 of NAVPERS 18068F October 2010 for Sailors).

Upon receipt of CTN2 Anderson's LIMDU paperwork and July 2017 NJP, assigned Special Security Officer (SSO) recommended and I endorsed service member's TS/SCI classified access and classified facility access badge be suspended, Security Access Eligibility Report (SAER) released, and process initiated for DoD Clearance Adjudication Facility (CAF) to determine if he should maintain a clearance. Final outcome of this decision is pending. The conditions listed in his LIMDU paperwork and the extensive range of medical appointments CTN2 Anderson's medical practitioners have recommended/assigned for his treatment prevent him from conducting his assigned mission for his MOS/RATE. Specifically, not having classified material/facility access prevents him from conducting his assign mission. Should his clearance be revoked, he would likely be required to cross-rate.

c. Include an explanation on what Mission Essential Tasks the member substantively can or cannot do regarding the primary duties of his/her MOS/Rate.

Without TS/SCI classified access and with his classified facility access badge suspended, Security Access Eligibility Report (SAER) released, and DoD Clearance Adjudication Facility (CAF) assessment for clearance eligibility pending, CTN2 Anderson is currently limited in his ability to complete primary duties assigned of his MOS/Rate and is unable to complete Mission Essential Tasks associated with his MOS/Rate. He is however, contributing approximately 10 hours weekly in a general mission capacity that is not specific to his MOS/Rate outside of classified facilities at this time.

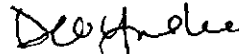
d. Submit Performance Evaluations/Fitness Reports (or Proficiency & Conduct Marks) for the two years immediately prior to the date the MEB was initiated.

14NOV16-15NOV15-Promotable, 15NOV16-16SEP01-Early Promote, 16SEP02-16NOV15-Non-observed, 16NOV16-17JUL20-Significant Problems.

e. Submit any pertinent information in reference to line of duty determinations and investigations that affect the member's unfitting condition(s).

Upon receipt of CTN2 Anderson's LIMDU paperwork and July 2017 NJP, assigned Special Security Officer (SSO) recommended and I endorsed service member's TS/SCI classified access and classified facility access badge be suspended, Security Access Eligibility Report (SAER) released, and process initiated for DoD Clearance Adjudication Facility (CAF) to determine if he should maintain a clearance. Final outcome of this decision is pending.

4. CONTACT INFO. For follow-on questions concerning this NMA, the POC at this command is Herbert M. Lamb, CTNCM, Command Senior Enlisted Leader, Cyber Strike Activity SIXTY THREE; (Commercial) 443-479-6065; hmlamb@cybercom.mil (email).


D. B. YUSKO

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

MEDICAL RECORDFor
Anderson, Daniel Dennis**Report Criteria**From: [REDACTED] 1985 To: 30 Oct 2017
Operator: Everett, Kalena D
Created On 30 Oct 2017 10:40:27
at WRNMMC

Comprehensive Information Report; EXCLUDE HIV Lab Results: Requested

Report Summary

Sections	Domain Requested	Record Counts	Warnings
Allergies			
Problems			
Diagnosis History			
Medications			
Procedures			
Family History			
Resulted Labs			
Radiology			
Immunizations			
Previous Encounters	✓	345	0
Clinical Notes			
Vitals			
			*0

**Report generated with no warnings.*

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Table Of Contents

MEDICAL RECORD	1
Report Criteria.....	1
Report Summary	1
Table Of Contents	2
Demographics	9
Previous Encounters.....	10
24 Oct 2017 at WRNMMC, Sleep (Pulm) CI Be by KHRAMTSOV, ANDREI N	10
20 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	12
20 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G.....	15
19 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	17
18 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J	20
18 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.....	23
18 Oct 2017 at WRNMMC, Psychiatry Be by TEKELENBURG, JAAP.....	24
17 Oct 2017 at WRNMMC, Int Med CL E Medical Home BE by MEYERS, NANCY	25
16 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	31
16 Oct 2017 at WRNMMC, Immunization Clinic Be by AGUGLIARO, ANTHONY J.....	34
16 Oct 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	35
16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	36
16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	37
13 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	39
13 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G.....	42
12 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	44
12 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	49
11 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A	51
11 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	54
11 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J	56
11 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.....	58
10 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A	60
06 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A	62
06 Oct 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B.....	64
05 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE.....	65
05 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A	67
05 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	71
04 Oct 2017 at WRNMMC, Sleep (Pulm) CI Be by KHRAMTSOV, ANDREI N	74
04 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	75
04 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	78
04 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	79
04 Oct 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY.....	84
03 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	86
02 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	88
02 Oct 2017 at WRNMMC, Sleep (Pulm) CI Be by KHRAMTSOV, ANDREI N	91
29 Sep 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E.....	99
29 Sep 2017 at WRNMMC, GI Proc CI BE by DAMIANO, MARK N.....	100
29 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	103
28 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	104
27 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	106
27 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	108
27 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	117
26 Sep 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S.....	122
26 Sep 2017 at WRNMMC, Int Med CL F Medical Home BE by ROBINSON, TYRONE L	124
25 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	128

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	133
22 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	134
22 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	137
21 Sep 2017 at WRNMMC, GI Clinic Bethesda by BELLE, LAVERN S	142
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	144
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	148
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	151
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	155
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G	158
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	162
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	163
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	166
19 Sep 2017 at WRNMMC, GI Clinic Bethesda by BHUSHAN, ANITA	170
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	173
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	176
19 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	181
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	182
18 Sep 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B	186
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	187
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	192
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	195
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	200
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	203
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	207
14 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	212
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	213
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	217
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	220
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	225
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	230
13 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	234
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	235
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	238
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	243
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	246
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	249
11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	253
11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	256
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by GRAGNANI, CYNTHIA T	260
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	261
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	265
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	267
08 Sep 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R	271
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	276
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	280
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	282
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	285
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	288
06 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	292
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	300
05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	304
05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	308
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	313
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	316
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	318

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	322
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	325
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	328
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	332
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	334
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	338
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	341
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	344
22 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	352
22 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	353
14 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	358
14 Aug 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	363
14 Aug 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.	365
10 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	366
09 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	367
08 Aug 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	368
07 Aug 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN	376
31 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	380
27 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	381
27 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN	386
27 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	390
25 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	398
20 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	399
18 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	401
18 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	409
13 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	414
12 Jul 2017 at WRNMMC, Integrative Hlth & Well BE by THOMAS, LAUREN A.....	421
10 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	423
10 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	431
10 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	433
07 Jul 2017 at WRNMMC, Psychiatry Be by WISE, JOSEPH E	438
07 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by MEADOR, KRISTINE P	440
06 Jul 2017 at WRNMMC, Psychiatry Consult Liaison Be by WORKS, LINDSAY K	441
06 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	445
27 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	447
21 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by FINK, CAITLIN M.....	452
19 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	454
16 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by NICHOLAS, LUKE C	459
13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	461
13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	462
12 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	467
08 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	475
07 Jun 2017 at WRNMMC, Allergy Clinic Bethesda by PETERSEN, MAUREEN MICHELE	476
06 Jun 2017 at WRNMMC, Int Med CL C Medical Home BE by SMITH, MICKALYNN J	481
01 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	482
25 May 2017 at WRNMMC, Allergy Clinic Bethesda by BANKS, TAYLOR ALLEN	484
23 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	487
22 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	489
17 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	490
16 May 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	495
16 May 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN.....	500
19 Apr 2017 at WRNMMC, Int Med CL F Medical Home BE by SMITH, MICKALYNN J	508
13 Apr 2017 at WRNMMC, GI Clinic Bethesda by WONG, ROY KWOCK.....	509
05 Apr 2017 at WRNMMC, Medical Readiness Clinic Bethesda by RENTA, DANA K.....	512
16 Mar 2017 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	522

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

01 Mar 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	523
01 Mar 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	528
08 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R.....	536
02 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R.....	539
01 Feb 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	542
01 Feb 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	547
04 Jan 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	555
04 Jan 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	560
06 Dec 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN	568
05 Dec 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	573
28 Nov 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	581
15 Nov 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN	582
24 Oct 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	589
11 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	597
04 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	599
28 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	606
08 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	614
06 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	615
25 Aug 2016 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M.....	622
23 Jun 2016 at WRNMMC, Int Med CL C Medical Home BE by ATCHERSON, KATHY A.....	626
22 Jun 2016 at WRNMMC, GI Clinic Bethesda by KWOK, RYAN M	627
15 Jun 2016 at WRNMMC, GI Clinic Bethesda by SHAH, NISHA AMISH	628
07 Jun 2016 at WRNMMC, Otolaryngology Clinic Bethesda by XYDAKIS, MICHAEL S	629
11 May 2016 at WRNMMC, GI Clinic Bethesda by LACZEK, JEFFREY T	631
22 Apr 2016 at WRNMMC, Medical Readiness Clinic Bethesda by TACKIE, DIANE A	635
18 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	644
12 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	648
11 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	651
05 Apr 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J.....	654
07 Mar 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J	656
29 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R.....	658
24 Feb 2016 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL	661
19 Feb 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J.....	663
16 Feb 2016 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	665
16 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by WILSON, BRYAN J	666
04 Feb 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P.....	669
02 Feb 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	670
19 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	673
13 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	676
08 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	677
06 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	678
05 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	679
29 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	682
22 Dec 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	685
15 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	687
14 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	689
08 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	690
08 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	691
01 Dec 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES.....	693
24 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	695
20 Nov 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P.....	697
17 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	698
12 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	700
10 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	702
09 Nov 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R.....	705

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

03 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	708
03 Nov 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	711
27 Oct 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	715
01 Oct 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	718
30 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by FALKNER, RACHEL E	723
29 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA	725
29 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL	726
28 Sep 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	729
23 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M	734
18 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA	736
15 Sep 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	737
09 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by CORSO, MEGHAN L	739
08 Sep 2015 at WRNMMC, Int Med Cons/Spec Care Cl Be by FIACCO, NICHOLAS RYAN	740
27 Aug 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	742
25 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	746
18 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	748
11 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	750
11 Aug 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	752
28 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	756
21 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	758
15 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	760
08 Jul 2015 at WRNMMC, Dermatology Clinic Bethesda by TAYLOR, BRADLEY MICHAEL	762
30 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	764
26 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	766
25 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	767
23 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	768
22 Jun 2015 at WRNMMC, Dermatology Clinic Bethesda by STEARNS, LAUREL R	770
16 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	773
11 Jun 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	775
09 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	779
02 Jun 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	781
27 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	784
22 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	786
21 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	788
20 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	789
18 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	792
18 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	795
15 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	797
14 May 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	799
13 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	804
11 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	807
11 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	809
08 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	811
07 May 2015 at WRNMMC, Int Med CL C Medical Home BE by ARGUINZONI, JUAN B	813
06 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	817
06 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	819
05 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	821
04 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	822
04 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	824
01 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	826
30 Apr 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	828
29 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	830
28 Apr 2015 at WRNMMC, Medical Readiness Clinic Bethesda by PARSON, MARSHEA S	832
27 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	843
23 Apr 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	845

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

22 Apr 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	855
23 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	857
20 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	859
19 Mar 2015 at WRNMMC, Substance Abuse NY by ARITA, ANTHONY A	861
17 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	865
30 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	867
23 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	874
22 Oct 2014 at WRNMMC, FLU CI Ki by JORDAN, TIMOTHY W	881
16 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	883
07 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by RINIS, DONNA L	890
01 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	895
26 Sep 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	896
25 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	900
24 Sep 2014 at WRNMMC, Orthotics & Prosthetics Srv Be by ANDERSON, PETER P	911
24 Sep 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	912
18 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	915
11 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	922
21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	929
21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	930
08 Aug 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	931
04 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	933
27 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by YORK, CARLA M	941
27 Jun 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	944
16 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M	947
16 Jun 2014 at WRNMMC, Int Med CL A Medical Home BE by CLARK, THOMAS S	952
04 Jun 2014 at WRNMMC, Int Med Cons/Spec Care CI Be by DOUGHERTY, DIANA L	954
30 May 2014 at WRNMMC, AMH M01A Red Ki by COLEMAN, AUDREY G	956
19 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O	958
06 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O	965
30 Dec 2013 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	973
07 Aug 2013 at WRNMMC, AMH M01A Red Ki by SLOAN, DAWN M	974
05 Aug 2013 at WRNMMC, Immunization Kimbrough by WRAY, KIM D	979
10 Apr 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	980
21 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR	985
19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR	986
19 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR	988
28 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	990
30 Nov 2012 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	994
05 Nov 2012 at WRNMMC, AMH M01B Blue Ki by DING, YIMING	998
24 Oct 2012 at WRNMMC, FLU CI Ki by AHLTA SYSTEM ADMINISTRATOR	1002
23 Oct 2012 at WRNMMC, GI Inflam Bowel Dis Be by COPSEY, HELEN C	1004
12 Oct 2012 at WRNMMC, Wounded Warrior GWOT by AGOSTO, ROBERT	1011
14 May 2012 at NH Pensacola FL, Corry MHP by BRADLEY, RACHAEL NAOMI	1012
10 May 2012 at NH Pensacola FL, Corry MHP by GUNTER, ROGER WILLIAM	1016
06 Mar 2012 at NH Pensacola FL, Readiness Center by TREVEN, LAUREN A	1019
02 Nov 2011 at NH Pensacola FL, Corry MHP by GRIMM, CHRISTOPHER T	1021
07 Oct 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1022
27 Jul 2011 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	1025
26 Jul 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T	1028
06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1030
06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1032
04 May 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1035
26 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1038
22 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1040
21 Apr 2011 at 81st Medical Group, Refractive Surgery by ROPP, CORBY D	1042

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Mar 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	1046
17 Mar 2011 at NH Pensacola FL, Pulmonary Function Lab by LEWIS, CHRISTOPHER T	1048
16 Mar 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	1052
17 Feb 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	1056
16 Feb 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T	1059
08 Feb 2011 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S	1062
24 Jan 2011 at NH Pensacola FL, Corry Prime Care by WIEDL, ERICA KITCHELL	1065
24 Nov 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	1068
15 Nov 2010 at NH Pensacola FL, Corry Prime Care by WILLIAMS, TREVOR MICHAEL	1073
13 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	1074
04 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	1079
28 Sep 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	1080
01 Sep 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	1083
25 Aug 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P	1086
20 Jul 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P	1089
14 Jun 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	1093
21 Apr 2010 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	1096
17 Mar 2010 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S	1100
09 Mar 2010 at NH Pensacola FL, Corry Prime Care by THOMAS, JOSHUA L	1102
22 Dec 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	1104
23 Sep 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	1105
16 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM	1107
20 Aug 2009 at NH Pensacola FL, Corry Prime Care by HEDARIA, ELIZABETH A	1109
07 May 2009 at NH Pensacola FL, Corry Health Promotion And Wel by LINVILLE, TREVOR S	1111
06 Mar 2006 at NH Pensacola FL, NATTC MHP by MAYNARD, PENELOPE A	1112

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 8

AR 0051

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Demographics

Name: Anderson, Daniel Dennis

SSN: ***-**-****

DoD ID: 1286180538

FMP/Sponsor SSN: 20/***-**-****

Date of Birth: [REDACTED] 1985

Sex: M

Race: White

Marital Status: Single, Never Married

Branch: N11 - United States Navy (USN) Active Duty (AD)

Rank: PETTY OFFICER SECOND CLASS (E5)

Medicare:

Religion: No Preference

PCM Location: 87832-HP0067

Addresses:

[REDACTED]

....

GLEN BURNIE, MD [REDACTED]

***** End of Demographics *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Previous Encounters**24 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N**

Encounter ID: BETH-30067722 Primary Dx: Obstructive sleep apnea (adult) (pediatric)

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **24 Oct 2017 1021 EDT**
Clinic: **SLEEP (PULM) CL BE**Appt Type: **PROC**
Provider: **KHRAMTSOV, ANDREI N.**Reason for Appointment: Written by ANDRADA, TEOTIMO F @ 24 Oct 2017 1021 EDT
psg interpretationA/P Last Updated by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT**1. Obstructive sleep apnea (adult) (pediatric)**

Procedure(s): -Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older x 1 (26-PROFESSIONAL COMPONENT)

Disposition Last Updated by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT

Released w/o Limitations

Follow up: as needed .

Note Written by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT**Walter Reed National Military Medical Center****Sleep Disorders Center**8901 Rockville Pike
Bethesda, MD 20889
Phone: 301-295-4547 Fax: 301-319-8197**Patient Name:** Anderson, Daniel**SSN:** [REDACTED]**Study Date:** 10/4/2017**Scorer:** L. Davis, RPSGT**Referring Provider:** Dr. Khramtsov**POLYSOMNOGRAM REPORT****Technical Description:**

Physiologic data were collected using a computerized Sensormedics polygraph interfaced with Somnostar Z4 amplifiers. The recording montage consisted of central, frontal and occipital EEG, EOG, chin EMG, thermocouple and pressure transducer airflow, chest and diaphragmatic movement, combined leg EMG, tracheal sounds and pulse oximetry. The patient was monitored throughout the study via infrared CCTV and recorded for review. Respiratory events and limb movements were scored according to *The AASM Manual for the Scoring of Sleep and Associated Events, Version 2.3*.

Polysomnographic Data:

The patient took 3mgs Eszopiclone prior to the study. The study duration was 419.5 minutes. The recorded total sleep time was 367.5 minutes with a sleep efficiency of 87.6%. The patient's latency to sleep was 16.5 minutes. The REM latency was 174.5 minutes. Sleep stage distribution revealed 12.9% Stage N1, 58.1% Stage N2, 16.1% Stage N3, 12.9% Stage REM and wake after sleep onset was 35 minutes. There were 100 arousals and 0 awakenings resulting in a total arousal index (TAI) of 16.3/hour of sleep.

There were 0 apneas (0 obstructive, 0 centrals, 0 mixed) and 37 hypopneas with an **apnea hypopnea index(AHI) of 6./hour**. The apnea hypopnea index during supine sleep(88 minutes) was 19/hour and 2/hour during non-supine sleep(280 minutes). The hypopnea index was 6./hour. The Central apnea index was 0/hour. Hypopneas were scored using nasal pressure signal drop by at least 30% followed by arousal or 3% oxygen desaturation..

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 10

AR 0053

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Oxygen saturation was normal at baseline. Oxygen saturation remained between 86% and 97% with mean value of 95% throughout the study. During the study the oxygen saturation was below 90% for 1 percent of the total sleep time. The average heart rate was 73 beats per minute. There were 0 PLMS and 0 PLMS with arousals with a PLMS index of 0/hour and a PLMS arousal index of 0/hour.

Medical Interpretation:

The patient underwent a Diagnostic PSG: Epworth Sleepiness Scale was 20/24. Sleep efficiency was good and there was adequate total sleep time to establish a diagnosis. Sleep architecture was disrupted. The patient had an AHI consistent with mild sleep apnea. The EKG did not demonstrate arrhythmias.

Diagnosis:

1. Obstructive Sleep Apnea(G47.33)

Suggestions for Clinical Care:

1. AutoPAP titration with pressures of 6-15 cm H2O and close clinical follow up.
2. Recommend sleeping in the lateral position, obtaining 7-8 hours of sleep per night, avoid of alcohol or other sedatives and maintaining an ideal body weight as these can improve sleep quality.
3. The patient should be counseled- as is done with all patients directly seen at this SDC- not to engage in any hazardous activities (such as driving) if excessively sleepy. Such sleepiness is to be reported to their physicians for further evaluation and treatment.

Interpreted by:

Andrei Khramtsov, MD
Diplomate, Sleep Medicine
Staff Physician, Sleep Disorders Center
WS#:5

Signed By **KHRAMTSOV, ANDREI N** (Staff Physician, Sleep Disorders Center, WRAMC) @ 24 Oct 2017 1042

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-30033585 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **20 Oct 2017 1237 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 20 Oct 2017 1245 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH	1 of 1	06 Jun 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 12

AR 0055

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2			18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Oct 2017 1237 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 20 Oct 2017 1239 EDT
History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.
Procedure: MT 120%. TMS Treatment for depression session #13 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.10 minutes. A procedural time out was done during which settings and patient was re-identified.
PROGRESS IN MEETING GOALS:
This is session # 13 with MT level at therapeutic treatment level for entire session.
Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided today will be SM last TMS appointment, as SM will be away on training for some time. ZUNG depression = 45, PHQ 9=13.

S/O Note Written by LANDE, RAYMOND G. @ 20 Oct 2017 1245 EDT

Reason for Visit

Visit for: Attending Note: A procedural time out was done during which settings and patient was re-identified.
45 minutes
Purpose of visit was for session of Transcranial Magnetic Stimulation. SM is receiving treatment for depression.
Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.
Patient arrived for TMS without evidence of distress. Confirmed that there was no metal above the neck. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes. WRNMMC PAO with SM's permission in room.
Objective
Plan: SM next session scheduled.

A/P Last Updated by LANDE, RAYMOND G. @ 20 Oct 2017 1247 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Last Updated by LANDE, RAYMOND G. @ 20 Oct 2017 1248 EDT**Released w/o Limitations****Follow up:** in the PSYCH DAY HOSP BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 20 Oct 2017 1248Note Written by BRAGGS, DEBORAH C. @ 20 Oct 2017 1333 EDT(Added after encounter was signed.)**nursing note**

SM enrolled for TMS for anxiety due to reports of reoccurrence of panic attacks. SM enrolled in TMS due to treatment resistant depression. SM start date for TMS was 9/12/17. SM end date for TMS 10/20/17. SM had #13 treatments for depression with at therapeutic level. SM had #10 for anxiety. SM will continue to follow up with outpatient behavioral health for behavioral health care. SM offers no c/o pain and no distress note.

PHQ 9=scores	GAD 7=scores	ZUND depression=scores	ZUNG anxiety=scores
	9/15=18		9/15=4
	9/22=15		9/22=50

10/6=15	10/6=51
10/13=16	10/13=56
10/20=13	1/20=45

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 14

AR 0057

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G

Encounter ID: BETH-30033488 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **20 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **HARDIN, JAMES G**

Reason for Appointment:

IOP

Appointment Comments:

etc

S/O Note Written by FOBIZSHI, MACANGELO M @ 23 Oct 2017 0621 EDT**History of present illness**

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Encounter Background Information: Creative Art Therapy Group
 Group 1115 - 1200:
 S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The Instructor explained how poetry could be used as a platform to express emotions and thoughts. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.
 O: Group member reported on time. SM was interactive in the group.
 Behavior: Appropriate
 Psychosis: None evident
 Speech: WNL
 Thoughts: Clear, organized
 Mood: Positive
 Affect: Congruent
 SI/Hi: None expressed
 Pain: None indicated
 A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/Hi. P: SM will continue group next week.

S/O Note Written by HARDIN, JAMES G @ 25 Oct 2017 1015 EDT**History of present illness**

The Patient is a 32 year old male.
 Process group: 0730-0845
 Focus of Session: weekend planning, role of sponsors
 S) The group discussed their plans for the weekend and the need to keep their time structured. We talked about the dangers of boredom and too much free time. Members talked about their relationships with others in the self-help community and the role of sponsors. SM fully participated in the discussion.
 O) Appearance: normal Behavior: Appropriate
 Speech: WNL Thoughts: WNL
 Mood: calm Affect: consistent
 Insight: fair Judgment: fair
 SI/Hi: None Current Med/Pain Issues: None
 A) SM was invested in group today.
 P) Next process group will be same time Monday.

Note Written by RAGLAND, MARY @ 24 Oct 2017 0725 EDT**Educational Group: Recovery Toolbox****Session #5: Sponsorship in Community Recovery Support Groups**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 15

AR 0058

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S: Psychoeducation re: what is sponsorship, how does one obtain a sponsor, ways to work with a sponsor for recovery. Participants discussed prior experiences with sponsors.

O: SM arrived on time for group.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/Hi: None

Med/Pain Issues: None

A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.

P: SM will attend next group as scheduled.

A/P Last Updated by HARDIN,JAMES G @ 25 Oct 2017 1016 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HARDIN,JAMES G @ 25 Oct 2017 1016 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse Program, WRAMC) @ 25 Oct 2017 1016

Note Written by DELEON,PATRICK D. @ 25 Oct 2017 1042 EDT

(Added after encounter was signed.)

S: Intensive Outpatient Program Seeking Safety group, topic "Honesty." Time 1000-1100. Discussion of the role of honesty in recovery, ways in which honesty gets impacted in active substance abuse, and situations which make honesty more difficult. Particular discussion of honesty with children and with therapists, and both the difficulties and benefits of open direct communication when emotions are high. SM actively engaged in group discussion, processed difficulties with AA, spoke about feeling judged and that things get oversimplified in AA. Peers and this SW acknowledging 'absolute' talk in AA while also reframing that as having basic principles which are helpful in time of crisis, and that can be explored more fully and individually in treatment and/or with sponsor.~

O: Client arrived on time to session. Alert and oriented x 3.~

Appearance: Appropriate~

Behavior: Appropriate~

Speech: Within Normal Limits~

Thoughts: Logical, linear, goal-directed~

Mood: Depressed~

Affect: Congruent~

Insight: Fair~

Judgment: Fair~

SI/Hi: None reported~

Med/Pain Issues: Irritable Bowel Syndrome~

A: SM active participant in group, open to feedback~

P: Continue in Intensive Outpatient Program, next Seeking Safety group 23 Oct

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 16

AR 0059

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

19 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-30017293 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **19 Oct 2017 1158 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites Refreshed by LANDE, RAYMOND G. @ 19 Oct 2017 1321 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 17

AR 0060

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: ***-**-****	DoD ID: 1286180538	Created: 30 Oct 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2				18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3				10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3				10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1				28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active				NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active				NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Oct 2017 1158 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 19 Oct 2017 1223 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #12 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 12 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 19 Oct 2017 1318 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:35-13:20).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 22/ # 12 at 120% MT.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Written by LANDE,RAYMOND G. @ 19 Oct 2017 1325 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 19 Oct 2017 1326

CHANGE HISTORY

The following Disposition Note Was Overwritten by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT:

The Disposition section was last updated by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT - see above. Previous Version of Disposition section was entered/updated by LANDE, RAYMOND G. @ 19 Oct 2017 1321 EDT.

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J

Encounter ID: BETH-30002526 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 Oct 2017 1325 EDT**
 Clinic: **PAIN MGMT CL BE**

Appt Type: **FTR**
 Provider: **SPEVAK, CHRISTOPHER J**

AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 18 Oct 2017 1325 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING	NR	16 Oct 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: ***-**-****	DoD ID: 1286180538	Created: 30 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	#0 RF0 TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1			
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2			
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1			
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3			
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1			
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2			
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR		14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR		05 Oct 2015

A/P Written by SPEVAK,CHRISTOHER J @ 18 Oct 2017 1326 EDT

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Disposition Written by SPEVAK,CHRISTOHER J @ 18 Oct 2017 1327 EDT

Released w/o Limitations

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By SPEVAK, CHRISTOHER J (Physician) @ 18 Oct 2017 1327

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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AR 0065

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-29999838 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **18 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **DELEON, PATRICK D.****Reason for Appointment:**

IOP

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 18 Oct 2017 1146 EDT**History of present illness**The Patient is a 32 year old male.
SM was not in Finding Meaning Group 1000-1045.**S/O Note Written by DAVIS, KRISTEN KATHLEEN @ 18 Oct 2017 1338 EDT****History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group 0730 - 0845

S: Topics discussed: Introductions, feeling words, and six categories of emotion. Group members described how they are feeling and where these feelings would fall in the six categories (mad, glad, sad, hurt, afraid and guilt/shame). SM identified feeling mad/sad for having to work last night and glad that the process is moving along for him to sell his house. SM helped orient new members when making introductions.

O: SM arrived late to group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Stable

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM participated appropriately in discussion. SM demonstrates commitment to sobriety/recovery.

P: SM will continue with groups as assigned.

Note Written by RAGLAND, MARY @ 19 Oct 2017 0959 EDT**Mind-Body Group, Session #4: Yoga 1100-1155****SM did not attend this group.****A/P Written by DELEON, PATRICK D. @ 23 Oct 2017 0729 EDT****1. Alcohol dependence, uncomplicated F10.20**

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON, PATRICK D. @ 23 Oct 2017 0730 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic. - Comments: Continue in Intensive Outpatient Program, next groups 20 Oct

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 23 Oct 2017 0730

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 23

AR 0066

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Oct 2017 at WRNMMC, Psychiatry Be by TEKELENBURG, JAAP

Encounter ID: BETH-29990523 Primary Dx: Encounter for other administrative examinations

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **18 Oct 2017 0627 EDT**
Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
Provider: **TEKELENBURG,JAAP**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by TEKELENBURG,JAAP @ 18 Oct 2017 0627 EDT
Care coordination

S/O Note Written by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT

Subjective

L/m at 0625 to notify of facility cancelled appointment for today at 0900 with Dr. Paul. Next scheduled appointment is 25 October at 0800. Please call for additional assistance 301-295-0500.

A/P Last Updated by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT

1. Encounter for other administrative examinations

Disposition Last Updated by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT
Referred for Appointment

Signed By TEKELENBURG, JAAP (Nurse) @ 18 Oct 2017 0629

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

17 Oct 2017 at WRNMMC, Int Med CL E Medical Home BE by MEYERS, NANCY

Encounter ID: BETH-29976219 Primary Dx: Unspecified asthma, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **17 Oct 2017 0915 EDT**
 Clinic: **INT MED CL E MEDICAL HOME
 BE**

Appt Type: **FTR**
 Provider: **MEYERS,NANCY NMN**

Reason for Appointment:

Cats Allergies, Asthma

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by TASHU,BIRTUKA A @ 17 Oct 2017 0937 EDT

BP: 141/93 Right Arm, HR: 98, RR: 18, T: 99.6 °F, HT: 69 in, WT: 78.6 kg, SpO₂: 96%, BMI: 25.59,
 BSA: 1.944 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 3/10 Mild,
 Pain Scale Comments: Pt stated that he has asthma/ cat allergies & irritable bowel pain. repeat b/p on left arm 131/93
 Comments: + Depression / Anxiety

Neg suicidal.

S/O Note Written by TASHU,BIRTUKA A @ 17 Oct 2017 0919 EDT**Chief complaint**

The Chief Complaint is: Asthma/ cat allergies & irritable bowel pain.

History of present illness

The Patient is a 32 year old male.

Pain Severity 3 / 10.

Pain assessment

Location: irritable bowel pain

Duration: chronic

Quality: 3/10

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

Allergies

Allergies Verified and Updated on 17 Oct 2017

NKDA

Current medication

Medication Review on 17 Oct 2017

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 25

AR 0068

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Photorefractive keratectomy
Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

S/O Note Written by MEYERS,NANCY NMN @ 17 Oct 2017 0957 EDT**Chief complaint**

The Chief Complaint is: Abdominal discomfort, request pulmonary referral.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Presents for referral pumony. VA has requested pt document allergy to cats as manifest by wheezing, and difficulty breathing.

Treated effectively with albuterol

Presently with and pain and bloating related to IBS

Notes from GI, lab and rad studies reviewed.

Last colo 2012.

Pt currently drinking a cup coffee which he stated he needed to drive

Had formed BM this morning

Denies nausea

Has used Levsin without improvement, attempts to maintain FODMAP diet.

Recently started on cymbalta.

Pain Severity 3 / 10.

Pain assessment

Location: abdominal

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

What makes it worse:

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Cymbalta 60 qd
 Probiotic one packet po daily
 Simethicone 80 mg po qid prn
 Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history
 IBS-D
 Generalized anxiety disorder
 Major depressive disorder
 ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 Photorefractive keratectomy
 Jaw surgery

Personal history

Social history reviewed Tobacco – none

Alcohol – none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M – Well

F – DM. MI / stent at age 40. Melanoma.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2.

Abdomen:

Visual Inspection: • Abdomen was distended.

Auscultation: • Bowel sounds were not diminished or absent.

Palpation: • Abdominal tenderness/tenderness with palpation. • No abdominal guarding. • No mass was palpated in the abdomen.

Test conclusions

Medication list was updated at the beginning of the visit.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 27

AR 0070

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Lab Result Cited by MEYERS,NANCY @ 17 Oct 2017 0952 EDT

Comprehensive Metabolic Panel	Site/Specimen	06 Jul 2017 1520
Albumin	SERUM	5.0
Alkaline Phosphatase	SERUM	61
Alanine Aminotransferase	SERUM	39
Bilirubin	SERUM	0.5
Urea Nitrogen	SERUM	9.0
Calcium	SERUM	10.5 (H)
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.96
Glucose	SERUM	87
Potassium	SERUM	4.3
Protein	SERUM	7.8
Sodium	SERUM	141
Anion Gap	SERUM	14
GFR Calculated Non-Black	SERUM	104.2
GFR Calculated Black	SERUM	120.4 <i>
Aspartate Aminotransferase	SERUM	26

Lab Result Cited by MEYERS,NANCY @ 17 Oct 2017 0951 EDT

CBC W/Diff	Site/Specimen	06 Jul 2017 1520
WBC	BLOOD	6.6
RBC	BLOOD	4.53
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	41.9
MCV	BLOOD	92.5
MCH	BLOOD	31.8
MCHC	BLOOD	34.4
RDW CV	BLOOD	12.3
Platelets	BLOOD	284
MPV	BLOOD	10.5
Neutrophils	BLOOD	63.3
Lymphocytes	BLOOD	26.9
Monocytes	BLOOD	8.3
Eosinophils	BLOOD	0.5
Basophils	BLOOD	0.5
ABS Neutrophils	BLOOD	4.2
ABS Lymphocytes	BLOOD	1.8
ABS Monocytes	BLOOD	0.6
ABS Eosinophils	BLOOD	0.0
ABS Basophils	BLOOD	0.0
Nucleated RBC/100 WBC	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED
Granulocytes Immature	BLOOD	0.5
Absolute Immature Granulocytes	BLOOD	0.03

Rad Result Cited by MEYERS,NANCY @ 17 Oct 2017 0948 EDT

ANDERSON, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 32yo [REDACTED] 1985 M
 ***** MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) *****
 POC Enc: #E4520771 POC Fac: WRNMMC
 Status: Complete (Amended)

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Event Date: 23-Oct-2012 15:54:00
 Exam #: 12359730
 Exam Date/Time: 02-Nov-2012 07:18:00
 Transcription Date/Time: 05-Nov-2012 09:56:00
 Provider: COPSEY, HELEN C
 Requesting Location:
 GSURG GI APU BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G
 Supervised By: MARCIA JAVITT, MD
 Approved By: JAVITT, MARCIA C
 Approved Date: 05-Nov-2012 09:48:00
 Supervised By: 115455 MARCIA JAVITT, MD
 Supervised By Date: 05-Nov-2012 09:48:00

Amended Report Text:

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

A/P Written by MEYERS,NANCY @ 17 Oct 2017 1002 EDT

1. **Unspecified asthma, uncomplicated:** Related to exposure cats. Pt request referral pulmonary per VA for documentation. Sxs are managed with albuterol

Consult(s): -Referred To: PULMONARY DISEASE NCR (Routine) Specialty: PULMONARY DISEASE Clinic: RM
PULMONARY IR Provisional Diagnosis: Unspecified asthma, uncomplicated

2. **Irritable bowel syndrome with diarrhea:** Referred back to GI. Diarrhea predominant. Consider nortriptyline if Cymbalta not effective in managing pain and sxs

Disposition Written by MEYERS,NANCY @ 17 Oct 2017 1002 EDT

Released w/o Limitations

Follow up: as needed .

Administrative Options: Consultation requested

Signed By MEYERS, NANCY (Physician) @ 17 Oct 2017 1003

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29962066 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **16 Oct 2017 1114 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE,RAYMOND G.**AutoCites Refreshed by LANDE,RAYMOND G. @ 16 Oct 2017 1249 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: ***-**-****	DoD ID: 1286180538	Created: 30 Oct 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2			18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 16 Oct 2017 1114 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 16 Oct 2017 1150 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #11 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 11 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Thursday.

S/O Note Written by LANDE, RAYMOND G. @ 16 Oct 2017 1249 EDT

Reason for Visit

Visit for: Attending Note: A procedural time out was done during which settings and patient was re-identified.

45 minutes

Purpose of visit was for another session of Transcranial Magnetic Stimulation for depression.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS without evidence of significant distress. Confirmed that there was no metal above the neck. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Objective

Plan: SM scheduled for next session.

A/P Written by LANDE, RAYMOND G. @ 16 Oct 2017 1251 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Written by LANDE, RAYMOND G. @ 16 Oct 2017 1251 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 16 Oct 2017 1251

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2017 at WRNMMC, Immunization Clinic Be by AGUGLIARO, ANTHONY J

Encounter ID: BETH-29961946 Primary Dx: Encounter for immunization

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **16 Oct 2017 1110 EDT**
Clinic: **IMMUNIZATION CLINIC BE**Appt Type: **PROC**
Provider: **AGUGLIARO, ANTHONY
JOHN****Reason for Appointment:** Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1110 EDT
flu shot**S/O Note** Written by AGUGLIARO, ANTHONY JOHN @ 16 Oct 2017 1112 EDT**Reason for Visit**

Visit for: immunization.

History of present illness

The Patient is a 32 year old male.

He reported: Previous history of Encounter Background Information:

Vaccinations

• Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Personal history

Patient to be vaccinated for influenza is older than 6 months of age. Patient is not sick today and has no allergies to eggs or any component of the vaccine. Patient has not had serious reaction to influenza in the past. Patient has no history of Guillain-Barre syndrome.

Therapy

• The drug reactions/side effects are being monitored: Details — Patient tolerated vaccinations without significant side effects discharged 15 minutes after administered and no adverse reactions noted.

Practice Management

Patient information sheet: Given to ___ Patient ___ Parent ___ Guardian on Vaccination Information Statement(s). Risks, benefits and limitations discussed and understood

A/P Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1113 EDT**1. Encounter for immunization**Procedure(s): -Influenza Split Virus Vaccine 0.5mL Dosage IM Preserv Free Quadrivalent x 1 - Influenza Seasonal, injectable quadrivalent - preservative free; Series #: 1; .5 mL; IM; Right Arm; Mfg: SmithKline; Lot: P5472.
-Immunization Administration One Vaccine x 1**Disposition** Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1113 EDT

Released w/o Limitations

Signed By AGUGLIARO, ANTHONY J (Physician) @ 16 Oct 2017 1113

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29961116 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **16 Oct 2017 1047 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **TOBAR, EDEN T**

Call Back Phone: [REDACTED]

AutoCites Refreshed by TOBAR, EDEN @ 16 Oct 2017 1047 EDT**Allergies**
•No Known Allergies**Vitals**
No Vitals Found.Reason for Telephone Consult: Written by TOBAR, EDEN @ 16 Oct 2017 1047 EDT
medsS/O Note Written by TOBAR, EDEN T @ 18 Oct 2017 0852 EDT**Subjective**

Received call from pt stating he has been on cymbalta 60 mg for five days after stopping effexor xr 75 mg every morning as per our taper plan prior to that. Pt states the day before his call, he began experiencing brain zaps, was finding it hard to concentrate, and has felt nausea for the two days prior to his call. He finds it hard to focus on driving. He asks what he can do about his effexor withdrawal and about being put on quarters. He is currently attending ATS IOP. Returned pt's call. We discussed adding back effexor xr 37.5 mg po qam to counteract his effexor withdrawal. Discussed taking it in the morning and his cymbalta at night to minimize drug interaction and potential for serotonin syndrome. Also prescribed hydroxyzine 10 mg, up to two tabs daily for agitation/nausea. Agreed to leave quarters slip at front desk for him to pick up, putting him on quarters until the morning of 18OCT. He has follow up with this provider the week of Oct 30th as he is in transition class next week.

A/P Last Updated by TOBAR, EDEN @ 18 Oct 2017 0853 EDT**1. Generalized anxiety disorder****→ Unassociated Orders, Procedures and Injuries/Accidents ←**

VENLAFAXINE XR-PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING #30 RF0 Ordered By:
TOBAR, EDEN Ordering Provider: TOBAR, EDEN T
hydroXYZine HCL-PO 10MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #30 RF1
Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR, EDEN @ 18 Oct 2017 0853 EDT**Discussed:** Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By TOBAR, EDEN (Physician/Workstation) @ 18 Oct 2017 0853

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29960995 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS** Date: **16 Oct 2017 1044 EDT** Appt Type: **ACUT**
 Treatment Facility: **WALTER REED** Clinic: **ATS ADULT BE** Provider: **HANGEMANOLE, DESPINA C**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

S/O Note Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1101 EDT**History of present illness**

The Patient is a 32 year old male.
 SM asked to speak with this writer as he is feeling 'out of it' due to withdrawal from his psychotropic medication Effexor. SM reported having 'brain zaps' in which he forgets his train of thought and has difficulty communicating. SM stated he's having trouble focusing in group. SM stated he is also feeling stressed regarding the pressures his command is putting on him at work. SM shared that he will ask his PCM for updated limdu paperwork to specify that he cannot be on watch and should not be driving back and forth from WR to Ft. Meade unless he has adequate time to do so. SM stated he would call Dr. Tobar for guidance. SM reported he spoke with Dr. Tobar and she put him on 48 hours SIQ and is re-prescribing a low dose of Effexor. SM stated he will attend TMS appointments and his PCM appointment tomorrow but would otherwise not be at appointments until Wednesday. SM appeared anxious and presented as tearful. SM will reschedule individual appointment for Wednesday.

A/P Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1109 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1109 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic. - Comments: SM will report for groups on Wednesday and reschedule individual appointments.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 16 Oct 2017 1110

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29961906 Primary Dx: Alcohol dependence, uncomplicated

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 16 Oct 2017 0730 EDT
Clinic: ATS ADULT BEAppt Type: GRP
Provider: HANGEMANOLE, DESPINA C**Reason for Appointment:**

IOP

Appointment Comments:

etc

S/O Note Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1113 EDT**History of present illness**

The Patient is a 32 year old male.

S: The group discussed addictive behaviors, meetings and relationship with command. SM reported that he does not interact as regularly with his command as many others in group but mostly does not get adverse reactions from them about his need for treatment. SM stated that he could understand how many in leadership may not understand addiction or the need for treatment just based on their lack of life experience with it. SM reported that he could understand how people may engage in addictive behaviors other than substance abuse and acknowledged that it's likely an outward manifestation of something going on internally with that person. ~O: SM arrived on time for group. SM was oriented x3. ~Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Anxious

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/Hi: None Current

Med/Pain Issues: None expressed ~A: SM is sharing openly and honestly with the group. SM gives appropriate feedback and appears engaged in group. SM can be tangential but is conscious of this and appears to be actively working to be more concise. ~P: SM will continue with IOP groups as scheduled.

S/O Note Written by FOBIZSHI, MACANGELO M @ 17 Oct 2017 0630 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session. The group topic was "Safety". The group focused on learning healthy safe coping skills. The group members identified safe and unsafe coping skills they have been using. The provider explained the three stages of healing from PTSD and substance abuse; safety, mourning and reconnection. The group members discussed what safety means to them and the signs of recovery. The group reviewed the examples of safe coping skills in the handout and identified some safe coping skills to practice. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/Hi: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/Hi. P: SM will continue group next week.

S/O Note Written by HARDIN, JAMES G @ 17 Oct 2017 1026 EDT**History of present illness**

The Patient is a 32 year old male.

Relapse Prevention Group (0900-0945)

Focus of Session: Identifying Triggers

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 37

AR 0080

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- S) SM participated in a group discussion about identifying triggers. SM reported that both internal and external factors can be triggers, with negative emotions being among the main triggers. SM listened as other suggested ways to cope and identified attending meetings and therapy appointments as his best ways to cope with triggers. SM participated actively in the group process.
- O) SM arrived on time for group. SM was dressed casually. SM's mood was calm and affect was congruent.
- A) SM seems invested in group at this time.
- P) Next relapse prevention group: Managing thoughts

S/O Note Written by HANGEMANOLE,DESPINA C @ 17 Oct 2017 1202 EDT**History of present illness**

The Patient is a 32 year old male.
 SM did not attend service dog training as he was put on SIQ orders for symptoms related to withdrawal from his psychotropic medication.

A/P Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1113 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1114 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic. - Comments: SM will continue with groups as scheduled.**Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 17 Oct 2017 1203**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29945631 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **13 Oct 2017 1213 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 13 Oct 2017 1336 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: ***-**-****	DoD ID: 1286180538	Created: 30 Oct 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017	
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017	
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR		14 Oct 2016	
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR		05 Oct 2015	

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Oct 2017 1213 EDT
TMS

S/O Note Written by POURZAND, MIRIAM @ 13 Oct 2017 1216 EDT

History of present illness

The Patient is a 32 year old male.

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression 45 minute session.

Subjective

TMS Session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 20/ #10 at 120% MT.

Objective

SM next session scheduled.

S/O Note Written by BLOBERG, BRIAN @ 13 Oct 2017 1232 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #10 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #10 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Monday 16OCT2017.

A/P Written by LANDE, RAYMOND G. @ 13 Oct 2017 1337 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Written by LANDE, RAYMOND G. @ 13 Oct 2017 1338 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 13 Oct 2017 1338

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G

Encounter ID: BETH-29946680 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **13 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **HARDIN, JAMES G****Reason for Appointment:**

IOP

Appointment Comments:

jbf

S/O Note Written by FOBI ZSHI, MACANGELO M @ 13 Oct 2017 1303 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. Patient reviewed the "check in" handout at the start of the session.

Patient shared all coping skills, and commitments completed since the previous group meeting. Patient denies any alcohol or substance use and any unsafe behaviors since the last group. Today's group today focused on harshness versus compassion. The group reviewed the handout provided by the therapist. The group members reviewed the examples of harsh self-talk and compassionate self-talk in the handout and discussed the ones they related to. The therapist discussed how harshness relates to PTSD and substance abuse. The group collectively talked about how compassion promotes growth and harshness prevents growth. The patient discussed ways to increase compassion in sobriety. At the end of the group session, the group members filled out a commitment sheet to be reviewed at the next group session: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P: SM will continue group next week.

S/O Note Written by FOBI ZSHI, MACANGELO M @ 13 Oct 2017 1342 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background Information: Creative Art Therapy Group

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The group members discussed the "What secret we keep" and "Kintsugi" poems. The Instructor explained how creative writing could be used as a platform to express emotions and thoughts. The group member discussed the poems provided and what it meant to them. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P: SM will continue group next week.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 42

AR 0085

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by HARDIN, JAMES G @ 17 Oct 2017 1021 EDTHistory of present illness

The Patient is a 32 year old male.

Process group: 0730-0845

Focus of Session: motivation, "nature vs nurture" re substance abuse

S) The group discussed their past experiences in treatment, mostly inpatient treatment, and what worked for them. We discussed "getting serious" about recovery as opposed to simply sitting in meetings, not paying attention. We talked about "identifying in" vs. "identifying out". Members talked about the moment when they realized they truly had an alcohol/drug problem. SM fully participated in the discussion.

O) Appearance: normal

Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: calm

Affect: consistent

Insight: fair

Judgment: fair

SI/HI: None Current

Med/Pain Issues: None

A) SM was invested in group today.

P) Next process group will be same time next week.

A/P Written by HARDIN, JAMES G @ 19 Oct 2017 0751 EDT1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by HARDIN, JAMES G @ 19 Oct 2017 0751 EDTReleased w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse Program, WRAMC) @ 19 Oct 2017 0751

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

12 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29939825 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **12 Oct 2017 1500 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

f/u

Appointment Comments:

dei

Note Written by PAUL, SHERIN @ 13 Oct 2017 0851 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Anderson (previously Merwin)
Patient last 4: 0538
Appt #: Intake + 15
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used:** CBT**Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Therapist and patient discussed recent events in his life. Patient continues to endorse significant frustration related to his interactions with his command. Therapist and patient processed his frustration and problem solved potential solutions. Patient stated that he was able to effectively end interaction with a female he was interested in after recognizing that they were not on the same page about what they wanted. Therapist provided positive reinforcement for this as this is different than his previous behavior. Patient also discussed initial interest in a new romantic partner. Patient is working to identify reasonable next steps for his future.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 46

AR 0089

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017*Reviewed with patient on:* 27 September 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 47

AR 0090

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.

A/P Written by PAUL, SHERIN @ 13 Oct 2017 0852 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 13 Oct 2017 0853 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 13 Oct 2017 0853

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29929434 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **12 Oct 2017 1204 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 12 Oct 2017 1309 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Oct 2017 1204 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 12 Oct 2017 1209 EDT**History of present illness**

The Patient is a 32 year old male.

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression 45 minute session.

Subjective

TMS Session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 49

AR 0092

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes. Adjustments were made to accommodate comfort. This session number 19/ #9 at 120% MT.
Objective
SM next session scheduled.

S/O Note Written by BLOBERG,BRIAN @ 12 Oct 2017 1229 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #9 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #9 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Written by LANDE,RAYMOND G. @ 12 Oct 2017 1310 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Written by LANDE,RAYMOND G. @ 12 Oct 2017 1310 EDT**Released w/o Limitations**

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 12 Oct 2017 1310

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

11 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A

Encounter ID: BETH-29912121 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **11 Oct 2017 1400 EDT**
Clinic: **OCCUP THERAP TBI BE**Appt Type: **PROC**
Provider: **NAVARRO,CARA A**AutoCites Refreshed by NAVARRO,CARA A @ 12 Oct 2017 1517 EDT**Family History**

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

Major depressive disorder, recurrent, moderate

Appointment Comments:

can

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 51

AR 0094

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 12 Oct 2017 1517 EDT
Questionnaires

A/P Written by NAVARRO,CARA A @ 12 Oct 2017 1518 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x 2

Disposition Written by NAVARRO,CARA A @ 12 Oct 2017 1525 EDT

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by PALAD,NOLAN @ 11 Oct 2017 1247 EDT

Consult Order

Referring Provider: PAUL, SHERIN

Date of Request: 27 Sep 2017

Priority: Routine

Provisional Diagnosis:

Major depressive disorder, recurrent, moderate

Reason for Request:

Rec Therapy: Patient would benefit from additional coping skills and building positive monitored socialization skills.

Note Written by NAVARRO,CARA A @ 12 Oct 2017 1524 EDT

Recreational Therapy

Recreational Therapy Program

Name: Anderson, Daniel P02

Date: 11 Oct 2017

Time: 97537 x 30 MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

SM arrives on time, groomed well and tired, stating he has not been sleeping well.

SM completed homework and reported goals he has to improve interpersonal relationships, decrease isolation and tolerate the community without being overwhelmed. Due to SM schedule he will not participate in Recreational Therapy programs till November.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 52

AR 0095

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Pending Appointments: 02 Nov 2017

PLAN:

1. Patient will attend follow up session on 02 Nov to set POC

Signed By **NAVARRO, CARA A** (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 12 Oct 2017 1525

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29910949 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **11 Oct 2017 1158 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 11 Oct 2017 1448 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 11 Oct 2017 1158 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 11 Oct 2017 1226 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #8 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #7 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 11 Oct 2017 1416 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:05-12:50).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 18/ #8 at 120% MT.

Objective

SM next session scheduled.

A/P Last Updated by BAHROO,BHAGWAN A @ 11 Oct 2017 1418 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; POURZAND,MIRIAM

Disposition Last updated by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 11 Oct 2017 1449

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 11 Oct 2017 1418 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 55

AR 0098

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

11 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J

Encounter ID: BETH-29908707 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **11 Oct 2017 1044 EDT**
Clinic: **PAIN MGMT CL BE**Appt Type: **FTR**
Provider: **SPEVAK, CHRISTOPHER J****AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 11 Oct 2017 1044 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 56

AR 0099

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1			06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3			06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1			06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2			18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3			10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active			NR		14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active			NR		05 Oct 2015

A/P Written by SPEVAK, CHRISTOHER J @ 11 Oct 2017 1045 EDT

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/II/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Disposition Written by SPEVAK, CHRISTOHER J @ 11 Oct 2017 1045 EDT

Released w/o Limitations

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By SPEVAK, CHRISTOHER J (Physician) @ 11 Oct 2017 1045

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

11 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-29910492 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **11 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **DELEON, PATRICK D.****Reason for Appointment:**

IOP

Appointment Comments:

jbf

S/O Note Written by BURTON, CARA N @ 11 Oct 2017 1217 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Educational Group: Finding Meaning (1000-1100): Spirituality and Personality

S: The focus of today's session was the connection between personality and spirituality. Group members were encouraged to assess their personalities during active substance use and at the current point of their recovery. They also reflected on how their personalities have changed since being sober. This SM shared openly about the ways in which substance use allowed him a release from his cares or ongoing frustrations. He engaged actively throughout the session and commented on what others shared appropriately.

O: SM arrived on time for group, was oriented x4 and engaged actively during the group exercises and discussion.

Appearance: Neat, clean, dressed appropriately to season

Behavior: Appropriate, engaged

Speech: WNL

Thoughts: Logical, WNL

Mood: Stable

Affect: Congruent, full range

Insight: Fair

Judgment: Fair

SI/Hi: None reported

Med/Pain Issues: None reported

A: SM interacted with group members and facilitators. He demonstrated an understanding of the concepts presented.

P: SM will attend the next group as scheduled.

Note Written by RAGLAND, MARY @ 16 Oct 2017 0952 EDT**Process Group 0730-0845**

S: Topics discussed: Introductions (Name, relationship to the military, substance of choice, sobriety date, and what brought Ct to ATS), Review of Group Rules/Expectations. Demonstrated understanding of Group Rules and assisted in explaining to new group members. Ct again spoke of his father's emotional abandonment of him and it's impact on his emotions--did not connect this to his substance use..

O: Ct arrived over 30 minutes late for group. Ct alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 58

AR 0101

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Judgment: Intact
 SI/HI: None reported
 Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

Note Written by RAGLAND, MARY @ 16 Oct 2017 1156 EDT

Mind-Body Group, Session #3: Breath Work 1100-1150

S: Psychoeducation re: purposes of using breath work (slowing thought process, slowing physiological processes, increase focus and concentration relaxation, linking body and mind), types of breath work (Counting, Mantras, Body focus, Guided/Imagery, Breathing while moving intentionally). Practiced several different types of breath work chosen by participants.

O: SM arrived on time for group. Alert/oriented x 3.

Appearance: Clean	Behavior: Appropriate
Speech: WNL	Thoughts: Logical
Mood: Stable	Affect: Congruent
Insight: Good	Judgment: Good
SI/HI: None	Med/Pain Issues: None

A: SM participated appropriately in discussion and activity.

P: SM will attend next group as scheduled.

A/P Written by DELEON, PATRICK D. @ 17 Oct 2017 0921 EDT

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON, PATRICK D. @ 17 Oct 2017 0921 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive Outpatient Program, next groups 13 Oct

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 17 Oct 2017 0922

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A

Encounter ID: BETH-29890663 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **10 Oct 2017 1059 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **BAHROO, BHAGWAN A**AutoCites Refreshed by BAHROO, BHAGWAN A @ 10 Oct 2017 1231 EDT**Allergies**
•No Known AllergiesReason for Appointment: Written by CHELLAPPA, MARY R @ 10 Oct 2017 1059 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 10 Oct 2017 1130 EDT**History of present illness**

The Patient is a 32 year old male.

Visit for: Transcranial magnetic Stimulation for Depression (1100-1135).

Subjective

TMS session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes.

Adjustments were made to accommodate comfort.

This session number #7 at 120% MT.

Objective

Next session was scheduled.

S/O Note Written by BLOBERG, BRIAN @ 10 Oct 2017 1133 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #7 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #7 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Written by BAHROO, BHAGWAN A @ 10 Oct 2017 1232 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 60

AR 0103

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): POURZAND,MIRIAM; BLOBERG,BRIAN

Disposition Written by BAHROO,BHAGWAN A @ 10 Oct 2017 1232 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BAHROO, BHAGWAN A (MD, Staff Psychiatrist, WRAMC) @ 10 Oct 2017 1232

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A

Encounter ID: BETH-29871173 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **06 Oct 2017 0854 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **BAHROO, BHAGWAN A**AutoCites Refreshed by BAHROO, BHAGWAN A @ 06 Oct 2017 1201 EDT**Allergies**

•No Known Allergies

Reason for Appointment: Written by BLOBERG, BRIAN @ 06 Oct 2017 0854 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 06 Oct 2017 0946 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (0900-0935).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes.

Adjustments were made to accommodate comfort.

This session number #6 at 120% MT.

Objective

Next session was scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 06 Oct 2017 0955 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #6; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 6 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Tuesday. ZUNG depression=51, PHQ 9=15.

A/P Written by BAHROO, BHAGWAN A @ 06 Oct 2017 1202 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 62

AR 0105

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

PROVIDER(S): POURZAND,MIRIAM; BRAGGS,DEBORAH C

Disposition Written by BAHROO,BHAGWAN A @ 06 Oct 2017 1203 EDT

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BAHROO, BHAGWAN A (MD, Staff Psychiatrist, WRAMC) @ 06 Oct 2017 1203

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 Oct 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B

Encounter ID: BETH-29877815 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **06 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **LESKO, STACEY BETH**AutoCites Refreshed by LESKO, STACEY B @ 06 Oct 2017 1330 EDT**Allergies**
•No Known Allergies**Reason for Appointment:**

process grou

Appointment Comments:

ctc

S/O Note Written by LESKO, STACEY BETH @ 06 Oct 2017 1330 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: S: The group discussed several topics today to include the how childhood family dynamics has impacted their addiction and recovery. Group members talked about trying new community support meetings and what they liked/didn't like about them. Lastly, members shared what they were doing over the 3-day weekend to stay safe and support their sobriety.

O: SM arrived on time for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM participated appropriately in group today, both giving and receiving feedback.

P: SM will continue with process groups as planned.

A/P Written by LESKO, STACEY B @ 06 Oct 2017 1332 EDT**1. Alcohol dependence, uncomplicated F10.20**

Procedure(s): -(90853) Psychiatric Therapy Group Interactive x 1

Disposition Written by LESKO, STACEY B @ 06 Oct 2017 1333 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic.Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 06 Oct 2017 1333

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE

Encounter ID: BETH-29863837 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **05 Oct 2017 1349 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **ABRAHAM, FENOTE**

AutoCites Refreshed by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Reason for Appointment: Written by ABRAHAM, FENOTE @ 05 Oct 2017 1349 EDT
 Medical Record Release

Appointment Comments: Written by ABRAHAM, FENOTE @ 05 Oct 2017 1349 EDT
 per medical records office AKA Merwin, Daniel D

Questionnaire AutoCites Refreshed by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT
Questionnaires

Note Written by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT

Medical record screened IAW the signed authorization of patient submitted through Medical Correspondence office. Patient not present.

Psychiatry records are sensitive, and screening was done diagnostically to determine whether it is appropriate to release this sensitive information to the patient as requested. In certain circumstances it can be unsafe for patient to read sensitive psychiatry notes. Record was carefully screened. Patient noted to have been diagnosed with MDD recurrent Moderate and GAD

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

No concerns arose during this screening about patient safety or the safety of others should patient read these records. Patient psychiatry records for ABHC clinic WR-Bethesda written by Paul, Tobar, Wise, Zembrzuska, Melton and Nilsen are authorized to be released as requested.

A/P Written by ABRAHAM, FENOTE @ 05 Oct 2017 1408 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by ABRAHAM, FENOTE @ 05 Oct 2017 1411 EDT

Released w/o Limitations

Signed By ABRAHAM, FENOTE (Psychiatrist, WNMCC) @ 05 Oct 2017 1411

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A

Encounter ID: BETH-29868902 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **05 Oct 2017 1300 EDT**
Clinic: **OCCUP THERAP TBI BE**Appt Type: **SPEC**
Provider: **NAVARRO,CARA A****AutoCites Refreshed by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT****Family History**

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:
Generalized anxiety disorder
Appointment Comments:
can

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT
Questionnaires**A/P** Last Updated by NAVARRO,CARA A @ 06 Oct 2017 0753 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x 6

Disposition Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: continue with services**Note** Written by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT**Consult Order****Referring Provider:** POURZAND, MIRIAM**Date of Request:** 13 Sep 2017**Priority:** Routine**Provisional Diagnosis:**

Generalized anxiety disorder

Reason for Request:

SM suffers from significant anxiety with avodiance would benefit from recreation therapy program please evaluate. sm cell [REDACTED]

Note Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT**Recreational Therapy****SUBJECT****Recreational Therapy Program****Name:** Anderson, Daniel P02**Last 4:** [REDACTED]**Date:** 05 Oct 2017**Time:** 97537 x 90MIN**Place:** Occupational Therapy Clinic**Intervention:** Recreational Therapy Initial assessment**Diagnosis:** MDD**Pain:** SM reports 4/10 in intestinal/stomach due to IBS**Fall Risk:** no**Education/ Counseling:** Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.**Referring Provider:** Dr. Paul**Provisional Diagnosis:** Major depressive disorder, recurrent, moderate**Reason for Request:** Patient would benefit from additional coping skills and building positive monitored socialization skills**Phone:** [REDACTED]
Email: [REDACTED]@gmail.com**Branch / Rank:** Navy/ P02**OBJECTIVE**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 68

AR 0111

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Patient was seen today for education, planning and training in prep for participation in Recreational Therapy programs.

ACTION

Patient was educated on application, agenda, safety, and program expectations for participation in upcoming Recreational Therapy programs. SM's homework is to write goals for Recreational therapy and what programs he can use to best practice the skills he is developing/learning. Patient was receptive to education and motivated with TX. Patient is in agreement with plan.

Assessment: Alert and oriented x 4. Presents to be in a pleasant mood although displayed signs of anxiety as evidenced by excessive talking and having scattered thoughts. SM was not able to identify personal goals for post military and has homework to complete prior to next session. SM relates challenges back to his childhood and contradicts self with what does and does not matter to him. SM was educated on what the scope of practice is for Recreational Therapy and how writer is not able to change or help SM with certain areas of his life. During conversation SM requires redirection to answer questions. Learning style- Combined Patient tolerated session well.

Barriers to learning: none

Community Reintegration: Isolates self in his home, refuses to go to a gym because "it's dirty"

Leisure Barriers: social avoidance due to indifference towards others, IBS challenges

Pending Appointments: 11 Oct 2017

Leisure interests include: cooking, video games, movies, TV shows

Learning Style: combined

Precautions: pain

Interventions Recommended:

<input checked="" type="checkbox"/> Aquatic	<input checked="" type="checkbox"/> Relaxation	<input type="checkbox"/> Physical conditioning
Horticulture		
<input type="checkbox"/> Arts & Craft	<input type="checkbox"/> Adaptive Sports	<input type="checkbox"/> 1:1 session
<input checked="" type="checkbox"/> Social Activities		
<input checked="" type="checkbox"/> Outdoor Activities	<input checked="" type="checkbox"/> Leisure counseling	<input type="checkbox"/> Cognitive
Activities	<input type="checkbox"/> Paddling	
<input checked="" type="checkbox"/> Yoga	<input type="checkbox"/> Archery	<input checked="" type="checkbox"/> Community
Reintegration		
<input type="checkbox"/> Hunting/Fishing	<input type="checkbox"/> Cooking Group	<input type="checkbox"/> Therapeutic Riding

Adaptive Equipment Utilized and/or recommended:

<input type="checkbox"/> Scissors (loop)	<input type="checkbox"/> Pencil Grip	<input type="checkbox"/> Knives/spoons/fork
<input type="checkbox"/> Cookware		
<input type="checkbox"/> Magnifying glass	<input type="checkbox"/> Talking books	<input type="checkbox"/> Ski/snowboard
<input type="checkbox"/> Bicycle		
<input type="checkbox"/> Prosthetics	<input type="checkbox"/> W/C, Rollator	<input type="checkbox"/> Assistive Tech
<input type="checkbox"/> Vehicle		
<input type="checkbox"/> Lift Systems(s)	<input type="checkbox"/> IDEO Brace	

Leisure & Community Reintegration Barriers:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

<input type="checkbox"/> Cognitive Skills	<input checked="" type="checkbox"/> Social Skills	<input type="checkbox"/> Communication
<input type="checkbox"/> Paralysis		
<input type="checkbox"/> Financial	<input type="checkbox"/> General Weakness	<input type="checkbox"/> ROM limitations
<input type="checkbox"/> Mobility		
<input type="checkbox"/> Perceptual Prob	<input type="checkbox"/> Grasp / Release	<input checked="" type="checkbox"/> Fears / Phobias
<input type="checkbox"/> Hearing Deficits		
<input type="checkbox"/> Visual Acuity	<input checked="" type="checkbox"/> Motivation	<input type="checkbox"/> Spasticity
<input checked="" type="checkbox"/> Pain		
<input checked="" type="checkbox"/> Attitude	<input checked="" type="checkbox"/> Self-confidence	<input type="checkbox"/> Transportation

PLAN:

1. Patient will attend follow up session on 11 Oct with completed homework and set POC

Discharge Recommendations:

- ☐ Utilization of Community Resources
- ☐ Adaptive equipment requested
- ☐ Continue program at home
- ☒ Encouragement of social / leisure participation

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 06 Oct 2017 0815

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29861230 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **05 Oct 2017 1158 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites Refreshed by LANDE, RAYMOND G. @ 05 Oct 2017 1314 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017	
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017	
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR		14 Oct 2016	
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR		05 Oct 2015	

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Oct 2017 1158 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 05 Oct 2017 1242 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #5 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 5 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 05 Oct 2017 1301 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:05-12:50).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 15/ #5 at 120% MT.

Objective

Next session was scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 05 Oct 2017 1303 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s):

-Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Last updated by LANDE, RAYMOND G. @ 05 Oct 2017 1314 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 05 Oct 2017 1315

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 05 Oct 2017 1314 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 05 Oct 2017 1314 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 05 Oct 2017 1304 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N

Encounter ID: BETH-29852335 Primary Dx: Sleep disorder, unspecified

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **04 Oct 2017 2000 EDT**
Clinic: **SLEEP (PULM) CL BE**Appt Type: **PROC**
Provider: **KHRAMTSOV, ANDREI N.****Reason for Appointment:**
split w 3% per Dr. K**A/P Last Updated by IRVINE, RAYMOND W @ 05 Oct 2017 0423 EDT****1. Sleep disorder, unspecified**

Procedure(s):

-Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older x 1 (TC-TECHNICAL COMPONENT) ADDITIONAL PROVIDER(S): PETRI, ROEL - This note pertains to polysomnography data collection only. The physician interpretation is appended to a separate procedure note. If there are no additional procedure notes visible within the electronic medical record, please call 301-295-4547 and ask to speak with one of the physician staff.

Disposition Last Updated by IRVINE, RAYMOND W @ 05 Oct 2017 0423 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: Please don't drive if sleepy.**Note Written by IRVINE, RAYMOND W @ 05 Oct 2017 0419 EDT****Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 27 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

R/o obstructive sleep apnea

Reason for Request:

32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 05 Oct 2017 0826

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29846543 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 04 Oct 2017 1235 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: LANDE, RAYMOND G.**AutoCites** Refreshed by LANDE, RAYMOND G. @ 05 Oct 2017 0703 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3		TAKE ONE SCOOP EVERY 3 of 3	10 May 2017	
		DAY MIXED IN LIQUID.				
		AFTER TWO WEEKS				
		INCREASE TO TWICE				
		EVERY DAY #0 RF3				
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG)		1 of 1	28 Apr 2017	
		EVERY FOUR HOURS FOR				
		BASELINE PAIN CONTROL				
		#0 RF1				
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active			NR	14 Oct 2016	
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active			NR	05 Oct 2015	

Reason for Appointment: Written by POURZAND, MIRIAM @ 04 Oct 2017 1235 EDT
TMS

S/O Note Written by POURZAND, MIRIAM @ 04 Oct 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

TMS session: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #4 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20:10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 4 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 04 Oct 2017 1334 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:01-12:45).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Adjustments were made to accommodate comfort.
This session number 14/ #4 at 120% MT.

Objective

Next session was scheduled

A/P Last Updated by BAHROO,BHAGWAN A @ 04 Oct 2017 1341 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; POURZAND,MIRIAM

Disposition Last updated by LANDE,RAYMOND G. @ 05 Oct 2017 0704 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 05 Oct 2017 0704

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 05 Oct 2017 0704 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 05 Oct 2017 0704 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 04 Oct 2017 1341 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29847918 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 1100 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

F/U

Appointment Comments:

CTC

S/O Note Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1324 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: CBT/Work Stress

S) SM reported that he has been feeling bad the last two days due to some stress with his direct supervisor. SM stated that he feels angry but was able to identify feeling disrespected as the main reason for his anger. SM and this writer used CBT techniques to work through the beliefs and emotional consequences of the conflict at work. SM explored how he can use cognitive reframing and expectation adjustment to reduce the stress around this conflict. SM stated that he had forgotten to do his gratitude list for the last couple days until his family reminded him to do it and stated he was happy for the accountability. SM reported group went well and he attended one SMART recovery meeting last week which he enjoyed. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to be thinking critically about his recovery and is open to feedback. SM seems to be open minded to using concrete techniques to address his depression and anxiety and is reflective and thoughtful in session.

Alcohol Use D/O, Severe

P) SM will follow up with social worker in two weeks. SM will begin continue with ATS groups as scheduled.

A/P Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1325 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1325 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 04 Oct 2017 1326

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 78

AR 0121

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29868491 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 06 Oct 2017 0704 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Anderson (previously Merwin)
 Patient last 4: 0538
 Appt #: Intake + 14
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male

Military Data:

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: CBT****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Therapist and patient discussed recent events in his life. He identified positive changes he was attempting to make. Therapist worked with patient to identify small concrete steps toward these changes. Therapist reminded patient not to shift from extremes. For example, patient, typically rigid, expressed a desire to sell his house and have no attachments to anything. Therapist worked with patient on reasonable changes. Further conversation focused on patient's interactional style with people.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Major Depressive Disorder, Single Episode, Moderate
Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:****Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 81

AR 0124

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017

Reviewed with patient on: 27 September 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.

2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 82

AR 0125

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.

A/P Written by PAUL, SHERIN @ 06 Oct 2017 0705 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 06 Oct 2017 0705 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Oct 2017 0706

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY

Encounter ID: BETH-29842898 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **04 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **RAGLAND, MARY****Reason for Appointment:**

process group

Appointment Comments:

ctc

Note Written by RAGLAND, MARY @ 04 Oct 2017 1007 EDT**Process Group 0730-0845**

S: Topics discussed: Introductions, stressors which impacted drinking and/or recovery. Ct shared openly about his prior treatment experiences for alcohol, his recent relapse episode which led to this ATS referral. Ct shared very openly about negative childhood experiences related to being the child of divorced parents. Ct described recent trouble for "sexual harrassment" presented in a way as warning the other group members not to "post photos of yourself on social media" or "ask a civilian to speak outside of work". Ct related to another peer about SMART Recovey and they determined they lived near each other. Ct suggested they carpool to meetings.

O: Ct arrived on time for group SM alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

A/P Written by RAGLAND, MARY @ 05 Oct 2017 0847 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by RAGLAND, MARY @ 05 Oct 2017 0847 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 84

AR 0127

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By RAGLAND, MARY (Physician) @ 05 Oct 2017 0847

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

03 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29829383 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **03 Oct 2017 1147 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 03 Oct 2017 1403 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment:Written by CHELLAPPA, MARY R @ 03 Oct 2017 1147 EDT
TMS**S/O Note** Written by BAHROO, BHAGWAN A @ 03 Oct 2017 1221 EDT**Reason for Visit**

Visit for: TransCranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 86

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

This session number 13/ #3 at 120% MT.

Objective

Plan: SM next session scheduled.

S/O Note Written by BRAGGS,DEBORAH C @ 03 Oct 2017 1226 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #3 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20:10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 3 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO,BHAGWAN A @ 03 Oct 2017 1223 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 03 Oct 2017 1403 EDT**Released w/o Limitations****Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 03 Oct 2017 1403**CHANGE HISTORY****The following Disposition Note Was Overwritten by** LANDE, RAYMOND G. @ 03 Oct 2017 1403 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 03 Oct 2017 1403 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 03 Oct 2017 1223 EDT.

Released w/o Limitations**Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 87

AR 0130

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

02 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29812077 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **02 Oct 2017 1146 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 88

AR 0131

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 02 Oct 2017 1146 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 02 Oct 2017 1248 EDT

Reason for Visit

Visit for: Transcranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 12/ #2 at 120% MT.

Objective

Plan: SM next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 02 Oct 2017 1250 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate: SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #2 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 2 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO, BHAGWAN A @ 02 Oct 2017 1252 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Last updated by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 02 Oct 2017 1414

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 02 Oct 2017 1252 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

02 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N

Encounter ID: BETH-29807781 Primary Dx: Sleep disorder, unspecified

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **02 Oct 2017 1000 EDT**
 Clinic: **SLEEP (PULM) CL BE**

Appt Type: **SPEC**
 Provider: **KHRAMTSOV, ANDREI N.**

AutoCites Refreshed by KHRAMTSOV, ANDREI N @ 02 Oct 2017 1019 EDT**Problems**

Loading...

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

Loading...

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 91

AR 0134

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Labs

26 Sep 2017 0736
ETG/ETS, UA (250 Cut-Off)
Ethyl Glucuronide

Site Specimen Result Units Ref Range
URINE negative <i> ng/mL Cutoff=250

26 Sep 2017 0736
Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>	ng/mL	(Negative)

22 Sep 2017 0745
ETG/ETS, UA (250 Cut-Off)
Ethyl Glucuronide

Site Specimen Result Units Ref Range
URINE negative <i> ng/mL Cutoff=250

22 Sep 2017 0745
Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>	ng/mL	(Negative)

19 Sep 2017 0720
ETG/ETS, UA (250 Cut-Off)

Site Specimen Result Units Ref Range

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 92

AR 0135

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

19 Sep 2017 0720

Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
Amphetamines	negative <i>		(Negative)
Barbiturates	negative <i>		(Negative)
Benzodiazepines	negative <i>		(Negative)
Cocaine	negative <i>		(Negative)
Opiates	negative <i>		(Negative)
Phencyclidine, UA	negative <i>		(Negative)
Cannabinoids	negative <i>		(Negative)
Methadone	negative <i>		(Negative)
Oxycodone	negative <i>	ng/mL	(Negative)

12 Sep 2017 0819

ETG/ETS, UA (250 Cut-Off)

Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	negative <i>	ng/mL	Cutoff=250

12 Sep 2017 0819

Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
Amphetamines	negative <i>		(Negative)
Barbiturates	negative <i>		(Negative)
Benzodiazepines	negative <i>		(Negative)
Cocaine	negative <i>		(Negative)
Opiates	negative <i>		(Negative)
Phencyclidine, UA	negative <i>		(Negative)
Cannabinoids	negative <i>		(Negative)
Methadone	negative <i>		(Negative)
Oxycodone	negative <i>	ng/mL	(Negative)

05 Sep 2017 0915

ETG/ETS, UA (250 Cut-Off)

Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	negative <i>	ng/mL	Cutoff=250

05 Sep 2017 0915

Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
Amphetamines	negative <i>		(Negative)
Barbiturates	negative <i>		(Negative)
Benzodiazepines	negative <i>		(Negative)
Cocaine	negative <i>		(Negative)
Opiates	negative <i>		(Negative)
Phencyclidine, UA	negative <i>		(Negative)
Cannabinoids	negative <i>		(Negative)
Methadone	negative <i>		(Negative)
Oxycodone	negative <i>	ng/mL	(Negative)

Vitals

Vitals Written by VELMA,SHEDRICK D @ 02 Oct 2017 0940 EDT

BP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO₂: 95%, BMI: 23.63, BSA: 1.879 square meters.

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats

Vitals Written by MARCIULIONIS,MANTAS @ 29 Sep 2017 0958 EDT

BP: 133/94, HR: 72, T: 97.5 °F, HT: 69 in, WT: 163 lbs, SpO₂: 96%, BMI: 24.07, BSA: 1.894 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Vitals Written by NDEGWAH,DOROTHY J @ 27 Sep 2017 1054 EDT

BP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No,

Pain Scale: 0 Pain Free

Vitals Written by WESLEY,LATASHA @ 26 Sep 2017 0859 EDT

BP: 135/94, HR: 79, RR: 18, T: 97.9 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,

BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10 Severe, Pain Scale Comments: headache- dull

Reason for Appointment:

R/o obstructive sleep apnea

Appointment Comments:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 93

AR 0136

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

dttp/irmac pt waived atc

Vitals**Vitals** Written by VELMA, SHEDRICK D @ 02 Oct 2017 0940 EDTBP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO₂: 95%, BMI: 23.63, BSA: 1.879 square meters.

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats**S/O Note** Written by KHRAMTSOV, ANDREI N. @ 12 Oct 2017 1254 EDT**Chief complaint**

The Chief Complaint is:

Difficulty staying asleep.

History of present illness

The Patient is a 32 year old male.

He reported: Military service in the Navy and currently on active duty.

Patient reports gasping, witnessed apnea, difficulty staying asleep, non refreshing sleep, hypersomnia, feeling tired, See paper note.

Past medical/surgical history**Diagnoses:**

No coronary artery disease

No congestive heart failure.

No hypertension

No pulmonary hypertension.

No diabetes mellitus.

Cerebral artery thrombosis - without cerebral infarction.

Depression Anxiety, Patient denies suicidal or homicidal ideation

Personal history

Behavioral: No caffeine use mild excessive and not a current smoker.

Alcohol: Alcohol use H/o EOH abuse.

Review of systems**Encounter Background Information:** Medication list reviewed.**Otolaryngeal:** No nasal passage blockage (stuffiness), no snoring, and snoring not exacerbated by nasal congestion.**Gastrointestinal:** Heartburn.**Genitourinary:** Nocturia.**Endocrine:** Decreased libido.**Musculoskeletal:** The legs do not feel restless.**Psychological:** Total Epworth Sleepiness score for likelihood of falling asleep during the day 19/24 Driving problems secondary EDS - yes and middle-night awakening with a choking sensation.

See paper note.

Physical findings**Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Awake. ° Alert. ° In no acute distress.

Neck:

Appearance: ° Neck circumference 38 cm.

Obstructions:

Obstructions: ° Airway was partially obstructed Mallampati class 2.

Lungs:

° Clear to auscultation is without wheezes, rales or ronchi.

Cardiovascular:

Heart Rate And Rhythm: ° Normal are normal, no murmurs, gallops or rubs appreciated.

Edema: ° Pretibial pitting edema not bilateral.

Neurological:

° Not oriented to time, place, and person. ° System: normal is grossly normal. Normal gait.

Objective

Assessment/Plan: The patient presents with some symptoms suggestive of Obstructive Sleep Apnea. y. Polysomnography/split has been ordered. Discussed with patient OSA, Insufficient Sleep Syndrome (ISS) and nasal congestion. The patient was counseled to maintain an ideal body weight to reduce the severity of the disease and related complications. The risks of alcohol and other sedatives were discussed. The patient was educated on positional therapy. The patient was counseled to avoid driving while excessively sleepy.(was stressed to patient with hypersomnia) !!!

A/P Written by KHRAMTSOV, ANDREI N @ 02 Oct 2017 1033 EDT**1. Sleep disorder, unspecified**

Medication(s): -ESZOPICLONE--PO 3MG TAB - TAKE ONE TABLET BY MOUTH EVERY NIGHT AS NEEDED FOR

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 94

AR 0137

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SLEEP #1 RF0**Disposition** Written by KHRAMTSOV, ANDREI N @ 12 Oct 2017 1302 EDT**Released w/o Limitations****Follow up:** as needed in the SLEEP (PULM) CL BE clinic. - Comments: meds. recon/immun.add**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: Given the multidisciplinary variables that have been considered in the

evaluation and management of this patient's sleep complaints the medical

decision making is of moderate to high complexity. The diagnostic

procedures and therapeutic interventions are of high technical complexity

thereby the overall data complexity for this patient's evaluation is

moderate to high. At least 30 minutes were spent face to face with this

patient (10 minutes reviewing questionnaire and history, 5 minutes reviewing

medical record, 10 minutes educating and counseling on good sleep practices

and strategies and 5 minutes coordinating care). PATIENT COUNSELED NOT TO OPERATE MOTOR VEHICLES IF FEELING

TIRED.

Note Written by WILLIAMS, FELICIA P @ 02 Oct 2017 0928 EDT**Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 27 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

R/o obstructive sleep apnea

Reason for Request:

32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.

Note Written by TERRY, SETH M @ 12 Oct 2017 1100 EDT**Questionnaire**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 95

AR 0138

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017



WALTER REED NATIONAL MILITARY MEDICAL CENTER
SLEEP DISORDERS CENTER
Building 9, 2nd Floor, Arrowhead Zone
8901 Wisconsin Ave, Bethesda, MD 20889
PHONE: 301-285-4547 FAX: 301-319-8187



See DD FORM 2005 for Privacy Act Statement

General Information

Patient Name: Daniel Anderson SSN: [REDACTED]
Age: 32 Gender: M Height: 6'4" Weight: 160 lbs
Status: ☒ Active Duty ☐ Retired ☐ Dependent ☐ National Guard/Reserve
Branch of Service: ☐ Army ☐ Air Force ☒ Navy ☐ Marine Corps ☐ Other: _____

Chief Complaint

Please briefly describe the reason for your Sleep Medicine evaluation

NOT SLEEPING / PCN.
INITIAL SLEEP STUDY WAS 11 AWAKE 7 REM
ALWAYS TIRED

Medical History

1. Do you have any of the following medical conditions? (select all that apply)

- ☐ High Blood pressure ☐ Diabetes ☐ Depression ☐ Fibromyalgia
☐ Heart failure ☐ Stroke ☐ Hypothyroidism ☐ High cholesterol
☐ GERD (heartburn/reflux) ☐ COPD ☐ Asthma ☐ Erectile Dysfunction
☐ Chronic Sinus Disease ☐ Peripheral vascular disease ☐ Heart Disease/heart attack

2. Please list any additional current or past medical problems

MAJOR DEPRESSION / ANXIETY (DIAGNOSED)
CHRONIC IBS-D (IRRITABLE BOWEL SYNDROME) PARANIT

3. Please list any medications you take on a regular basis:

Name	Dose (if known)	Reason for Taking
<u>EFFEXOR</u>	<u>150 MG</u>	<u>DEPRESSION</u>
<u>ATREXIN COMB</u>		<u>ALCOHOL - SUD TO BE STOPPED</u>

4. Have you ever smoked cigarettes? ☒ No ☐ Yes

• At what age did you start: _____ Number of Packs/day: _____ Number of years: _____

5. As a child, did you have any of the following? (select all that apply)

- ☐ Chronic sinus congestion/nasal allergies ☐ Tonsillectomy/Adenoidectomy
☐ Parents that smoked cigarettes ☐ Overweight

CHRONIC ASTHMA

6. Do you have any family members with a sleep disorder (i.e. obstructive sleep apnea, narcolepsy)

DO NOT KNOW

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

7. Do you experience the following (select all that apply)

- ☐ Heartburn/Reflux Disease ☒ Caffeine ☐ Sinus congestion/nasal allergies
☐ Shortness of breath ☐ Erectile dysfunction ☐ Decreased libido (sex drive)
☒ Irritability or moodiness ☒ Urinating more than once per night

8. Have you had surgery on your upper airway? (tonsillectomy, septoplasty, UPPP, sinuses, etc)

Type of Operation

Tonsillectomy

2002

Septoplasty

2017

Sleep-Related Symptoms

Symptom Yes No

Difficulty falling asleep ☐ ☒Difficulty staying asleep ☒ ☐Wake up frequently at night ☒ ☐Snoring ☐ ☒Non-refreshing sleep ☐ ☒Daytime sleepiness ☐ ☒Stop breathing at night ☐ ☒Urinating frequently at night ☒ ☐Waking up short of breath ☐ ☒Waking up choking/gasping ☒ ☐Heartburn at night ☐ ☒Nasal congestion disrupts sleep ☐ ☒Sweaty at night ☐ ☒Dry mouth in the morning ☐ ☒Restless sleep ☒ ☐

Symptom Yes No

Uncontrollable urge to sleep ☒ ☐Muscle weakness w/ emotional experience ☐ ☒Sleep paralysis (can't move on awakening) ☐ ☒Sleep attacks (fall asleep unexpectedly) ☐ ☒Dreaming/hallucinations at sleep onset ☒ ☐Legs feel restless ☐ ☒Unpleasant sensation in legs ☐ ☒Sensation is worse at night ☐ ☒Sensation worse with inactivity ☐ ☒Sensation improves with movement ☐ ☒Sleep walking ☐ ☒Sleep talking ☐ ☒Unusual movements during sleep ☐ ☒Dream enacting behavior ☐ ☒

Sleep Hygiene

1. What is your typical sleep period?

Weekdays - Average Bedtime: 10 PM Average Wake Time: 6 AM Average Duration: 8 hours
 Weekends - Average Bedtime: 10 PM Average Wake Time: 7 AM Average Duration: 9 hours

2. How long does it usually take you to fall asleep? 5-15 minutes

3. Do you take naps during the day? ☐ Yes ☒ No

If yes: How many days/week? _____ How long? _____ minutes

4. Do you routinely exercise each day? ☒ Yes ☐ No

If yes, at what time: 3 PM

5. Do you do any of the following?

- ☐ Drink caffeine (coffee, tea, soda) within 2-3 hours of bedtime?
☐ Drink alcohol within 2-3 hours of bedtime?
☐ Watch TV or read in bed?
☐ Take prescription or over the counter stimulants?
☐ Do you try to go to bed and wake up at the same time every day?

☐ Yes ☒ No☐ Yes ☒ No☐ Yes ☒ No☐ Yes ☒ No☒ Yes ☐ No

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Epworth Sleepiness Scale:

How likely are you to fall asleep in the following situations.

0 = never 1 = slight chance 2 = moderate chance 3 = high chance

Situation	Chance of Dozing
Sitting and reading	2
Watching TV	2
Sitting, inactive in a public place (e.g. theater or a meeting)	2
As a passenger in a car for an hour without a break	3
Lying down to rest in the afternoon when circumstances permit	3
Sitting and talking to someone	1
Sitting quietly after a lunch without alcohol	1
In a car, while stopped for a few minutes in the traffic	2

TOTAL: 10

Fatigue

Please circle the number below that describes your fatigue over the past 2 weeks.



FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1. Do you have difficulty concentrating because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Do you have difficulty remembering things because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty driving short distances (<100 miles) because you're tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Do you have difficulty driving long distances (>100 miles) because you're tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 12 Oct 2017 1302

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Sep 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E

Encounter ID: BETH-29797254 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Sep 2017 1149 EDT**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **BRIDGES, EDWARD E**

Call Back Phone: [REDACTED]

A/P Written by BRIDGES, EDWARD E @ 29 Sep 2017 1153 EDT

1. Irritable bowel syndrome with diarrhea: 32M with history of IBS-D, now with more formed stools since starting Effexor 3 months ago but persistent abdominal cramping.

-Will retrial peppermint oil 200mg daily for his abdominal cramping, with concurrent 4 week trial of protonix 40 mg daily to offset heartburn risk. We may increase peppermint oil to twice daily if clinically effective and tolerated. The patient will also continue to avoid heartburn triggers, including fatty meals, ETOH, coffee, spicy foods, and late night meals.

-Regarding other spasmodics: (1) He has previously failed hyocymine, (2) He is a poor candidate for dicyclomine given its CNS effects, which may exacerbate his underlying psychiatric condition and pharmacotherapy

-Continue Effexor or transition to cymbalta per psychiatry

-Continue low fodmap diet, including no beer, no wine, no rum, no broccoli, no lettuce, no onions, no garlic, no beans, no spinach, no cabbage, no asparagus, no fruits, no sausage, no chorizo, no eggs, no polyols, and no dairy

-Additional recommendations to follow final anorectal manometry testing today.

Disposition Written by BRIDGES, EDWARD E @ 29 Sep 2017 1153 EDTSigned By BRIDGES, EDWARD E (Physician) @ 29 Sep 2017 1154

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

29 Sep 2017 at WRNMMC, GI Proc Cl BE by DAMIANO, MARK N

Encounter ID: BETH-29794499 Primary Dx: Fecal urgency

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 29 Sep 2017 1000 EDT
Clinic: GI PROC CL BEAppt Type: PROC
Provider: DAMIANO, MARK NReason for Appointment:
ANORECTAL MANOMETRY/BALLOON EXPULSION STUDY
Appointment Comments:
CGBM**Vitals**

Vitals Written by MARCIULIONIS, MANTAS @ 29 Sep 2017 0958 EDT

BP: 133/94, HR: 72, T: 97.5 °F, HT: 69 in, WT: 163 lbs, SpO₂: 96%, BMI: 24.07, BSA: 1.894 square meters,
Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

A/P Last Updated by BRIDGES, EDWARD E @ 29 Sep 2017 1158 EDT

1. Fecal urgencyProcedure(s): -Rectal Balloon Distension Test x 1 ADDITIONAL PROVIDER(S): BRIDGES, EDWARD E;
BELLE, LAVERN S
-Manometry Rectal x 1 ADDITIONAL PROVIDER(S): BRIDGES, EDWARD E; BELLE, LAVERN S**2. Fecal smearing**

Disposition Last Updated by BRIDGES, EDWARD E @ 29 Sep 2017 1158 EDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By DAMIANO, MARK N (Gastroenterology Staff, Walter Reed NMMC Bethesda) @ 29 Sep 2017 1211

Note Written by BRIDGES, EDWARD E @ 26 Oct 2017 1232 EDT
(Added after encounter was signed.)**Walter Reed National Military Medical Center
Gastroenterology
Rectal Manometry Report**

Patient Name: Daniel Dennis Anderson SSN: [REDACTED] Date: 9/29/2017

Age: 32 Sex: Male Race: Caucasian Phone #: [REDACTED] Referring

Provider: Bridges, Edward

Reason for study: The patient is a 32 y/o active duty male, with a history of substance abuse, anxiety, and depression, referred for rectal manometry in evaluation of fecal urgency and rare fecal smearing. He also reports a history of IBS-D dating to childhood, with daily abdominal cramping that peaks prior to defecation and is relieved after bowel movements. Historically, he has experienced 1 large volume liquid brown stool (BSS#7) per day, however, his stools have become more formed (BSS#4) over the past 3 months since starting Effexor and continuing a low FODMAP diet. Unfortunately, there has been no concurrent resolution of his abdominal cramps, which continue to be triggered by physical activity, anxiety, and stress. Peppermint oil was previously trialed for his cramps but discontinued shortly after starting due to heartburn, which resolved with peppermint oil cessation. He reports 5 to 15 minute urgency before

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

defecating on every occasion and 2 episodes of trace fecal smearing in the setting diarrhea within the last year. He denies post stool leakage. His psychiatrist is currently considering transition to Cymbalta from Effexor.

CT A&P 2012 (evaluation of abdominal pain): Focal wall-thickening at the hepatic flexure with proximal stool retention.

Colonoscopy (McNally) in 2012: Mild congestion in the sigmoid but no masses or polyps; biopsies were unremarkable.

MRE 2012: Normal.

1. Physical Exam:

- a. **Appearance:** No internal/external hemorrhoids. Normal surrounding skin. No anal fissure.
- b. **Neurological exam:** Normal sensation to sharp/dull with cutaneous sphincter reflex not elicited.
- c. **DRE resting internal sphincter tone:** Normal
- d. **DRE pubo-rectalis sling:** Normal descent with paradoxical squeeze of external sphincter.
- e. **DRE external sphincter squeeze press:** Normal

2. Manometry findings:

- a. **Sensory threshold to rectal distention:** 15 ml (NL ≤ 20 ml)
- b. **Internal/External Resting Pressure (IAS):** 81 mmHg (NL = 59-74 mmHg)
- c. **External Sphincter Contractile Pressure (EAS):** 318 mmHg (NL > 100 mmHg)
- d. **Internal Sphincter relaxation with rectal distention:** Normal
- e. **Graduated relaxation:**

Bolus (ml)	Relaxation (mmHg)
15	10
20	18
30	34
40	33
50	54

3. Findings:

- Normal external sphincter squeeze pressure and normal descent of pubo-rectalis on DRE.
- Normal internal sphincter relaxation with balloon distension.
- Manometric evidence of elevated internal anal sphincter resting and normal external sphincter contractile pressure.
- Normal sensory threshold.
- Normal balloon expulsion test (able to expel 60mL water filled balloon within 60 seconds).

4. Impression:

- The patient's normal anorectal manometry is not consistent with a defacatory disorder.

5. Recommendations :

- Treat for IBS-D.
- Follow up with referring provider, Dr Bridges.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 30 Oct 2017

RVU code – 91120, 91122
Damiano

Reporting Dr. Bridges /Dr.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29792215 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Sep 2017 0800 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

etc

S/O Note Written by HANGEMANOLE, DESPINA C @ 29 Sep 2017 1133 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Treatment Planning

S) SM reported that he has been busy with appointments and will be finishing up with the VA this week. SM stated he had a sleep study on Monday and acknowledged he will be starting IOP process groups on Wednesday and then full IOP on 11 October. SM stated that he went to an AA meeting but walked out and spent time in his car trying to figure out why he had such a problem with AA. SM expressed that he felt the people in AA were of lower intelligence and didn't have much motivation to work on their problems behaviorally, though they verbalized a desire to change. SM stated he then went to a SMART recovery meeting and felt much more engaged there. SM stated he appreciates the CBT focus. SM was encouraged to keep an open mind about AA and he acknowledged there were many things about AA philosophy that he agreed with but that the meetings just didn't resonate with him. SM stated that he would need to be vigilant regarding the tendency to rationalize a return to drinking when he is "feeling better". SM stated that he feels he is working on the spiritual bankruptcy of addiction by connecting with his family and trying to connect more with friends. SM and this writer reviewed treatment planning goals. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed casually. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM was insightful in developing his treatment plan. SM appears to be thinking critically about his recovery and is open to feedback.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin ATS groups on 4 October.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 29 Sep 2017 0842 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 29 Sep 2017 0843 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.
 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 29 Sep 2017 1133

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

28 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29784961 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **28 Sep 2017 1304 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 104

AR 0147

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by SANTIAGO, HANNAH L @ 28 Sep 2017 1304 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 28 Sep 2017 1333 EDT

Reason for Visit

Visit for: TransCranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 11/ #1 at 120% MT.

Objective

Plan: SM next session scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 28 Sep 2017 1335 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; SANTIAGO, HANNAH L

Disposition Last updated by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 28 Sep 2017 1419

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 28 Sep 2017 1336 EDT.

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 105

AR 0148

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

27 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29768079 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Sep 2017 1144 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 27 Sep 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 27 Sep 2017 1144 EDT
TMSS/O Note Written by BRAGGS, DEBORAH C @ 27 Sep 2017 1216 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 80% up to 120%. TMS Treatment for depression session #1 at non therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total of stimulation time of 21.21 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 1 with MT level at non- therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 106

AR 0149

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 27 Sep 2017 1241 EDT

Reason for Visit

Visit for: Initial session for TransCranial Magnetic Stimulation for depression (11:50-12:30)

Motor threshold was determined on 12 September 2017 and SM has so far received a total of 9 sessions for Anxiety.

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 10/initial session started at 80% and ended with 120% MT.

Objective

Plan: SM next session scheduled.

A/P Last Updated by BAHROO,BHAGWAN A @ 27 Sep 2017 1253 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 27 Sep 2017 1355

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 27 Sep 2017 1253 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 107

AR 0150

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29765423 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Sep 2017 1100 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR, EDEN @ 27 Sep 2017 1120 EDT**Allergies**

•No Known Allergies

VitalsVitals Written by NDEGWAH, DOROTHY J @ 27 Sep 2017 1054 EDT

BP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No,
 Pain Scale: 0 Pain Free

Appointment Comments:
 etl/phq9/gad7

VitalsVitals Written by NDEGWAH, DOROTHY J @ 27 Sep 2017 1054 EDT

BP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters,
 Tobacco Use: No, Alcohol Use: No,
 Pain Scale: 0 Pain Free

Note Written by TOBAR, EDEN @ 27 Sep 2017 1543 EDT**Followup Note**

Patient: Daniel Anderson (previously Merwin) Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #13

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. We last met three weeks ago, at which time we increased his Effexor xr to 225 mg po qam. Today pt states he doesn't think it has been helpful. He completed IOP last Thursday. He is going through the MEB process, getting his VA appts done. He is starting TMS with IOP today. He has a sleep study coming up. He was prescribed ramelteon during IOP which he didn't think was helpful. He has tried taking melatonin 10 mg OTC which is more helpful. He officially had his name changed and is working with his therapist on trying to figure out what he wants from here. He states he forgot to ask her about being referred to a sexual trauma group as he discusses a male cousin tried to force himself on pt when pt was age five but pt says he was able to get away. He describes another incident when he was older and at a sleepover at a friend's and the friend tried to force himself sexually on pt so pt fled. We discussed he should bring this up with his individual therapist before considering pursuing group therapy. He continues to take naltrexone but admits he did drink half a beer once. He is still in ATS and told them. He continues to have IBS symptoms and states GI suggested discussing switching his SNRI to Cymbalta with me. He denies suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 109

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

06SEP17 phq9= 19 (#9=1); gad7= 19

27SEP17 phq9= 18 (#9=0); gad7= 17

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement

Anderson, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 110

AR 0153

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

[] Good coping/problem solving skills [x] Hopefulness present
 [] Faith/religion commitment [] Positive future orientation

Allergies: nkda**Medications:**

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE WITH ONE 150 MG
 CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING 3 Ordered 06 Sep
 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 0 Refill
 VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY
 DAY 0 Active 06 Sep 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 2 Active
 Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14
 DAYS. 0 Active 09 Aug 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY
 AS NEEDED FOR GAS 2 Active 18 May 2017@0001

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED
 IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May
 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin
 Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and
 Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol
 and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost
 custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine
 per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were
 divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt
 states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive
 to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 111

AR 0154

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

'uncle's son" when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in casual clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:fair

Speech:talkative

Mood:stable

Affect:full

Thought Process: circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	Date	Time	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM	04 Jan 2017	1232	U/L	(10.0-71.0)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Hepatic Function Panel	SERUM	04 Jan 2017	1232		
Albumin	4.9 g/dL				(3.5-5.2)
Alkaline Phosphatase	58 U/L				(40-129)
Alanine Aminotransferase	34 U/L				(0-41)
Aspartate Aminotransferase	24 U/L				(0-40)
Bilirubin	0.3 mg/dL				(0.15-1.2)
Bilirubin Direct	<0.2 mg/dL				(0.0-0.3)
Protein	7.6 g/dL				(6.6-8.7)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Basic Metabolic Panel	SERUM	22 Jun 2016	1240		
Urea Nitrogen	14.8 mg/dL				(6-20)
Carbon Dioxide	28 mmol/L				(22-29)
Chloride	98 mmol/L				(98-107)
Creatinine	1.00 mg/dL				(0.7-1.2)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mCL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mCL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mCL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mCL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mCL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mCL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mCL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mCL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Carbon Dioxide	SERUM	29	mmol/L	(22-29)	
Chloride	SERUM	98	mmol/L	(98-107)	
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)	
Glucose	SERUM	89	mg/dL	(74-106)	
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)	
Protein	SERUM	7.6	g/dL	(6.6-8.7)	
Sodium	SERUM	141	mmol/L	(136-145)	
Anion Gap	SERUM	14	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)	
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)	
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)	

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: since pt is not finding Effexor helpful, agreed to cross taper of Effexor to Cymbalta as

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

follows:

Week 1: Decrease Effexor XR from 225 mg to 150 mg every day.

Week 2: Decrease Effexor XR from 150 mg to 75 mg every day.

Week 3: Stop taking Effexor XR 75 mg. In its place, start Cymbalta 60 mg daily.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will abstain from drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Normal b12 panel drawn after July 2017 visit.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of medication plan with patient who stated understanding and agreement with plan.

Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 27 Sep 2017 1544 EDT**1. Generalized anxiety disorder**

Medication(s): -DULoxetine--po 60MG CPDR - TAKE ONE CAPSULE BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 27 Sep 2017 1544 EDT**Released w/o Limitations****Follow up:** 1 month(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 75MG CPSR 24H - TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 115

AR 0158

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Discontinued RAMELTEON—PO 8MG TAB -

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT

Additional A/P Information:

Discontinued PSEUDOEPHEDRINE—PO 30MG/5ML SOLN -

Signed By TOBAR, EDEN (Physician/Workstation) @ 27 Sep 2017 1544

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29771713 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Sep 2017 1000 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

IOP Discharge

Appointment Comments:

bsd

Note Written by PAUL, SHERIN @ 27 Sep 2017 1404 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Anderson (previously Merwin)
Patient last 4: 0538
Appt #: Intake + 13
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Patient was last seen 14 August 2017. Patient recently completed IOP. He stated that he learned a lot of new tools from IOP and had things he knew refreshed. Patient is hopeful about the future and the potential options he has about paths. Patient relayed his ideas to the therapist. Therapist encouraged patient to work on breaking down larger goals into small concrete goals. This includes personal well-being and mental health. Patient will be referred to OT and Rec Therapy to work on coping and increasing life functioning. Therapist and patient discussed next steps in MEB. He is almost complete with VA appointments. Therapist and patient discussed patient's schedule and appointment load.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked**Mental Status Exam:**

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 118

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) **Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) **good insight/judgment**, (X) **a desire to resolve their disorder**, (X) **verbal agreement to the treatment plan**

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 119

AR 0162

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low (X) Intermediate () High

Harm to Others: (X) Not Elevated () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: (X) Outpatient () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017

Reviewed with patient on: 27 September 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would NOT like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 120

AR 0163

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.A/P Last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT**1. Generalized anxiety disorder**

Consult(s): -Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL
Clinic: OCCUP THERAP BE Provisional Diagnosis: Major depressive disorder, recurrent, moderate

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT**Released w/o Limitations**

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Administrative Options: Consultation requested

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 27 Sep 2017 1420**CHANGE HISTORY**The following Disposition Note Was Overwritten by PAUL, SHERIN @ 27 Sep 2017 1420 EDT:

The Disposition section was last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT - see above. Previous Version of Disposition section was entered/updated by PAUL, SHERIN @ 27 Sep 2017 1405 EDT.

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following A/P Note Was Overwritten by PAUL, SHERIN @ 27 Sep 2017 1420 EDT:

The A/P section was last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT - see above. Previous Version of A/P section was entered/updated by PAUL, SHERIN @ 27 Sep 2017 1405 EDT.

1. Generalized anxiety disorder**2. Major depressive disorder, recurrent, moderate**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PAUL, SHERIN @ 27 Sep 2017 1417 EDT:Signed PAUL, SHERIN (Clinical Psychologist) @ 27 Sep 2017 1405

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 121

AR 0164

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

26 Sep 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29747424 Primary Dx: Encounter for other administrative examinations

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **26 Sep 2017 1000 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **GRP**
Provider: **DELSESTO, BARBARA SUE**AutoCites Refreshed by DELSESTO, BARBARA S @ 26 Sep 2017 1127 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 122

AR 0165

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

IOP Discharge

Appointment Comments:

bsd

S/O Note Written by DELSESTO, BARBARA SUE @ 26 Sep 2017 1127 EDT**Reason for Visit**

Visit for: Case Management. Patient came in to meet with CM about his plan ahead after discharge from IOP. He will see Dr. Paul 27 Sep at 1000 and Dr Tobar at 1100. He interested in an occupational therapy consult for more group activity and support dogs information. We discussed his duty assignment and a possible PCS LIMDU. CM to contact Command about a possible reassignment and a fresh start after the IOP.

History of present illness

The Patient is a 32 year old male.

He reported: Military service Profile Type: LIMDU permanent

MEB status: Patient has been assigned to a PEBLO and has started his VA appointments.

Not thinking about suicide. Patient reports no S.I/H.I or any safety issues. CM information provided to him for any further questions or issues.

CM to work on a plan of care to include his Commander's input for a new duty assignment. SM seems hopeful about his future plans to include going back to school and voc rehab upon transition from the NAVY.

A/P Written by DELSESTO, BARBARA S @ 26 Sep 2017 1135 EDT**1. Encounter for other administrative examinations****Disposition** Written by DELSESTO, BARBARA S @ 26 Sep 2017 1136 EDT**Released w/o Limitations**

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DELSESTO, BARBARA S (Nurse Case Manager, Walter Reed National Military Medical Center) @ 26 Sep 2017 1136

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 123

AR 0166

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

26 Sep 2017 at WRNMMC, Int Med CL F Medical Home BE by ROBINSON, TYRONE L

Encounter ID: BETH-29745556 Primary Dx: Ingrowing nail

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **26 Sep 2017 0845 EDT**
Clinic: **INT MED CL F MEDICAL HOME
BE**Appt Type: **FTR**
Provider: **ROBINSON, TYRONE
LEHMON****Reason for Appointment:**

f/u eye surgery/wrist pain

Appointment Comments:

jsn

Vitals**Vitals** Written by WESLEY, LATASHA @ 26 Sep 2017 0859 EDTBP: 135/94, HR: 79, RR: 18, T: 97.9 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,

BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10 Severe, Pain Scale Comments: headache- dull

S/O Note Written by ROBINSON, TYRONE LEHMON @ 27 Sep 2017 1535 EDT**Chief complaint**

The Chief Complaint is: PRT waiver- Sore Rt wrist, Dry eyes.

History of present illness

The Patient is a 32 year old male.

32 year old male pt, here today for PTR waiver-sore Rt wrist, and continous dry eyes- corrective surgery 2011. Doing well today. See depression screen.

Right wrist pain: occurs multiple times a week, lasts for several minutes while typing on computer, no specific prior injury or trauma. No numbness or tingling, no weakness. No morning pains.

IBS-D: currently on limdu, unable to participate in physical activity due to IBS symptoms, LIMDU/med board initiated Jul2017.

Dry eyes, also reports vision worsening.

Ingrown toenail: recurrent infections approx 3-4 times past year. Currently no signs of infection.

Good general overall feeling /health.

Pain assessment 9/26/17

Location: Headache

Duration: intermittent

Quality: moderate

Factors that correlate with onset: unknown

Frequency: intermittent

Average level:

Worst level: 10/10

Least level:

What makes it better: unknown

What makes it worse:

Pain Severity 7/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 Naltrexone 50 mg po daily
 Venlafaxine XR 150 mg po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco – none

Alcohol – none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M – Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard. • No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2. • No gallop was heard. • No click was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Nails:

• Nails: 1st toe nail with erythema lateral edge, mild swelling, no pus or drainage.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 125

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

A/P Written by ROBINSON, TYRONE L @ 27 Sep 2017 1542 EDT**1. Ingrowing nail:** Recurrent left 1st toe ingrowing and paronychia, currently no indication for abx or drainage, will refer to podiatry for permanent removal

Consult(s):

-Referred To: PODIATRY NCR (Routine) Specialty: PODIATRY Clinic: RM PODIATRY IR Provisional
Diagnosis: Ingrowing nail**2. Dry eye syndrome of bilateral lacrimal glands**

Medication(s):

-CARBOXYMETHYLCELLULOSE--OPT 0.5% SOLN - INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #1 RF2 Ordered By: ROBINSON, TYRONE L Ordering Provider: ROBINSON, TYRONE LEHMON

3. Pain in right wrist: No paresthesias or tenderness, no signs of nerve impingement or ganglion, advised using hand pad while using computer and moving hands frequently.**Disposition** Written by ROBINSON, TYRONE L @ 27 Sep 2017 1543 EDT**Released w/ Work/Duty Limitations:** Profile: Ingrowing nail L60.0 from 27 Sep 2017 to 27 Sep 2017; Comment: updated PRT waiver for IBS-D issue and toenail**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By ROBINSON, TYRONE L (Physician) @ 27 Sep 2017 1544**CHANGE HISTORY***The following S/O Note Was Overwritten by ROBINSON, TYRONE L @ 26 Sep 2017 0925 EDT:**S/O Note Written by WESLEY, LATASHA @ 26 Sep 2017 0848 EDT***Chief complaint**

The Chief Complaint is: PRT waiver- Sore Rt wrist, Dry eyes.

History of present illness

The Patient is a 32 year old male.

32 year old male pt, here today for PTR waiver-sore Rt wrist, and continous dry eyes- corrective surgery 2011. Doing well today. See depression screen.

<<Note accomplished in TSWF-CORE>>

Good general overall feeling /health.

Pain Severity 7/ 10.

Pain assessment 9/26/17

Location: Headache

Duration: intermittent

Quality: moderate

Factors that correlate with onset: unknown

Frequency: intermittent

Average level:

Worst level: 10/10

Least level:

What makes it better: unknown

What makes it worse:

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 126

AR 0169

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM, MI / stent at age 40. Melanoma.

Review of systems

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 127

AR 0170

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

25 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29733883 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **25 Sep 2017 1105 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 128

AR 0171

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT
Discharge Summary

S/O Note Written by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT

History of present illness

The Patient is a 32 year old male.

S/O Note Written by DONKIN, LAURA G @ 22 Sep 2017 1122 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Social Work Discharge Summary

Admission Date: 29 August, 2017

Discharge Date: 22 September, 2017

While at Psychiatry Continuity Services (PCS), in the Intensive Outpatient Program (IOP) and the Comprehensive Recovery Program (CRP), patient PO2, has been involved in psycho-educational groups and individual therapy. He was compliant with his medication management. He also has been receiving TMS treatments for anxiety, and may continue with TMS to treat his depression post discharge.

PO2 will return to duty at Ft Meade, but will attend medical/mental health appointments most days. SM is to start the IOP at Addictions Treatment Service (ATS) on Monday. This program is 3 days per week. SM will also return to the care of Dr. Paul and Dr. Tobar, both at WRNMMC Outpatient Behavioral Health. PO2 has made progress in his treatment and reports a reduction in anxiety. In his future mental health treatment, he would like to move forward from processing his childhood trauma and accept who he is. PO2 has also focused on learning about his personality traits and how to form meaningful relationships. No SI/HI plan or intent present.

S/O Note Written by POURZAND, MIRIAM @ 25 Sep 2017 1320 EDT

Chief complaint

The Chief Complaint is: Met with SM for 30 minutes for discharge meeting.

History of present illness

The Patient is a 32 year old male.

He reported: Feeling tired (fatigue).

Sleep disturbances.

<<Note accomplished in the TSWF BH Spec AIM form>>

HISTORY OF PRESENT ILLNESS: adapted from intake note from 8/29/17: Pt is a 32 y/o single Caucasian male ADN E5 with

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 129

AR 0172

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

almost 12 years TIS, HDS: Ft. Meade, MOS: Network Intelligence, referred to PCS by outpatient provider at WRNMMC d/t continued symptoms of anxiety and depression. SM reports he has not worked in one month, has lost access to the building, and was demoted from E6 to E5 in 7/2017 d/t social media sexual harassment sent to a female co-worker. SM reports having anxiety symptoms as far back as childhood d/t his father. In 2008, SM started picking his scalp (neurotic excoriation) while deployed aboard a ship d/t stress and anxiety. SM also developed MRSA. SM reports in 2010 he had a bad 2 year relationship breakup with a woman whom was an alcoholic and taking medication. SM states in 2012 he started seeing behavioral health d/t having suicidal ideation, being discontent with life, and the bad breakup. SM endorses guilt, decreased appetite and fear of gaining weight and losing 10 lbs. in the last month (stating he does not want to look like his father as well as end up with diabetes as he has), states feels as though he has sleep paralysis and at times sleeps too much but other times difficulty falling and staying asleep, +anxiety and worrying, reports being hypersexual stating he could have intercourse daily as well as ejaculate three times a day, +anger/irritability, +isolation, states does not like sun exposure, fantasizes about life-space things, watches television a lot which in turn creates increased anxiety (example: watches Game of Thrones and Walking dead but does not look at it as just a TV show, fantasizes that it is real). SM states he works on computer gaming and enjoys cooking. Reports he was in debt for \$35,000 but sold one of his homes and now debt has decreased to \$19,000. States his debt was from buying his brother a car and giving his family money.

Personal history**PAST MEDICAL HISTORY**

IBS; PRK; tonsillectomy; childhood asthma; neurotic excoriation (scalp picking);

PSYCHIATRIC HISTORY

Suicide attempt as a child by taking bottle of aspirin d/t conflict with father, vomited but no treatment; age 17 suicide attempt via consuming large quantity of alcohol, no treatment; 6/16/2014 Integrated Health WRNMMC x 2 visits d/t anxiety; 8/2014-10/2014 WRNMMC outpatient BH d/t anxiety; 4/2015-11/2015 WRNMMC outpatient BH d/t depression/anxiety, also attended CBTI group; 8/2016 Integrative Health WRNMMC d/t mood swings/anxiety x 1 visit; 9/2016 started seeing outpatient BH WRNMMC d/t mood swings/anxiety. MEDICATIONS HAVE BEEN RECONCILED to include current medications, OTC, and supplements. Previously trialed meds: Zoloft (increased fatigue), melatonin, lexapro (felt flat), Unisom, Wellbutrin XL (increased anxiety), and Lunesta (ineffective). SM currently taking: Effexor 225 mg daily and Naltrexone 50 mg daily, Rozerem 8 mg qhs.

SOCIAL / DEVELOPMENTAL / SPIRITUAL HISTORY

Pt is 32 year single Caucasian male with almost 12 yrs TIS, Navy E-5 (recently demoted from E-6), MOS cyber security. Pt reports that he was born in California to very young, unmarried parents, who later married and then divorced. Pt reports that he has 2 sisters, who are ages 30 and 29. He also has a half brother, and half sister who he does not have contact with. Pt reports that father had custody for most of childhood, and mother had to pay support. Both parents were physically abusive. Father was on welfare and frequently negligent of his parental duties. Pt states that father's excessive discipline was to make them fearful. Pt reports 2 incidents of sexual trauma from unwanted contact. Once by older cousin and another time in middle school with friend grabbing him. Pt was moved numerous times during childhood. Pt said that there were times when he was living in a ghetto due to father living off welfare and spending all their money. Pt appears to currently have emotional support from mother and sisters. He has a very contentious relationship with father, thus recently changing his name. Pt said that he barely passed high school, and had a 2.2 GPA. He attributes this to his struggle with IBS, excessive running schedule and not doing homework. He joined the Navy immediately following high school. He has difficulty with relationships and is not currently in one. He denies religious affiliation.

Family history**FAMILY PSYCHIATRIC, SUBSTANCE USE AND MEDICAL HISTORY**

Mother is diagnosed with Bipolar disorder. Younger sister also diagnosed with Bipolar disorder. Youngest sister diagnosed with depression. Both sisters have had multiple suicide attempts. Maternal grandmother also Bipolar.

Review of systems

Head: No headache.

Gastrointestinal: No constipation.

Musculoskeletal: No localized joint pain, no localized joint swelling, and no limb pain.

Neurological: No dizziness, no motor disturbances, and no gait abnormality. No sensory disturbances.

Psychological: No social isolation.

Physical findings**General Appearance:**

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed - oriented to place, person, time, and situation. * No hallucinations. * Memory was unimpaired - recent and remote memories are intact. * Judgement was not impaired.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 130

AR 0173

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal . Full range, stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Plan**TREATMENT GOALS AND OBJECTIVES****Patients goals**

1. Figure out how to cope with prior life events- partially met
2. Move on from things- partially met

Treatment objectives

1. Improve psychological functioning-partially met
2. Decrease number of episodes of trichotillomania- partially met reports for 2 days
3. Reduction in symptoms as evidence by self reported measures BHDP by 20% post completion of program -unmet

DISCHARGE TREATMENT PLAN AND STRATEGY

Medication: Effexor 225 mg daily, naltrexone 50 mg daily, Rozerem 8mg qhs

Psychotherapy: continue in out pt

Referrals: watch pad sleep study-completed, Alpha-Stim-completed, TMS treatment for anxiety completed reports not effective, TMS for depression treatment to start, SM completed extensive psychological testing

Estimated Frequency and Duration of Treatment: sm requires continued BHC

Other:

- [x] Treatment Options and Education: Diagnosis and treatment options - including risks, benefits, side effects, and choice to decline treatment, were discussed with the patient who expressed an understanding of the diagnosis and plan.
- [x] Treatment plan was collaboratively discussed with the patient.
- [x] Yes [] No...Patient agrees with plan? If not, what part?

DATE: 9/22/17

Notes**RISK LEVEL**

I assessed warning signs, risk factors, and protective factors. After considering these factors in the context of this patient's clinical presentation, I consider this patient to be a:

- [] High Acute Risk for Suicide
- [] Intermediate Acute Risk Suicide
- [] Low Acute Risk for Suicide
- [X] No Elevated Acute Risk Suicide

[X] Patient is not considered to be a risk of harm toward others.

A/P Written by POURZAND, MIRIAM @ 25 Sep 2017 1320 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms. Sm completed program, discharged today.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 131

AR 0174

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1
 -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND, MIRIAM @ 25 Sep 2017 1322 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 25 Sep 2017 1322

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29717413 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **22 Sep 2017 1020 EDT**
Clinic: **ATS ADULT BE**Appt Type: **ACUT**
Provider: **HANGEMANOLE, DESPINA C**Reason for Appointment: Written by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1020 EDT
recent slipS/O Note Written by HANGEMANOLE, DESPINA C @ 02 Oct 2017 0913 EDTHistory of present illness

The Patient is a 32 year old male.

SM reported to clinic and requested to speak to this writer. SM stated that he had half a beer the other night due to being emotional. SM reported that he is still committed to sobriety. SM acknowledged that a higher level of care would need to be explored if it was determined that SM could not maintain abstinence in an outpatient setting. SM stated he did not feel he needed Level III care at this time. SM agreed to start IOP process groups on 4 October and full IOP on 11 October.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1030 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1030 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue with group.
30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 02 Oct 2017 0942

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29714923 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 22 Sep 2017 0902 EDT
 Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
 Provider: LANDE, RAYMOND G.

AutoCites Refreshed by LANDE, RAYMOND G. @ 22 Sep 2017 1400 EDT

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 134

AR 0177

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 22 Sep 2017 0902 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 22 Sep 2017 1257 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #9 and #7 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 9 and # 7 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided today will be SM last appointment for anxiety and SM will begin treatment for depression on return to clinic Wednesday September 27. Next session scheduled for Wednesday. ZUNG anxiety=50, GAD 7=15.

S/O Note Written by BAHROO, BHAGWAN A @ 22 Sep 2017 1332 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 9 was the # 7 session at 120% MT.

Objective

Next session scheduled.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 135

AR 0178

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 22 Sep 2017 1334 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT

Released w/o Limitations

Follow up: as needed in 5 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 22 Sep 2017 1401

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 22 Sep 2017 1334 EDT.

Released w/o Limitations

Follow up: as needed in 5 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 136

AR 0179

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

22 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29714760 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 22 Sep 2017 0857 EDT
 Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
 Provider: POURZAND, MIRIAM

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 1009 EDT

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3			28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 22 Sep 2017 0857 EDT
IOP

S/O Note Written by EARLEY, KERRIE GLYN @ 22 Sep 2017 1004 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Mindfulness (0800-0850) Facilitated by Kerrie Earley, LCSW

Purpose: Educate in the practice of Mindfulness, including the rationale for incorporating this as a practice into daily life as a means of improving effectiveness in using other skills and managing difficult situations. Living with awareness in the present moment (neither ruminating on the past, nor worrying about the future), focusing on one thing at a time in a non-judgmental way and doing what works are some of the core concepts of Mindfulness practice that will be repeated and encouraged throughout the course of treatment.

Today patients discussed what mindfulness is and what it is not- emphasizing the role of practice, its use in understanding emotions and improving memory, how it can be used in different situations, etc. Group members discussed emotion/rational/wise minds to consider how to navigate awareness of thoughts without pushing away emotions. Group then practiced mindfulness activities and discussed their ability to participate in the activities as well as implications for improving daily life.

This patient arrived late in the session, but actively tried each exercise and engaged in discussion about how effective it was in the moment. He was thoughtful about how the skills play out in certain areas of his life.

There was no indication of S/I or H/I present. Next mindfulness group scheduled for 29 September.

S/O Note Written by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Guest Speaker Group 0900-0950: Facilitator: Chaplain Edwards, Dr. Gragnani, and Ms. Buford, RN

PURPOSE: The purpose of this group is to have guest speakers bring various topics that would be relevant to group members and their treatment/recovery. Group topics range from finance experts, VA experts, Chaplain, and Med Board experts.

TOPIC: Today, Chaplain Clifton Edwards from the Pastoral Care Department discussed what is Spirituality, what it should be, what is your spirituality/what makes you come alive, then had an open forum discussion. Group members discussed what they consider to be their connection to the spiritual world or what motivates them.

PARTICIPATION: SM attended group, was attentive to facilitator, and participated in group discussion. No evidence of S/I/HI. Next group 29Sept2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 22 Sep 2017 1052 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0840 Check in to PCS Team A. Late due to ATS appt this a.m. Denied SI/HI. SM will be discharged from PCS today.

S/O Note Written by SMITH,JESSICA ANN @ 22 Sep 2017 1112 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HPCPS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1518 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check out note: SM was discharged from program today; did not check out with this writer.

A/P Last updated by POURZAND,MIRIAM @ 25 Sep 2017 1103 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms. Sm completed program, discharged today.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S):
DONKIN,LAURA G

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Written by POURZAND,MIRIAM @ 25 Sep 2017 1104 EDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 25 Sep 2017 1105****CHANGE HISTORY****The following S/O Note Was Deleted by POURZAND,MIRIAM @ 25 Sep 2017 1102 EDT:****History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Social Work Discharge Summary

Admission Date: 29 August, 2017

Discharge Date: 22 September, 2017

While at Psychiatry Continuity Services (PCS), in the Intensive Outpatient Program (IOP) and the Comprehensive Recovery Program (CRP), patient PO2, has been involved in psycho-educational groups and individual therapy. He was compliant with his medication management. He also has been receiving TMS treatments for anxiety, and may continue with TMS to treat his depression post discharge.

PO2 will return to duty at Ft Meade, but will attend medical/mental health appointments most days. SM is to start the IOP at Addictions Treatment Service (ATS) on

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 139

AR 0182

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Monday. This program is 3 days per week. SM will also return to the care of Dr. Paul and Dr. Tobar, both at WRNMMC Outpatient Behavioral Health. PO2 has made progress in his treatment and reports a reduction in anxiety. In his future mental health treatment, he would like to move forward from processing his childhood trauma and accept who he is. PO2 has also focused on learning about his personality traits and how to form meaningful relationships. No SI/HI plan or intent present.

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 25 Sep 2017 1102 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 25 Sep 2017 1102 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 22 Sep 2017 1124 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): DONKIN, LAURA G
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 22 Sep 2017 1124 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 22 Sep 2017 1124 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 22 Sep 2017 1113 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by SMITH, JESSICA ANN @ 22 Sep 2017 1113 EDT:

The A/P section was last updated by SMITH, JESSICA ANN @ 22 Sep 2017 1113 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 22 Sep 2017 1053 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 22 Sep 2017 1053 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 22 Sep 2017 1053 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 140

AR 0183

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 22 Sep 2017 1010 EDT.

1. Generalized anxiety disorder

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 141

AR 0184

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

21 Sep 2017 at WRNMMC, GI Clinic Bethesda by BELLE, LAVERN S

Encounter ID: BETH-29711562 Primary Dx: Other specified counseling

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 1834 EDT**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **BELLE, LAVERN S**

Call Back Phone: [REDACTED]

AutoCites Refreshed by BELLE, LAVERN S @ 21 Sep 2017 1834 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY	3 of 3	06 Sep 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 142

AR 0185

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	MOUTH EVERY MORNING #0 RF3 TAKE ONE TABLET BY 0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE ONE CAPSULE BY 0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE 2 BY MOUTH EVERY 2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	DAY #0 RF3 TAKE ONE PACKET BY 1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH 2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		14 Oct 2016
			05 Oct 2015

Reason for Telephone Consult: Written by BELLE, LAVERN S @ 21 Sep 2017 1834 EDT
Scheduled patient for an Anorectal Manometry Procedure.

S/O Note Written by BELLE, LAVERN S @ 21 Sep 2017 1835 EDT

Subjective

Scheduled patient for an Anorectal Manometry Procedure, to be conducted on 29 September 2017 at 1000 hrs. Patient was educated about pre-procedure details, which includes use of an enema prior to procedure, and what she should expect during the procedure. Patient will be given an enema in clinic 10-45 minutes before procedure. Patient verbalized understanding of all given instructions.

A/P Written by BELLE, LAVERN S @ 21 Sep 2017 1836 EDT

1. Other specified counseling

Procedure(s): -Non-Physician Phone Call To Pt/Provider Lengthy (21-30 min) x 1

Disposition Last Updated by BELLE, LAVERN S @ 21 Sep 2017 1836 EDT

Referred for Appointment

Signed By BELLE, LAVERN S (Physician/Workstation) @ 21 Sep 2017 1836

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29708145 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 1353 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0746 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 144

AR 0187

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 21 Sep 2017 1353 EDT
CRP

Appointment Comments: Written by CLOPPER, TAMMY J @ 21 Sep 2017 1353 EDT
TB

S/O Note Written by CLOPPER, TAMMY J @ 21 Sep 2017 1354 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 121200

Afternoon Track: CRP

Appointments Reported this afternoon: 1200 TMS

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 21 Sep 2017 1431 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1423

Afternoon Track: CRP

Appointments Reported for Friday: TMS 1200; Discharging

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1431 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Life Skills Group

1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "Getting Others to Support Your Recovery." After reviewing the hand-out, group members shared

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 145

AR 0188

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

who is helpful in their recovery and how to get others to help. This SM actively contributed to group discussion. No SI/HI plan or intent present. The next group will be on 28 September, 2017.

S/O Note Written by GHOLSON,GEORICA K @ 21 Sep 2017 1440 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMUNICATION SKILLS 1330-1430.

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician

Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.

Intervention: Discuss and identify passive, passive aggressive, aggressive, and assertive communication strategies. Discuss impact of each communication style on the listener and when each communication style is appropriate. Group discussed how emotions affect behaviors related to the various communication styles. SM participated in group. SM was able to identify characteristics of all three communication styles. Additionally, he identified his style as passive and discussed how feedback from others has impacted how he communicates with other people.

No indication of SI/HI.

Next group scheduled for October 5, 2017.

A/P Last updated by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 22 Sep 2017 0747 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0747**CHANGE HISTORY**

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 21 Sep 2017 1432 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 146

AR 0189

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 21 Sep 2017 1432 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 21 Sep 2017 1432 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 21 Sep 2017 1355 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29699149 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **21 Sep 2017 0754 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 21 Sep 2017 1409 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 148

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 21 Sep 2017 0754 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C. @ 21 Sep 2017 1229 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #8 and #6 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 28.52 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 8 and # 6 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided that tomorrow will be service member last TMS appointment as SM has medical appointments next week which will keep him from coming in for treatments. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 21 Sep 2017 1407 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 8 was the # 6 session at 120% MT.

Objective

Next session scheduled.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 149

AR 0192

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT**1. Generalized anxiety disorder**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Disposition Last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT**Released w/o Limitations****Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 21 Sep 2017 1410**CHANGE HISTORY**The following A/P Note Was Overwritten by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT:

The A/P section was last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT - see above. Previous Version of A/P section was entered/updated by BAHROO, BHAGWAN A @ 21 Sep 2017 1407 EDT.

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 21 Sep 2017 1409 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1409 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 21 Sep 2017 1407 EDT.

Released w/o Limitations**Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 150

AR 0193

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29699044 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 0751 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 21 Sep 2017 1411 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 151

AR 0194

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 21 Sep 2017 0751 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1021 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1113 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0755

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1114 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1055

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 152

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by MILLER,PENNY E @ 21 Sep 2017 1248 EDT**Reason for Visit**

Visit for: (0915-1050) - Intensive Outpatient Program-"Improv Workshop" (Staff: Penny Miller, recreation therapist, Helen Lowenstein, social worker and Lisa Banks-Williams, advanced practice nurse) -

Objective: To provide an opportunity for creativity, self-expression and socialization through verbal and non-verbal improv activities.

Activity: This workshop was facilitated by Amelia Baine, a special guest, comedian and Seema Reza, WRNMMC hospital recreational arts coordinator. Patients were introduced to the activity of improv, used during this session as the intervention for this session. This session patients learned strategies to and were encouraged to take an active role. Patients were provided with directives in order to participate in several activities. Participation in the provided activities facilitated team work, socialization and an opportunity for enjoyment. A safe supportive environment was provided offering patients a structured experience for exploration and a chance to step out of their comfort zones. This writer served as activity coordinator as well as an emotional support, facilitating the group end of activity processing component.

Participation: This patient willingly participated during the session. He disclosed that he is typically shy and serious, however today he did something out of his comfort zone. He reported that he enjoyed his improv experience and is motivated to participate in the future. Pt was supportive of others and interacted well with staff and peers. A total of 11 patients attended this group. The next creative writing session is scheduled for Thursday September 28, 2017.

This note was written by Penny Miller, recreation therapist.

A/P Last updated by DONKIN,LAURA G @ 21 Sep 2017 1115 EDT

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by LANDE,RAYMOND G. @ 21 Sep 2017 1412 EDT**Released w/o Limitations**

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 21 Sep 2017 1412**CHANGE HISTORY**The following A/P Note Was Overwritten by DONKIN,LAURA G @ 21 Sep 2017 1022 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 21 Sep 2017 1022 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 21 Sep 2017 0754 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 153

AR 0196

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 154

AR 0197

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29695182 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **20 Sep 2017 1437 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0905 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2	2 of 2	18 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 155

AR 0198

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by SMITH, JESSICA ANN @ 20 Sep 2017 1437 EDT
LST

S/O Note Written by SMITH, JESSICA ANN @ 20 Sep 2017 1438 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at: 1230

Program Track:

(x) Comprehensive Recovery Program (CRP)

() Interpersonal Recovery Program (IRP)

() Trauma Recovery Program (TRP)

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH, JESSICA ANN @ 20 Sep 2017 1507 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at: 1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 156

AR 0199

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by VANFOSSEN, MALLORY B @ 20 Sep 2017 1526 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist; and Maggie Hardy, LCSW-C, Social Worker. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. This session also allowed pts to explore the cycle of an intense emotional experience. Pts were lead in a discussion the wave skill from DBT that describes the means of experiencing emotion, according the symbol of a wave in the sea. Pts were then asked to render their own emotional wave using art media, to show us the experience of an evolving emotional state. 2D materials were used, consisting of pastels, chalks, and various types of paint on large paper. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of: how we can use the art process to understand the wave skill, how the process of art making can engage us to feel emotions as we create them visually, how this process of feeling emotion in real time can be channeled into a "safe" action, such as art making, rather than acting on them through other means, and how the depiction of the wave can be described objectively (or separately from self) to further our understanding of emotional experiences, rather than naming and discussing individual feelings. There was no indication of SI/HI. Next art therapy session will be held Thursday 21 September, 2017.

A/P Last updated by POURZAND, MIRIAM @ 22 Sep 2017 0906 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

Disposition Written by POURZAND, MIRIAM @ 22 Sep 2017 0906 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0906**CHANGE HISTORY****The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 22 Sep 2017 0906 EDT:**

The A/P section was last updated by POURZAND, MIRIAM @ 22 Sep 2017 0906 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 20 Sep 2017 1508 EDT.

1. Generalized anxiety disorder

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 157

AR 0200

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G

Encounter ID: BETH-29693459 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Sep 2017 1336 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DONKIN, LAURA G**

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 20 Sep 2017 1336 EDT
 Treatment Plan Review Team A

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 0838 EDT

History of present illness

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Daniel Anderson
 20 SEPT 2017
 Follow-Up Data Only
 Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.
 Behavioral Health Vitals (patient reported):
 Overall health reported as: Good
 Pain Level (0-10): 0 Currently treated: N/A
 Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: Yes
 # past attempts as of 09/06/2016: 3
 Most recent Suicidal Ideation: 1-2 weeks ago
 Suicidal Ideation Duration: Fleeting - a few seconds or minutes
 Suicidal Ideation Frequency: 2-5 times a week
 Protective Elements Stopping Suicidal Actions: Family, Fear of failing
 Harm Others Risk over next week as of 9/20/2017 - None Active Plan: N/A
 Patient with access to weapons: No
 Recent Outcome Measures (last 30 days)
 BASIS24 - Score: 2.52 - High levels of general distress reported (9/20/2017)
 PHQ9 - Score: 20 - Severe depressive symptoms reported. Evaluation indicated. (9/20/2017)
 GAD7 - Score: 17 - Moderate anxiety symptoms reported. Evaluation indicated. (9/20/2017)
 PCL-5 - Score: 54 - Moderate PTSD symptoms reported (9/20/2017)
 PCL-C: N/A
 AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)
 CSI - Score: -2 - Pt reports no significant other - no score (9/13/2017)
 ISI - Score: 23 - Clinical insomnia (severe) (9/20/2017)
 BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017).

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 0850 EDT

History of present illness

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Treatment Progress/Goals
 problem #1: anxiety
 Goal: reduction
 Objective: sxs reduction by 20% next BHDP screening
 Intervention: TMS
 Measure: GAD score 17 9/20/17 indicating moderate anxiety
 Progress: SM had 15% reduction in anxiety
 Problem #2: depression
 Goal: reduction
 Objective: sxs reduction by 20% next BHDP screening

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Intervention: medication increase Effexor 150 mg to 225 mg on 9/6/17
 Measure: PHQ9 severe 20 depression score 9/20/17
 Progress: sm reports increase severity due to returning to work
 Pt was present () was not present (x) during review of treatment plan. Pt present during review with Dr. Pourzand.

S/O Note Written by POURZAND, MIRIAM @ 22 Sep 2017 1048 EDT**History of present illness**

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Met with SM to complete BHDP from 940-0950. Sm completed program, discharged today. Returning only for TMS treatment for depression and anxiety.

Note Written by POURZAND, MIRIAM @ 22 Sep 2017 1048 EDT**NOTES FROM TODAY'S SESSION:**

Treatment modality currently used: Not Set

Response to treatment: [] None [x] Some [] Significant [] Marked

RISK ASSESSMENT:

Clinician-determined risk level at start of appointment - No risk level set

MEDICATIONS:

Current side effects: daytime fatigue

Current response: doesn't feel any changes with Effexor, reports rozerem effective

Allergies were reviewed as indicated. Allergic to cats and dogs

OBJECTIVE (O):**MENTAL STATUS EXAM:**

Appearance: well-kept

Behavior/Orientation: x4, appropriate

Abnormal Movements: trichotillomania-back of hair picking- 25% of waking hours-reports less past few days

Rapport: appropriate

Speech: non pressured

Mood: grumpy per report, but presents pleasant

Affect: full ranging

Thought Process: clear, direct, oriented

Thought Content: non delusional

Judgment: good

Insight: good

Impulsivity: none impulse- hx of ETOH

Cognition: Average

Fund of Knowledge: well

OTHER OBJECTIVE FINDINGS/LAB RESULTS:**ASSESSMENT (A):****DIAGNOSIS:** anxiety d/o**SAFETY RISK:**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 159

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

LEARNING/NEEDS ASSESSMENT:

Patient would like the following information at this appointment: none

PLAN (P):

Patient was educated about and stated understanding of the diagnosis and treatment options.

Patient collaborated on and agreed to the following treatment plan:

High Interest Case? No

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☒ CBC ☒ LFTs ☒ TSH ☒ Chem 8 ☐ Lipids

☒ Fasting Glucose ☒ HCG ☒ UDS ☒ Vit B12 ☐ _____

Safety Plan:

Patient is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Medication:

Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Patient reports taking medications as prescribed: Yes/No

Patient reports following changes in medication:

MED	SIG	Target Dose	Target Symptoms
Effexor XR	225 mg daily	, for depression and anxiety treatment	
Rozerem	8 mg qhs	for sleep	
Naltrexone	50 mg daily-	prevent ETOH cravings	

Other Interventions (Social, Occupational, Case Management): recreation therapy referral entered 9/13/17

Prognosis:

☐ Excellent ☐ Good ☐ Fair ☒ Guarded ☐ Poor

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 160

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Follow-up: PSYCHIATRY/WRNMMC KEMEZIS,PAT 26Sep2017@1000 GRP/90
PENDING

PSYCHIATRY BE/WRNMMC PAUL,SHERIN 27Sep2017@1000 FTR/60
PSYCHIATRY BE/WRNMMC TOBAR,EDEN 27Sep2017@1100 FTR/30
Sm scheduled to be discharged from PCS 9/21, will continue to present for TMS only

Referrals: recreation therapy, TMS

Occupational:

1. The Command WAS NOT directly notified of the current condition of the patient.
2. Patient HAS NOT granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile HAS NOT been written for patient by this writer today.

Profile:

SM in process of MEB

Is Service Member able to carry and fire weapon, from a Behavioral Health perspective (safety)? No

Is Service Member able to have access to sensitive information (to the level of current clearance)? Yes

Is Service Member able to deploy? No

Can Service Member perform MOS duties? N

A/P Last updated by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT

1. Generalized anxiety disorder

Procedure(s):
-Psychiatric Diagnostic Evaluation Review of Records and Reports x 1
-Psychologic Testing And Report Administered By Computer x 1
-Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1056 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Signed By DONKIN, LAURA G (Physician) @ 22 Sep 2017 1056

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 21 Sep 2017 0859 EDT.

1. Generalized anxiety disorder

Procedure(s):
-Psychologic Testing And Report Administered By Computer x 1
-Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29690929 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 20 Sep 2017 1142 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: POURZAND, MIRIAM**Reason for Appointment:** Written by CHELLAPPA, MARY R @ 20 Sep 2017 1142 EDT
CRP**S/O Note** Written by HARDY, MARGARET L @ 20 Sep 2017 1451 EDT**History of present illness**

The Patient is a 32 year old male.

Art Therapy (1230-1430) Facilitated by: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist;
Co-facilitated by Margaret Hardy, LCSW-C, Social Worker

This writer co-facilitated art therapy in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations.

OBJECTIVE- This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding.**PROMPT:** Create a wave. Name the art and be present mindfully while creating - without judgment.**PARTICIPATION:** There was no indication of SI/HI. SM drew to the prompt and participated in group discussion integrating the process of doing the art and the symbolic meanings uncovered.**FOLLOW-UP:** Next Art Therapy session will be Tuesday, 26 SEP 2017 at 0900 hours. SM will have safety check-out with their assigned Treatment Team prior to leaving for the day.**Therapy**

Intervention: Art Therapy

Group Therapy

A/P Last Updated by HARDY, MARGARET L @ 20 Sep 2017 1458 EDT**1. Generalized anxiety disorder F41.1:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. SM reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. SM presents for additional support and to learn and implement safe/ Positive coping mechanisms.Procedure(s): -(90853) Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY, MARGARET L;
VANFOSSEN, MALLORY B**Disposition** Written by POURZAND, MIRIAM @ 22 Sep 2017 1049 EDT**Released w/o Limitations****Follow up:** 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By** POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 1050

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 162

AR 0205

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29684296 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **20 Sep 2017 0758 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 20 Sep 2017 1441 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 163

AR 0206

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Sep 2017 0758 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 20 Sep 2017 1227 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #7 and #5 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 7 and # 5 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 20 Sep 2017 1409 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no

physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30,

AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 7 was the # 5 session at 120% MT.

Objective

Next session scheduled.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 164

AR 0207

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 20 Sep 2017 1411 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 20 Sep 2017 1441 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 20 Sep 2017 1441

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 20 Sep 2017 1441 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 20 Sep 2017 1441 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 20 Sep 2017 1412 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29684270 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **20 Sep 2017 0757 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM****AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0717 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 166

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 10 May 2017 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3				
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 10 May 2017 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3				
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 28 Apr 2017 HOURS FOR CONGESTION #0 RF3				
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 28 Apr 2017 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1				
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR 14 Oct 2016				
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR 05 Oct 2015				

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Sep 2017 0757 EDT
IOP

S/O Note Written by GHOLSON, GEORICA K @ 20 Sep 2017 1018 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Finis Taylor, MD, Alex Yilmaz, MS4, and Chelsea Schifferle, MS3. Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored the relation between activating events, beliefs and consequences and how they can dispute their beliefs and adopt effective new beliefs. Intervention: Discussion of the ABCDE model and addressing distressing events in their lives. Group members focused on the ABC portion of the ABCDEF model. Patients discussed a distressing situation, emotions from the situation and the beliefs and thoughts associated with the emotion. Patients also discussed the origin of these thoughts and beliefs. Participation: Patient was attentive throughout psycho education and participated in group discussion. SM was open in discussing a distressing situation related to his military experience. He discussed how his beliefs and automatic thoughts were changed due to life experiences and maturity. He also expressed how challenging it can be to reflect on his emotions and alter his automatic thoughts.

No evidence of SI/II. Next group session is 27 September 2017.

S/O Note Written by DONKIN, LAURA G @ 20 Sep 2017 1037 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Positive Psychology Group 0800-0900 facilitated by Laura Donkin, LCSW and Dr. Deutsch. The purpose of the group is to assist patients in viewing themselves and their situations based on their strengths, rather than weaknesses or symptoms, with the aim of helping them flourish and live a fulfilling life. Today's group was focused on reviewing the factors identified by Dr. Martin Seligman, which are present in people who describe themselves as happy. The discussion was focused on Engagement. There were 2 hand-outs. One hand-out introduced Dr. Seligman's ideas. Another identified the 10 qualifiers of FLOW by Mihaly Csikszentmihalyi. SM actively contributed to group discussion. The next group will be held @ 0800 on 27 July. No SI/II plan or intent present.

S/O Note Written by FRIEDLANDER, JOSHUA N. @ 20 Sep 2017 1052 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Group Therapy Grounding 1000-1100: Instructed group in the definition of

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

grounding and identified different types of grounding skills and how to use them. Pts asked to practice at least one grounding skill this week for review at next week's session. Handouts provided. Pt participated actively. No evidence of SI/HI.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1418 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0800

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1422 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1434 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 168

AR 0211

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 22 Sep 2017 0718 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0718

CHANGE HISTORY

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT - see above.Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 20 Sep 2017 0800 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 169

AR 0212

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

19 Sep 2017 at WRNMMC, GI Clinic Bethesda by BHUSHAN, ANITA

Encounter ID: BETH-29676953 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1530 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **BHUSHAN, ANITA**

Reason for Appointment:

follow up

Appointment Comments:

dtp/rmac pt waived atc

Vitals**Vitals** Written by NG, ANDREW J @ 19 Sep 2017 1515 EDT

BP: 137/87, HR: 76, RR: 14, T: 97.9 °F, HT: 69 in, WT: 164.2 lbs, SpO₂: 95%, BMI: 24.25,
 BSA: 1.9 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

S/O Note Written by BRIDGES, EDWARD E @ 19 Sep 2017 1549 EDT**History of present illness**

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Abdominal pain is worse with intake of insoluble fibers, although, this regimen does resolves his liquid stools producing semi formed stools. Also worse during physical activity and with increased anxiety/stress. He has seen nutrition, adopted a low fodmap diet (no beer, no wine, no rum, no broccoli, no lettuce, no onions, no garlic, no beans, no spinach, no cabbage, no asparagus, no fruits, no sausage, no chorizo, no eggs), and found partial relief in frequency of pain and fecal urgency. He also reports similar relief in symptom frequency with avoiding dairy, caffeine, and sugar-substitutes. He reports reduced stool output with decreased oral intake. He previously tested for celiac serologies and inflammatory markers. Denies EIM's of IBD, as well family h/o IBD. Reports fecal staining twice in the setting diarrhea. Reports 5-15 minute urgency before defecating on every occasion. Denies post defecatory leakage.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

Allergies

Allergies Verified and Updated

NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.

Effexor - started after previously diagnosed IBS-D (used for Anxiety/Depression)

Naltrexone started after previously diagnosed IBS-D (used for ETOH avoidance)

Simethicone qid.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Anxiety/depression

IBS-D

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

PRK

LaForte1 May 2017.

Personal history

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 170

AR 0213

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Family history

Family medical history

No malignant neoplasm of the gastrointestinal tract.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Neck:

Appearance: • Of the neck was normal.

Eyes:

General/bilateral:

Sclera: • Normal.

Lymph Nodes:

• Submandibular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Musculoskeletal System:

Functional Exam:

General/bilateral: • Mobility was not limited.

Other:

General/bilateral: • No muscle tenderness.

Neurological:

• Oriented to time, place, and person.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Skin:

• Showed no ecchymosis. • Temperature was normal. • No skin lesions.

Lab Result Cited by BRIDGES, EDWARD E @ 19 Sep 2017 1611 EDT**Tissue Transglutaminase Ab IgA+IgG Panel**

Tissue Transglutaminase Ab IgA

SERUM

Site/Specimen

<2 <i>

06 Oct 2016 1307

Tissue Transglutaminase Ab IgG

SERUM

<2 <i>

Lab Result Cited by BRIDGES, EDWARD E @ 19 Sep 2017 1610 EDT

IgA

Site/Specimen

06 Oct 2016 1307

IgA

SERUM

256

Lab Result Cited by BRIDGES, EDWARD E @ 19 Sep 2017 1610 EDT**Helicobacter pylori Ag EIA**

Order #

160511-04658 (NNMC Bethesda)

Filler #

160606 NBL 374 (NNMC Bethesda)

Status:

Final

Ordering Provider:

SHAH, NISHA AMISH

Priority:

ROUTINE

Date Ordered:

11 May 2016 0843

Date Resulted:

10 Jun 2016 0857

COLLECT_SAMPLE:

STOOL

Order Comment:

to be done two weeks after stopping protonix

BACTERIOLOGY RESULT:

OBSERVATION: Negative

Specimen:

Feces

Collected:

06 Jun 2016 1312

Results:

Final report

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 171

AR 0214

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lab Result Cited by BRIDGES, EDWARD E @ 19 Sep 2017 1610 EDT

ESR	Site/Specimen	11 Apr 2016 1043
ESR	BLOOD	5

Lab Result Cited by BRIDGES, EDWARD E @ 19 Sep 2017 1300 EDT**Helicobacter pylori Ag EIA**

Order #	160511-04658 (NNMC Bethesda)
Filler #	160606 NBL 374 (NNMC Bethesda)
Status:	Final
Ordering Provider:	SHAH, NISHA AMISH
Priority:	ROUTINE
Date Ordered:	11 May 2016 0843
Date Resulted:	10 Jun 2016 0857
COLLECT_SAMPLE:	STOOL
Order Comment:	to be done two weeks after stopping protonix

BACTERIOLOGY RESULT: OBSERVATION: Negative

Specimen:	Feces
Collected:	06 Jun 2016 1312

Results:	Final report
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A/P Last Updated by BRIDGES, EDWARD E @ 19 Sep 2017 1646 EDT**1. Irritable bowel syndrome with diarrhea:** 32WM with IBS-D predominant symptoms complicated fecal urgency/soiling, with some element of FODMAP associated osmotic diarrhea. Comprehensive evaluation has otherwise been unremarkable.

- Will refer for ARM, possibly followed by biofeedback given reported history of urgency with every bowel movements and occasional fecal soiling (twice)

- Continue dietary modification as noted, including low fodmap and low fructose

- Will trial OTC citrucel to increase stool bulk

- Would suggest Nortryptiline or cymbalta for psychiatry to prescribe to attenuate his IBS related cramping

Disposition Last updated by BHUSHAN, ANITA @ 22 Sep 2017 1218 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note Written by BHUSHAN, ANITA @ 22 Sep 2017 1218 EDT**

I saw and evaluated the patient, and agree with the above findings and plan.

Discussed the plan with patient at length. All questions answered. Pt v/u and agrees.

Signed By BHUSHAN, ANITA (Physician) @ 22 Sep 2017 1218**CHANGE HISTORY****The following Disposition Note Was Overwritten by BHUSHAN, ANITA @ 22 Sep 2017 1218 EDT:**

The Disposition section was last updated by BHUSHAN, ANITA @ 22 Sep 2017 1218 EDT - see above. Previous Version of Disposition section was entered/updated by BRIDGES, EDWARD E @ 19 Sep 2017 1647 EDT.

Released w/o Limitations**Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

40 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 172

AR 0215

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29675580 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1154 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 173

AR 0216

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL	UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 1154 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 19 Sep 2017 1230 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified. Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location. Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate. Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins. Adjustments were made to accommodate comfort. This session number 6 was the # 4 session at 120% MT.

Objective

Next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 19 Sep 2017 1232 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session 6 and #4 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.05 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 6 and # 4 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 174

AR 0217

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 19 Sep 2017 1233 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 19 Sep 2017 1420

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 19 Sep 2017 1233 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29675591 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1154 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 20 Sep 2017 1038 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 176

AR 0219

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 1154 EDT
CRP

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1448 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1155.
Pt denies SI/HI.
Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1449 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1430.
Pt denies SI/HI.
Pt reports following appts on tomorrow, 20 September: none.
Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by DONKIN, LAURA G @ 19 Sep 2017 1518 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Intensive Anger Management Group 1230-1330. 19 September, 2017.
Facilitators: Laura Donkin, LCSW-C and Ms. Gardiner.
Purpose: The purpose of this group is to help people understand the effect that anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the triggers and precipitants that lead to anger and frustration.
Topic: "What's Your Style?" Members explored where they learned their styles of anger, the consequences, the personal physical effects, and how others are affected by this style of anger. We also explored various styles of expressing anger. Most members participated in the exercise. This SM actively contributed to group discussion. The next group will be held on Tuesday, 26 August @ 1230. No indications of suicidal/homicidal ideation, plan or intent.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 177

AR 0220

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by GHOLSON, GEORICA K @ 19 Sep 2017 1540 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: (1330-1420) Comprehensive Recovery Program- Emotional Regulation- Crisis Management-

Facilitators: Penny Miller, recreation therapist and Georica Gholson, PhD, psychologist. PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group

focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports. ACTIVITY: Today's group focused on "Who Can You Tell Your Narrative to?" to provide increased awareness about one's social supports and using their supports before, during and after a crisis. The group discussed individuals they felt comfortable talking with and people they do not feel comfortable discussing their issues with. Various perspectives were explored in addition to strengths and challenges for each patient. Each group member was provided with a worksheet to develop a plan to assess who is in their support network.

PARTICIPATION: Patient actively participated in the discussion. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for

Tuesday 8/29/17.

S/O Note Written by MILLER, PENNY E @ 20 Sep 2017 0942 EDT**Reason for Visit**

Visit for: (1330-1420) Comprehensive Recovery Program- Emotional Regulation- Crisis Management- Facilitators: this writer Penny Miller, recreation therapist and Georica Gholson, psychologist.

PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.

ACTIVITY: Today's group focused on

"Who Can You Tell Your Narrative to?" to provide increased awareness about one's social supports and using their supports before, during and after a crisis. The group discussed individuals they felt comfortable talking with and people they do not feel comfortable discussing their issues with. Various perspectives were explored in addition to strengths and challenges for each patient. Each group member was provided with a worksheet to develop a plan to assess who is in their support network.

PARTICIPATION: Patient was alert, attentive and willingly contributed to the group discussion. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 8/29/17.

S/O Note Written by POURZAND, MIRIAM @ 20 Sep 2017 1039 EDT**History of present illness**

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

1200-1220-met with sm for follow up. Sm requesting tms treatment for depression. Sm currently undergoing tms treatment for anxiety reports no results. Reviewed BHDP scores-self report with sm and asked sm his current sxs.reporting fleeting suicidal thoughts (denies at time of assessment) reports no plan.

FOLLOW UP PLANS

discussed with treatment team sm to follow up with tms treatment team. Scheduled discharge from program on 9/21/17

.....

Physical findings**General Appearance:**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 178

AR 0221

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.
Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.**Psychiatric:**Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Cooperative.
Mood: ° Euthymic.
Affect: ° Normal. Full range, stable, appropriate to situation, normal intensity, congruent with mood.
Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.
Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.**A/P Last updated by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT**

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.
Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 20 Sep 2017 1249 EDT**Released w/o Limitations****Follow up:** 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 20 Sep 2017 1249****CHANGE HISTORY***The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT:*

The A/P section was last updated by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 179

AR 0222

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

@ 19 Sep 2017 1245 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs. duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

19 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29679274 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **19 Sep 2017 1100 EDT**
Clinic: **ATS ADULT BE**Appt Type: **FTR**
Provider: **HANGEMANOLE, DESPINA C****S/O Note Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1411 EDT****History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Scheduling

S) SM reported that he continues to have IBS issues. SM and this writer discussed upcoming schedule and SM went over scheduled VA appointments. SM agreed to begin ATS IOP process groups on 4 October and full IOP on 13 October. SM stated he was doing well and had no concerns to discuss. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate. New appointment summary sheet reviewed and signed.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that are being addressed through PCS and BH. SM would benefit from engaging in community recovery.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will work on treatment planning goals as homework. SM will begin ATS groups on 4 October.

A/P Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1409 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1410 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 19 Sep 2017 1412

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 181

AR 0224

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29668633 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 19 Sep 2017 0805 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: POURZAND, MIRIAM**AutoCites Refreshed by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 182

AR 0225

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 0805 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 19 Sep 2017 0952 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by FRIEDLANDER, JOSHUA N. @ 19 Sep 2017 1056 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Group Therapy Distress Tolerance Skills 1000-1050: Instructed group in how to identify moments of distress, how to build up motivation to improve their coping skills in those moments, and how to develop coping skills to better tolerate those moments. Handouts provided. Pt participated actively. No evidence of SI/HI.

S/O Note Written by HARDY, MARGARET L @ 19 Sep 2017 1059 EDT

History of present illness

The Patient is a 32 year old male.

Creative Writing group (0900 - 1000) Facilitated by Margaret Hardy, LCSW-C, and Seema Reza, Creative Writer. This group is co-led by two providers to address the high acuity of the group members and to have a staff member available should a group member become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively.

PURPOSE: Introduce patients to writing as a means for self-expression, stress relief, and to increase engagement with treatment. The relationship between writing and healing is evidence-based. Research supports that writing combines the objective (what happened) with the subjective (how you felt about it). Writing helps Patients gain insight and process trauma, life events, and gain understanding of their feelings and behavior. Further, research supports that writing for 20 minutes on a consistent basis results in positive effects on white blood cell counts, reduces sick visits, and reduces blood pressures.

TOPIC: In today's group of 10 patients, MS Reza explained the purpose and benefit of writing including biological and emotional to include learning to use words rather than actions as well as areas for further exploration in mental health therapy. Then MS Reza

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 183

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

read Wild Geese, by Mary Oliver followed by group discussed of which lines stood out for them followed by reading of 'Permission Granted', by David Allen Sullivan. Writing prompt was to write from the first few words of each stanza.

PARTICIPATION: Patient participated fully in group. Provider observed no evidence of SI/HI.

FOLLOW-UP: Next Creative Writing Group is scheduled for Thursday, 21 SEP 2017 at 0900 hours. Next IOP group is Distress Tolerance at 1000 hours today.

S/O Note Written by DONKIN, LAURA G @ 19 Sep 2017 1207 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0805-0850. SM presented in positive mood and stated that he had slept well the previous night. We discussed pending discharge on Thursday and SM said that he has outpatient behavioral health appointments scheduled but needs to schedule ATS appointments. SM expressed anxiety about managing multiple appointments and work schedule and seemed especially concerned about all the driving this would entail. We then discussed his current relationships with 2 different women and what he hopes to gain from these relationships. We explored his schizoid traits and his emotional needs. On the one hand he enjoys spending time with women, but then wants no expectations and greatly values his alone time. We also explored what triggered the escalation in his anxiety level, which he now connects with his deployment on a ship for basically 3 years off the coast of Japan. SM had very little privacy or shore leave. SM feels that the military component of his work is especially difficult given his personality traits. We will meet again on Thursday for discharge. No SI/HI plan or intent present.

S/O Note Written by VANFOSSSEN, MALLORY B @ 19 Sep 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0800.

Pt denies SI/HI.

Pt reports following appts this morning: none.

S/O Note Written by VANFOSSSEN, MALLORY B @ 19 Sep 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1050.

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 184

AR 0227

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by POURZAND, MIRIAM @ 20 Sep 2017 1035 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 20 Sep 2017 1035**CHANGE HISTORY***The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT:*

The A/P section was last updated by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 19 Sep 2017 0954 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 185

AR 0228

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B

Encounter ID: BETH-29670106 Primary Dx: Encounter for observation for other suspected diseases and conditions ruled out

Patient: ANDERSON, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: Outpatient

Date: 18 Sep 2017 1300 EDT
Clinic: ATS ADULT BE

Appt Type: GRP
Provider: LESKO, STACEY BETH

AutoCites Refreshed by LESKO, STACEY B @ 19 Sep 2017 0854 EDT

Allergies
•No Known Allergies

Reason for Appointment:
PCS understanding sub abuse
Appointment Comments:
ctc

S/O Note Written by LESKO, STACEY BETH @ 19 Sep 2017 0854 EDT**History of present illness**

The Patient is a 32 year old male.
He reported: Encounter Background Information: TOPIC: Understanding Substance Abuse (1230 - 1320)
S: The group discussed what constitutes low risk drinking vs. high risk drinking (0-1-2-3 rule), standard drink sizes, and national data on adult drinking behaviors. Further discussion had on the risk of mixing medications with alcohol. Group members commented and asked questions on material presented.
O: Appearance: Neat and Clean
Behavior: Appropriate
Speech: WNL
Thoughts: Logical
Mood: Euthymic
Affect: Congruent
Insight: Fair
Judgment: Fair
SI/II: Convincingly Denies
A: SM engaged in discussion both providing and receiving feedback appropriately.
P: SM will continue with PCS IOP as scheduled.

A/P Written by LESKO, STACEY B @ 19 Sep 2017 0854 EDT

1. **Encounter for observation for other suspected diseases and conditions ruled out Z03.89**
Procedure(s): -(90853) Psychiatric Therapy Group Interactive x 1

Disposition Written by LESKO, STACEY B @ 19 Sep 2017 0855 EDT**Released w/o Limitations**

Follow up: in the ATS ADULT BE clinic.

Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 19 Sep 2017 0855

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29659365 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **18 Sep 2017 1155 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM****AutoCites Refreshed by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 187

AR 0230

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3			28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 1155 EDT
TRP

S/O Note Written by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: UNDERSTANDING SUBSTANCE USE: MONDAY @ 1230-1320. Co-Facilitators: Georica Gholson, PhD and Stacy Lesko, Addictions Counselor
PURPOSE: The purpose of this group is to help patients gain an understanding about substance use. Additionally, the group educates patients about medication interactions with and physiological impact of illicit substance use.
TODAY'S INTERVENTION: Group discussion centered on understanding alcohol use. Patients took a substance use quiz and discussed the legal limits, physiological impact, heredity, interaction effects with different medications, and impact of intoxication of alcohol use.
PARTICIPATION: SM was attentive and actively participated in group. No evidence of SI/Hi. Next group session is 2 October 2017.

S/O Note Written by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Symptom Management Group: Facilitated by Dr. Pourzand, psychiatric nurse practitioner 1330-1355
Purpose: Learn to ameliorate and manage symptoms and live a functional and productive life.
Goals/ Objectives: learn resources to manage symptoms, identify personal symptoms, and identify how to manage symptoms.
Activity: Symptom management jeopardy -team exercise
Participation: SM achieved goals/ objectives by participating in activity
Assessment: No indication of distress. No indication of SI/Hi
Plan: Next group scheduled for Monday September 25, 2017.

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 1446 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
Reason for Visit
Check in for Afternoon Programming 1230-1430

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

5 min Check in at: 1155

Program Track:

☒ Comprehensive Recovery Program (CRP)☐ Interpersonal Recovery Program (IRP)☐ Trauma Recovery Program (TRP)☐ Leisure Skills Training (LST)

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations ☐ Yes ☒ No Suicidal Ideation ☐ Yes ☒ No.**S/O Note** Written by DONKIN, LAURA G @ 18 Sep 2017 1449 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at: 1400

Plan for Next Day of Programming

☒ Attend IOP Program tomorrow morning☐ OtherDisposition: ☒ Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations ☐ Yes ☒ No Suicidal Ideation ☐ Yes ☒ No.**A/P** Last updated by DONKIN, LAURA G @ 18 Sep 2017 1450 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2
 ADDITIONAL PROVIDER(S): GHOLSON, GEORICA K;
 DONKIN, LAURA G
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND, MIRIAM @ 19 Sep 2017 1057 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 19 Sep 2017 1057**CHANGE HISTORY**

The following S/O Note Was Deleted by LOWENSTEIN, HELEN @ 18 Sep 2017 1448 EDT:

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1330-1420 Therapy Interfering Behaviors Group. Led by Helen Lowenstein LCSW.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 189

AR 0232

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

PURPOSE: Provide Education on Therapy Interfering Behaviors for TRP patients. To understand how certain behaviors can cause interference with progress.
 TOPIC: Therapy Interfering Behaviors. Hand out had 5 blocks to fill out How did the problem develop, Triggers for the recent episode, the problem, things that kept problem going, and positive things that I've got going for me. This was tied into having patients share what their interfering behaviors have been and what if any are they having now.

PARTICIPATION: SM was an active participant at times throughout the group. SM shared his anger can get in the way of seeking help and the stigma. No evidence of S/I or H/I. Next group to meet 10/02/17 at 1330.

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 1447 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 1447 EDT - see above. Previous Version of A/P section was entered/updated by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): GHOLSON, GEORICA K; LOWENSTEIN, HELEN T

The following A/P Note Was Overwritten by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT:

The A/P section was last updated by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): GHOLSON, GEORICA K

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

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The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT:

The A/P section was last updated by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 18 Sep 2017 1220 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 190

AR 0233

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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AR 0234

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29653480 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **18 Sep 2017 0858 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.**AutoCites Refreshed by LANDE, RAYMOND G. @ 18 Sep 2017 1306 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 0858 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 18 Sep 2017 1210 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified. Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location. Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate. Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins. Adjustments were made to accommodate comfort. This session number 5 was the # 3 session at 120% MT.

Objective

Next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 18 Sep 2017 1234 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #5 and #3 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.05 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 5 and # 3 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 193

AR 0236

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 18 Sep 2017 1213 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 18 Sep 2017 1306 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 18 Sep 2017 1306

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 18 Sep 2017 1306 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 18 Sep 2017 1306 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 18 Sep 2017 1213 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29651041 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **18 Sep 2017 0752 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM**AutoCites Refreshed by POURZAND, MIRIAM @ 19 Sep 2017 1054 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 195

AR 0238

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 0752 EDT
IOP

S/O Note Written by HARDY, MARGARET L @ 18 Sep 2017 0936 EDT

History of present illness

The Patient is a 32 year old male.

Seeking Safety: (Safety) 0800-0850

Facilitators: This group was co-led by Margaret Hardy, LCSW-C and Penny Miller, CTRS, LCSW-C

This writer co-facilitated Seeking Safety Group in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations.

CHECK-IN - mood today was indifferent. Patient's stated the following about this weekend: good coping was, pretended to like myself and cooking for others; no unsafe behavior; commitment was met - cooked for others. Community resource update was to talk with his Social Worker about Command expectation of work while in the IOP Program. Patient's takeaway was - I need to work on boundaries, saying no and no sharing too much information with everybody.

PARTICIPATION: Patient participated fully. There was no indication of SI/HI.

FOLLOW-UP: Next Seeking Safety Group will be Monday, 25 SEPT 2017. The next group today is Common Concerns at 0900 hours. Please see Penny Miller's note of today for additional information.

Therapy

Intervention This Appointment - Group Therapy - Provider normalized ongoing suicidal ideation which began in childhood with recognition that patient knows what to do when things worsen for him, and has sought help.

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 0949 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by MILLER, PENNY E @ 18 Sep 2017 0953 EDT

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 196

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Reason for Visit

Visit for: (0800-0850); IOP Program- Seeking Safety Group: Facilitated by this writer Penny Miller, recreation therapist and Margaret Hardy, social worker.

Purpose: Seeking Safety is a psychoeducational group developed for individuals with co-occurring disorders PTSD and Substance Abuse Disorders based on five central ideas (1) safety as the priority of this first-stage-treatment (2) integrated treatment of PTSD and substance abuse (3) a focus on ideals (4) four content areas: cognitive, behavioral, interpersonal, and case management and (5) attention to the therapist processes.

Activity: "Safety", the topic introduced today is described as the first stage of healing from both PTSD and substance abuse, and the foremost guiding principle throughout this treatment. This session the group reviewed samples of unsafe coping verses safe coping, stages of morning, signs of recovery as well as a list of over 80 safe coping skills were provided. A discussion around the topic was facilitated, providing participants with an opportunity to share their personal experiences.

Participation: Pt was attentive and willingly contributed to the group process. Pt disclosed feelings of guilt and resentment regarding issues of neglect he'd experienced from his father, whom was his primary caretaker as a child. He is reading journals provided to him by his mother, and as a result is still coping with the emotional pain. He also disclosed that he feels that he does not have any boundaries and as a result never set boundaries in past relationships. He stated that he notices that when he does not set boundaries in relationships he ends up regretted not doing so. He was encouraged to meet with his individual therapist to further develop in that area. Next Seeking Safety group is scheduled for Monday 25 September 2017 at 0800. No evidence of SI/HI plan or intent noted.

S/O Note Written by GWIN, KRISTIN MICHELLE @ 18 Sep 2017 0959 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

IOP Common Concerns Group: "Effective Communication" 0900-0950

Facilitator: Kristin Gwin, LCSW-C and Delacie Gardiner

PURPOSE: The purpose of this group is for group members to process role of their symptoms and the impact they may or may not have within the following areas: Marriage and/or Relationship Problems, Parenting Difficulties, Family Function, Social Function. These general areas bring up group discussions centering on the following areas: Fear and Worry, Depression, Family Roles, and Family Dynamics. Discussion also are had on how Family, Financial Difficulties, Avoidance, and Isolation can have an impact on the symptoms that the group members may be experiencing and how that can be communicated to those they are close to. Skills that are reviewed include Effective Communication, Communication Styles, Identifying Family Roles, Coping Skills, and Setting Appropriate Boundaries.

TOPIC: Today, the group topic was the Communication Traps". Group members reviewed 10 of the most common communication traps to include Generalizing, Preaching, Mindreading, Dwelling on the Past, Stomping Out, and Labeling. Group members discussed how they and other around them fall into this trap, and how to negotiate communication in a more effective way by being aware of the traps they most commonly fall into.

PARTICIPATION: Sm had no evidence of homicidal/suicidal ideation. SM was quiet in group however appeared to be actively listening to the group content. Next group is scheduled for 09/25/17.

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 1443 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0745

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 1444 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1055

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 197

AR 0240

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Immediate Future Plans:

- (x) Comprehensive Recovery Program (CRP) 1230-1430
 () Interpersonal Recovery Program (IRP) 1230-1430
 () Trauma Recovery Program (TRP) 1230-1430
 () Attend IOP Program tomorrow morning
 () Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND, MIRIAM @ 19 Sep 2017 1055 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 19 Sep 2017 1055**CHANGE HISTORY**The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT - see above. Previous Version of A/P section was entered/updated by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 198

AR 0241

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

The following A/P Note Was Overwritten by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT:

The A/P section was last updated by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 18 Sep 2017 0936 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 199

AR 0242

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29643565 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 1149 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 15 Sep 2017 1346 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 200

AR 0243

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 15 Sep 2017 1149 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 15 Sep 2017 1240 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 4 was the # 2 session at 120% MT.

Objective

Next session scheduled

S/O Note Written by BRAGGS, DEBORAH C @ 15 Sep 2017 1251 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #4 and #2 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 4 and # 2 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Monday. ZUNG anxiety=54, GAD 7=18.

A/P Last Updated by BAHROO, BHAGWAN A @ 15 Sep 2017 1244 EDT

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 201

AR 0244

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
 PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT**Released w/o Limitations****Follow up:** as needed in 3 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 15 Sep 2017 1347****CHANGE HISTORY***The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT:*

The Disposition section was last updated by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 15 Sep 2017 1243 EDT.

Released w/o Limitations**Follow up:** as needed in 3 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 202

AR 0245

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29643553 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 1148 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 15 Sep 2017 1205 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 203

AR 0246

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 15 Sep 2017 1148 EDT
CRP

S/O Note Written by CLOPPER, TAMMY J @ 15 Sep 2017 1259 EDT
History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 1230
Afternoon Track: CRP
Appointments Reported this afternoon: 1200 TMS
Pain level Reported (0-10): Denies
Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 15 Sep 2017 1407 EDT
History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1400
Afternoon Track: CRP
Appointments Reported for Monday: TMS 1200
Pain level Reported (0-10): Denies
Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by GRAGNANI, CYNTHIA THERESA @ 15 Sep 2017 1507 EDT
History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1350) Staff present: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist, Dr. Gragnani, Psychologist. Pt attended CRP Art Therapy group. This session provided the patient with opportunity to practice creativity and utilize a new outlet for expression, while focusing on art making as a therapeutic practice. This SM was actively engaged in the activity, openly answered questions, and shared with the group. SM was also able to speak to the art making process and how this informed chosen imagery, as well as the insights that were gained. There was no indication of SI/HI.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 204

AR 0247

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by VANFOSSEN, MALLORY B @ 15 Sep 2017 1546 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist, Dr Gragnani, Clinical Psychologist. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. Pts were encouraged to consider topics or lingering thoughts that they may have been introduced to in other groups, images that may have been triggered lately, or using the art to process or explore concepts that they may feel the need to further investigate. Pts were instructed to focus on the topics that may be difficult to express in words. Materials consisted of pastels, pencils, markers, crayons, chalks, acrylic paints, and various sculptural 3D materials. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of coping skills required to focus and allow self to express material visually, persevering through frustration and uncertainty, creating meaning from the process and materials in a way that words alone cannot, the purpose and inclination of self-judgment and criticism related to art making and other activities. There was no indication of SI/HI. Next art therapy session will be held Monday 18 September, 2017.

A/P Last updated by GRAGNANI, CYNTHIA T @ 15 Sep 2017 1508 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1
 ADDITIONAL PROVIDER(S): GRAGNANI, CYNTHIA THERESA

Disposition Written by POURZAND, MIRIAM @ 18 Sep 2017 0944 EDT**Released w/o Limitations**

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 18 Sep 2017 0944**CHANGE HISTORY**

The following A/P Note Was Overwritten by GRAGNANI, CYNTHIA T @ 15 Sep 2017 1508 EDT:

The A/P section was last updated by GRAGNANI, CYNTHIA T @ 15 Sep 2017 1508 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 15 Sep 2017 1207 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 205

AR 0248

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29637426 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 0744 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 15 Sep 2017 1140 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 207

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0
RF3Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
OralTAKE ONE SCOOP EVERY 3 of 3 10 May 2017
DAY MIXED IN LIQUID.
AFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mLDRINK 10ML EVERY 6 3 of 3 28 Apr 2017
HOURS FOR CONGESTION
#0 RF3

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active

DRINK 20ML (400MG) 1 of 1 28 Apr 2017
EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL
#0 RF1FLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE

NR 14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

NR 05 Oct 2015

Reason for Appointment:Written by CHELLAPPA,MARY R @ 15 Sep 2017 0744 EDT
IOPS/O Note Written by EARLEY,KERRIE GLYN @ 15 Sep 2017 1045 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Core Mindfulness Skills: 0800-0850- Facilitated by Kerrie Earley, LCSW

Purpose: Patients will be provided with information regarding the practice of Mindfulness, including the rationale for incorporating this as a practice into daily life. Mindfulness functions as a foundation for being in "Wise Mind"-a state of mind where individuals are more able to engage in skillful behavior and regulate emotions more effectively. Living with awareness in the present moment (neither ruminating on in the past, nor worrying about the future), focusing on one thing at a time in a non-judgmental way and doing what works are some of the core concepts of Mindfulness practice.

Today patients discussed concepts of selective attention, multitasking, and focus in the context of mindfulness. Group members watched two videos and discussed the role of mindfulness in day to day life and in using coping. One group member started speaking at length about a recent accident and his reactions. SW asked follow up questions and redirected him to the topic as he was using graphic and violent language, and patient became upset and declined to finish the story. He left the group and other group members presented as anxious and frustration. SW and patients discussed use of mindfulness to understand their emotions and reactions, their coping skills, and their options for moving forward. Group members provided feedback on the group and ideas for future session. This patient was actively engaged throughout the session. He discussed memories of his father having been brought up in the group and noted recent focus on mindful communication with others in his life.

There was no indication of S/I or H/I present. Next Core Mindfulness Skills group is scheduled for 22 August, 2017.

S/O Note Written by GWIN,KRISTIN MICHELLE @ 15 Sep 2017 1100 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

IOP Guest Speaker Group 0900-1000:

Facilitator: Brian Pampino, Kristin Gwin, LCSW-C , Tammy Buford, RN

PURPOSE: The purpose of this group is to have guest speakers bring various topics that would be relevant to group members and their treatment/recover. Group topics range from finance experts, VA experts, Chaplin, and Med Board experts.

TOPIC: Today, Mr. Pampino from Fleet and Family Services/Financial Department discussed the Eight Steps to Financial Fitness. He engaged the group to discuss budget planning, retirement planning, the cash flow formula, and spending. Group members engaged actively in discussing how to set themselves up for financial fitness and what needs to be considered to do so.

PARTICIPATION: . SM was actively involved in listening to the presentation of the guest speaker and taking notes, and well as asked clarifying questions to better understand the material. SM had no evidence of homicidal/suicidal ideation. SM actively participated. Next group is scheduled for 09-22-17.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 208

AR 0251

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1244 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0740

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1245 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1303 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 1000-1050. SM presented in positive mood and was talkative and smiling throughout session. SM started off session weighing his options for future jobs. He admitted to having many options and considers this a positive. He spent a considerable amount of time discussing his issues with male/female relationships and comparing the 2 women he is currently seeing. SM admits that he needs work on verbal communication and how to be mindful of his word choices. We also discussed what he is hoping to gain from relationships and explored his needs in regards to relationships. SM admitted to having a hard time with male relationships and usually gravitates towards females. SM considered that this may have to do with his experiences being bullied as an adolescent. We discussed his psychiatric diagnosis and the treatment team's decision not to change it. He seemed to accept this without a problem. SM is still contending with his IBS symptoms and shared his frustration. He will work on word mindfulness this weekend. We will meet on Tuesday. No SI/HI plan or intent present.

S/O Note Written by SMITH, JESSICA ANN @ 15 Sep 2017 1317 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH, JESSICA ANN @ 15 Sep 2017 1318 EDT

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 209

AR 0252

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 18 Sep 2017 0932 EDT

Released w/o Limitations

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 18 Sep 2017 0933

CHANGE HISTORY

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 15 Sep 2017 1318 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 15 Sep 2017 1318 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 15 Sep 2017 1311 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 15 Sep 2017 1248 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 15 Sep 2017 1248 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 15 Sep 2017 1140 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 210

AR 0253

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

14 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29632074 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**

Date: **14 Sep 2017 1327 EDT**
Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 14 Sep 2017 1330 EDT

Subjective

Provider was contacted by Dr. Benton regarding collateral information of patient for assessment purposes. Provider presented observational data based on record review and recall of interactions with patient.

A/P Last Updated by PAUL, SHERIN @ 14 Sep 2017 1330 EDT

1. Generalized anxiety disorder

Disposition Last Updated by PAUL, SHERIN @ 14 Sep 2017 1330 EDT

Follow up: in the PSYCHIATRY BE clinic.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 14 Sep 2017 1330

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29630836 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 Sep 2017 1238 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
OralRF3
TAKE ONE SCOOP EVERY 3 of 3 10 May 2017
DAY MIXED IN LIQUID.Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mLAFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active

DRINK 10ML EVERY 6 3 of 3 28 Apr 2017
HOURS FOR CONGESTIONFLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE#0 RF3
DRINK 20ML (400MG) 1 of 1 28 Apr 2017
EVERY FOUR HOURS FOR
BASELINE PAIN CONTROLAFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE#0 RF1
NR 14 Oct 2016

NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 1238 EDT
CRP**S/O Note** Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1253 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1145 Check in to afternoon program. SM denied SI/HI. Will attend groups this afternoon.

S/O Note Written by DONKIN, LAURA G @ 14 Sep 2017 1406 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Life Skills Group

1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "11 Warning Signs of Depression and Relapse." Group members shared their individual warning signs and explored how they should react. This SM actively participated in group discussion. No SI/HI plan or intent present. The next group will be on 22 September.

S/O Note Written by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMUNICATION SKILLS 1330-1420

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician

Purpose: Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.

Intervention: Group members were given a handout that discussed 3 different responses to criticism - passive, aggressive, and assertive. Group members learned the differences between the types and discussed which ones they engage in when encountering criticism. Also, group members discussed how the expressed feedback to other people. Lastly, group members discussed how the messenger and delivery style of the message impacts how they receive feedback and criticism.

Participation: SM participated in group discussion.

Assessment: No indication of distress. No indication of SI/HI

Plan: Next group scheduled for Thursday 21 September 2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1541 EDT

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Page 214

AR 0257

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1430 Check out of PCS for the day. SM denied SI/HI. 1200 TMS tomorrow - will report for groups in morning.

A/P Last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
-Psychiatric Therapy Individual Approximately 30 Minutes x 2
-Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND, MIRIAM @ 15 Sep 2017 0754 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 15 Sep 2017 0754

CHANGE HISTORY

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
-Psychiatric Therapy Individual Approximately 30 Minutes x 1
-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT:

The A/P section was last updated by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 215

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1254 EDT.

1. Generalized anxiety disorder

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 216

AR 0259

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29629914 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 Sep 2017 1141 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 14 Sep 2017 1319 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 217

AR 0260

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 1141 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 14 Sep 2017 1227 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 3 was the first session at 120% MT.

S/O Note Written by BRAGGS, DEBORAH C @ 14 Sep 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #3 and #1 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.45 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 3 and # 1 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO, BHAGWAN A @ 14 Sep 2017 1229 EDT

1. Generalized anxiety disorder

Procedure(s):

-Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 218

AR 0261

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Last updated by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 14 Sep 2017 1319

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 14 Sep 2017 1229 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29623620 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 Sep 2017 0756 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 220

AR 0263

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0
RF3Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
OralTAKE ONE SCOOP EVERY 3 of 3 10 May 2017
DAY MIXED IN LIQUID.Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mLAFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3DRINK 10ML EVERY 6 3 of 3 28 Apr 2017
HOURS FOR CONGESTION

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active

#0 RF3
DRINK 20ML (400MG) 1 of 1 28 Apr 2017EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL
#0 RF1FLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE

NR 14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 0756 EDT
IOP**S/O Note** Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 0801 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800 Check in to PCS Team A. SM denied SI/HI. No appts scheduled today.

S/O Note Written by GHOLSON, GEORICA K @ 14 Sep 2017 1013 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Interpersonal Effectiveness (0800-0850) Georica Gholson, PhD and Narce Pratt, LCSW-C

Purpose: Patients will examine their patterns of relating to others. Patients will begin to explore how to interrupt unhelpful patterns and foster healthy patterns of relating. Patients will be challenged to find a balance between passivity (as well as passive-aggressive behavior) and aggression. Patients will rehearse ways to effectively ask for what they want, keep relationships they want or need to keep and maintain their self-respect. Developing and maintaining a level of healthy interpersonal boundaries will also be addressed.

Today group began with introductions and recognition of one way they have helped or been helped by others this week. All patients participated. Patients were introduced to the idea of identifying the goal of their interactions- getting what they want/need, keeping the relationship, or maintaining self-respect. Group members considered ways of approaching difficult conversations and were introduced to the DEAR-MAN skills, emphasizing the importance of asking or asserting rather than hinting, and being aware of one's approach. Group members discussed the idea of how or when this is used as manipulation. Group members discussed approaches to the skill and the idea that sometimes people are not will or able to give them what they want or need. This patient was actively engaged in the discussion.

There was no indication of S/I or H/I present. Next interpersonal effectiveness group is scheduled for 21 September 2017.

S/O Note Written by DONKIN, LAURA G @ 14 Sep 2017 1036 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 221

AR 0264

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by HARDY, MARGARET L @ 14 Sep 2017 1057 EDT**History of present illness**

The Patient is a 32 year old male.

Creative Writing group (0900 - 1000) Facilitated by Margaret Hardy, LCSW-C, and Seema Reza, Creative Writer. This group is co-
led by two providers to address the high acuity of the group members and to have a staff member available should a group member
become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively.

PURPOSE: Introduce patients to writing as a means for self-expression, self-care, stress relief, and to increase engagement with
treatment. The relationship between writing and healing is evidence-based. Research supports that writing combines the objective
(what happened) with the subjective (how you felt about it). Writing helps Patients gain insight and process trauma, life events, and
gain understanding of their feelings and behavior. Further, research supports that writing for 20 minutes on a consistent basis
results in positive effects on white blood cell counts, reduces sick visits, and reduces blood pressures.

TOPIC: Ms Reza read - What Secrets We Keep (pg 10-11) by Shinji Moon from his book, The Anatomy of Being (2012). Group
participates wrote for 7 minutes from prompt, For so many years I've held words beneath my tongue like ... The second poem by
the same author was Kintsugi (pg 13). Prompt: We were never taught ... Final poem was Joy by Seema Reza from her book,
When the World Breaks Open.

PARTICIPATION: Patient participated fully. Provider observed no evidence of SI/Hi during group.

FOLLOW-UP: Next Creative Writing Group is scheduled for Thursday, 21 SEP 2017 at 0900 hours. Next IOP group is Recreation
Therapy at 1000 hours today.

S/O Note Written by PRATT, NARCEDALIA @ 14 Sep 2017 1114 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Interpersonal Effectiveness (0800-0850) Narcedalia Pratt, LCSW-C and Dr.
Gholson, Ph.D.

Purpose: Patients will examine their patterns of relating to others. Patients will begin to explore how to interrupt unhelpful
patterns and foster healthy patterns of relating. Patients will be challenged to find a balance between passivity (as well as passive-
aggressive behavior) and aggression. Patients will rehearse ways to effectively ask for what they want, keep relationships they want
or need to keep and maintain their self-respect. Developing and maintaining a level of healthy interpersonal boundaries will also be
addressed.

Topic: Today group focused on DEAR-MAN skill for getting what one wants/needs in a relationship. This writer served as co-
facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion,
and checking for safety with members who leave the room.

Participation: SM was actively engaged in the group discussion.

There was no indication of SI/ or H/I present. Next interpersonal effectiveness group is scheduled for 21 September 2017.

S/O Note Written by LOWENSTEIN, HELEN T @ 14 Sep 2017 1233 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

(1000-1050) - Recreation Therapy- "This group was facilitated by Penny Miller, recreation therapist and Helen
Lowenstein, social worker LCSW.

Purpose: To provide an opportunity for healthy communication, problem-solving, encourage teamwork and compromise.

TOPIC: Ice breaker/group activity. Hand out provided that asked patients to identify other group members to Find Someone
Who. There were 20 questions asked such as have you lived in another country, have you lived in the barracks and so forth.
Patients were asked to talk with others they normally don't talk with. This allowed patients to work together and experience team
work, utilize communication skills, and movement.

Participation: PT was an active participant throughout the group. No evidence of SI/ or H/I. Next session is scheduled for
9/21/17, 1000.

S/O Note Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1251 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1100 Check out of morning program. SM denied SI/Hi. Will return for
afternoon groups.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by POURZAND, MIRIAM @ 15 Sep 2017 0748 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Met with sm for BHDP treatment plan individual encounter placed.

A/P Last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1253 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 2
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by POURZAND, MIRIAM @ 15 Sep 2017 0749 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 15 Sep 2017 0749**CHANGE HISTORY****The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1253 EDT:**

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1253 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 14 Sep 2017 1037 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1 ADDITIONAL PROVIDER(S): DEUTSCH, ANNE MARIE
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 14 Sep 2017 1037 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 14 Sep 2017 1037 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 223

AR 0266

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1 ADDITIONAL PROVIDER(S): DEUTSCH, ANNE MARIE

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 0802 EDT.

1. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 224

AR 0267

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29621315 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **13 Sep 2017 1552 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY	0 of 1	06 Sep 2017		
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	MOUTH EVERY DAY #0 RF1				
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY	0 of 1	06 Sep 2017		
PROBIOTIC (VSL#3) DS-PO PACK	Active	MOUTH EVERY DAY #0 RF1				
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	TAKE 2 BY MOUTH EVERY	2 of 3	06 Sep 2017		
		DAY #0 RF3				
		TAKE ONE PACKET BY	1 of 1	06 Jun 2017		
		MOUTH EVERY DAY #0 RF1				
		CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017		
		FOUR TIMES A DAY AS				
		NEEDED FOR GAS #0 RF2				
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017		
		UNDER TONGUE EVERY				
		EIGHT HOURS AS NEEDED				
		FOR ABDOMINAL PAIN #0				
		RF3				
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY	3 of 3	10 May 2017		
		DAY MIXED IN LIQUID,				
		AFTER TWO WEEKS				
		INCREASE TO TWICE				
		EVERY DAY #0 RF3				
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6	3 of 3	28 Apr 2017		
		HOURS FOR CONGESTION				
		#0 RF3				
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG)	1 of 1	28 Apr 2017		
		EVERY FOUR HOURS FOR				
		BASELINE PAIN CONTROL				
		#0 RF1				
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016		
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015		

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT
Treatment Plan Update Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Anderson
13 SEPT 2017
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):
Overall health reported as: Good
Pain Level (0-10): 0 Currently treated: N/A
Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No
past attempts as of 09/06/2016: 3
Most recent Suicidal Ideation: Within the past week
Suicidal Ideation Duration: Fleeting - a few seconds or minutes
Suicidal Ideation Frequency: Once a week
Protective Elements Stopping Suicidal Actions: Family, Fear of failing
Harm Others Risk over next week as of 9/13/2017 - None Active Plan: N/A
Patient with access to weapons: No
Recent Outcome Measures (last 30 days)
BASIS24 - Score: 2.63 - High levels of general distress reported (9/13/2017)
PHQ9 - Score: 21 - Severe depressive symptoms reported. Evaluation indicated. (9/13/2017)
GAD7 - Score: 20 - Severe anxiety symptoms reported. Evaluation indicated. (9/13/2017)
PCL-5 - Score: 61 - Significant PTSD symptoms reported (9/13/2017)
PCL-C: N/A
AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 226

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

CSI - Score: -2 - Pt reports no significant other - no score (9/13/2017)

ISI - Score: 25 - Clinical insomnia (severe) (9/13/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT PLAN UPDATE Treatment team met Wednesday 30 AUG to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). SM has been referred to Recreation Therapy and has started TMS treatment for anxiety. His discharge date from PCS is 21 SEPT.

S/O Note Written by POURZAND, MIRIAM @ 14 Sep 2017 0949 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: BHDP completed see add note section.

Note Written by POURZAND, MIRIAM @ 14 Sep 2017 0949 EDT**Met with SM to complete BHDP from 0920-0950****NOTES FROM TODAY'S SESSION:**

Treatment modality currently used: Not Set

Response to treatment: [] None [x] Some [] Significant [] Marked

RISK ASSESSMENT:

Clinician-determined risk level at start of appointment - No risk level set

MEDICATIONS:

Current side effects: none

Current response: doesn't feel any changes

Allergies were reviewed as indicated. Allergic to cats and dogs

OBJECTIVE (O):**MENTAL STATUS EXAM:**

Appearance: well-kept

Behavior/Orientation: x4, appropriate

Abnormal Movements: trichotillomania-back of hair picking- 25% of waking hours

Rapport: appropriate

Speech: non pressured

Mood: grumpy per report, but presents pleasant

Affect: full ranging

Thought Process: clear, direct, oriented

Thought Content: non delusional

Judgment: good

Insight: good

Impulsivity: none impulse- hx of ETOH

Cognition: Average

Fund of Knowledge: well

OTHER OBJECTIVE FINDINGS/LAB RESULTS:**ASSESSMENT (A):****DIAGNOSIS:**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 227

AR 0270

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

anxiety d/o

SAFETY RISK:

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ HighHarm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.☐ Patient released to Chain of Command with the following limitations: _____**LEARNING/NEEDS ASSESSMENT:**

Patient would like the following information at this appointment: none

PLAN (P):

Patient was educated about and stated understanding of the diagnosis and treatment options. Patient collaborated on and agreed to the following treatment plan:

High Interest Case? No

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____Labs: ☒ CBC ☒ LFTs ☒ TSH ☒ Chem 8 ☐ Lipids☒ Fasting Glucose ☒ HCG ☒ UDS ☒ Vit B12 ☐ _____Safety Plan:

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety

Goal: reduction

Objective: sxs reduction by 20% next BHDP screening

Intervention: TMS

Measure: GAD score 20 9/13/17 indicating severe anxiety

Progress: to be determined sm recently started TMS anxiety treatment on 9/13/17

Problem #2: depression

Goal: reduction

Objective: sxs reduction by 20% next BHDP screening

Intervention: medication increase Effexor 150 mg to 225 mg on 9/6/17

Measure: PHQ9 severe 21 depression score

Progress: sm reports increase severity due to circumstantial due to command stress

Therapy Type: CBT, DBTPlanned Frequency:

Patient's capacity to participate in and benefit from therapy is evidenced by:

☒ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication:

Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 228

AR 0271

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery. Patient reports taking medications as prescribed: Yes/No
Patient reports following changes in medication:

MED	SIG	Target Dose	Target Symptoms
Effexor XR	225 mg daily	for depression and anxiety treatment	
Rozereem	8 mg qhs	for sleep -sm has not started medication yet	
Naltrexone	50 mg daily	prevent ETOH cravings	

Other Interventions (Social, Occupational, Case Management): recreation therapy referral entered 9/13/17

Prognosis:

[] Excellent [] Good [] Fair [x] Guarded [] Poor

Follow-up: PSYCHIATRY/WRNMMC KEMEZIS,PAT 26Sep2017@1000 GRP/90 PENDING

PSYCHIATRY BE/WRNMMC PAUL,SHERIN 27Sep2017@1000 FTR/60
PSYCHIATRY BE/WRNMMC TOBAR,EDEN 27Sep2017@1100 FTR/30
Sm scheduled to be discharged from PCS 9/21, will continue to present for TMS only

Referrals: recreation therapy, TMS

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile:**SM in process of MEB**

Is Service Member able to carry and fire weapon, from a Behavioral Health perspective (safety)? **No**
 Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
 Is Service Member able to deploy? **No**
 Can Service Member perform MOS duties? **No**

A/P Last updated by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1 ADDITIONAL
 PROVIDER(S): POURZAND,MIRIAM
 -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1304 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 14 Sep 2017. 1304

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 13 Sep 2017 1553 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 229

AR 0272

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29615608 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **13 Sep 2017 1159 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM**AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1334 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 230

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0
RF3Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
OralTAKE ONE SCOOP EVERY 3 of 3 10 May 2017
DAY MIXED IN LIQUID,
AFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mLDRINK 10ML EVERY 6 3 of 3 28 Apr 2017
HOURS FOR CONGESTION
#0 RF3

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active

DRINK 20ML (400MG) 1 of 1 28 Apr 2017
EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL
#0 RF1FLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE

NR 14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 1159 EDT
LST**S/O Note** Written by SMITH, JESSICA ANN @ 13 Sep 2017 1327 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at: 1230

Program Track:

☒ Comprehensive Recovery Program (CRP)☐ Interpersonal Recovery Program (IRP)☐ Trauma Recovery Program (TRP)

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by EARLEY, KERRIE GLYN @ 14 Sep 2017 0635 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Service Dog Training Group 1230-1405 -Facilitated by Kerrie Earley, LCSW;
SPC Santiago, behavioral health tech Co-Led by Jen Blessing service dog trainer

Purpose: This group's intent is to provide a therapeutic opportunity for active hands on involvement in process training dogs in the service dog training program. The group reviews the concept of mindfulness and provides an experiential opportunity to incorporate skills into daily life. In attempt to bridge the gap between information and application, this group provides a practical exercise to apply coping skills in action within a safe supportive environment.

Group members review concepts of mindfulness practice and considered how those skills may be useful with service dog training as well as in other areas of their lives. Patients were asked to be mindful about their own moods, reactions, and behaviors in addition to the dogs. Patients were guided through training exercises, and were given time to pet the dogs and ask questions. Participation: This patient was very motivated and engaged. He reported a strong connection with dogs and had working knowledge of training. He noted the possibility that it is something he wants to pursue further.

Next opportunity for art, recreational, and off-unit activities will occur next Wednesday. Service Dog Training group is held twice monthly. No suicidal, homicidal, plan or intent present.

S/O Note Written by SMITH, JESSICA ANN @ 14 Sep 2017 0843 EDT**History of present illness**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 231

AR 0274

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1420

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 14 Sep 2017 1327 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 14 Sep 2017 1327**CHANGE HISTORY**The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT - see above. Previous Version of A/P section was entered/updated by EARLEY,KERRIE G @ 14 Sep 2017 0636 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 232

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by EARLEY, KERRIE G @ 14 Sep 2017 0636 EDT:

The A/P section was last updated by EARLEY, KERRIE G @ 14 Sep 2017 0636 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 13 Sep 2017 1334 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

13 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29615449 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Sep 2017 1100 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

jbf

Note Written by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1227 EDT**Focus Of Session: Recent Cravings**

S) SM reported that he has been having less frequent IBS episodes but reported that when they do happen they are more intense. SM stated that he has been doing the gratitude list as a family text and while sometimes it's difficult to find things to be grateful for it is forcing dialogue with his family. SM reported he's been less successful with his "to do list" goals, but agreed to step back from trying to accomplish one goal a day and try to accomplish 2-3 goals per week instead. SM stated he went to one meetings in the last 3 weeks and found it "ok". SM agreed to continue going to one meeting per week. SM reported he is not sure if PCS is helpful and is not learning many new skills but is finding some self discovery through group discussion. SM reported he has two weeks of groups left and then he will continue getting TMS through PCS for another 2 weeks. SM stated he's been having more cravings and shared that his BH provider may switch him from Naltrexone to Campral. SM stated he's been getting through the cravings by eating and sleeping. He stated his anxiety is also increasing and was able to identify some of the reasons this may be happening. SM reported he had a preliminary sleep study which resulted in a consult to the sleep clinic. SM reported he is hopeful that if his sleep improves his anxiety, cravings and concentration issues may also improve. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that are being addressed through PCS and BH. SM would benefit from engaging in community recovery. Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week. SM will work on treatment planning goals as homework.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1153 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1159 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 13 Sep 2017 1228

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29608213 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL D
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 13 Sep 2017 0752 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: LANDE, RAYMOND G.AutoCites Refreshed by LANDE, RAYMOND G. @ 13 Sep 2017 1345 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 235

AR 0278

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017	
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3		3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC. GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active			NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC. CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active			NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 0752 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 13 Sep 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #2 at none therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.50 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 2 with MT level at non-therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 13 Sep 2017 1341 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 2 started at 95% and ended with 120% MT.

Objective

Next session was scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 13 Sep 2017 1344 EDT

1. Generalized anxiety disorder

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 13 Sep 2017 1346

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 13 Sep 2017 1345 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29608135 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Sep 2017 0750 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1006 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 238

AR 0281

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 0750 EDT
IOP

S/O Note Written by HART, DANIEL C @ 13 Sep 2017 1111 EDT

History of present illness

The Patient is a 32 year old male.

Core Beliefs

IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Dan Hart, M.D., J.T. Cederberg, D.O., and Sam Woodle, MS4

Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored understanding and identifying core beliefs. Patients also discussed how core beliefs are related to their automatic thoughts and emotional experiences. Intervention: Discussion of maladaptive and adaptive core beliefs and how to support/challenge them. Participation: Patient initially stated that he was "indifferent" at the outset of the group but later was attentive throughout psycho education and participated in group discussion - he volunteered to share his core belief and the rest of his worksheet. No evidence of SI/HL. Next group session is ABCDE Model.

S/O Note Written by SMITH, JESSICA ANN @ 13 Sep 2017 1317 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-In at :0750

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH, JESSICA ANN @ 13 Sep 2017 1321 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-Out at :1015

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 239

AR 0282

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Immediate Future Plans:

- (x) Comprehensive Recovery Program (CRP) 1230-1430
- () Interpersonal Recovery Program (IRP) 1230-1430
- () Trauma Recovery Program (TRP) 1230-1430
- () Attend IOP Program tomorrow morning
- () Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 13 Sep 2017 1325 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by GHOLSON,GEORICA K @ 13 Sep 2017 1346 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Dan Hart, M.D., J.T. Cederberg, D.O., and Sam Woodlee, MS4

Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored understanding and identifying core beliefs. Patients also discussed how core beliefs are related to their automatic thoughts and emotional experiences. Intervention: Discussion of maladaptive and adaptive core beliefs and how to support/challenge them. Participation: Patient was attentive throughout psycho education and participated in group discussion. No evidence of SI/Hi. Next group session is 20 September 2017.

S/O Note Written by POURZAND,MIRIAM @ 13 Sep 2017 1418 EDT**History of present illness**

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

0945-1010 met with SM for follow up. Sm reports anxiety and depression remains aware Effexor recently increased from 150 to 225 mg daily. Also aware recently started TMS so TMS and effexor should be beneficial in sx reduction but will take some time. Sm reports sleep problems taking melatonin in the past and somewhat effective. Rozorem 8 mg qhs ordered reviewed administration and potential side effects. Sm aware to take medication on an empty stomach. Also discussed discharge planning referral entered for rec therapy as adjunct treatment. Also gave sm list of discharge appts as sm has end date of 9/21/17 will present only for TMS.

FOLLOW UP PLANS

end of the week

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Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 240

AR 0283

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal. Full range, stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

S/O Note Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1626 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800-0850: Positive Psychology group, co-facilitated by Dr. Deutsch, psychologist and SPC Santiago, psychiatric technician. This group is designed to help members learn ways to increase well-being, meaning, and joy in their lives using research-based methods of positive psychology. The model used is that developed by Martin Seligman, using the PERMA acronym: positive emotion, engagement, relationships, meaning and accomplishment. Today's group was a discussion of positive emotion. Members discussed "what constitutes a good life?", then identified positive emotions which come from each of our senses. This SM. There was no evidence of SI/HI. Released without limitations to attend 0900 group. Next Positive Psychology group will meet in one week.

A/P Last updated by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):	-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1
Consult(s):	-Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE Provisional Diagnosis: Generalized anxiety disorder

Disposition Written by POURZAND, MIRIAM @ 14 Sep 2017 1320 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 241

AR 0284

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 14 Sep 2017 1321**CHANGE HISTORY****The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT:**

The A/P section was last updated by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 13 Sep 2017 1325 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN
Consult(s): -Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE
Provisional Diagnosis: Generalized anxiety disorder

The following A/P Note Was Overwritten by SMITH, JESSICA ANN @ 13 Sep 2017 1322 EDT:

The A/P section was last updated by SMITH, JESSICA ANN @ 13 Sep 2017 1322 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 13 Sep 2017 1043 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Consult(s): -Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE
Provisional Diagnosis: Generalized anxiety disorder

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 242

AR 0285

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29599553 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **12 Sep 2017 1153 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 243

AR 0286

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 1153 EDT TRP

S/O Note Written by VANFOSSEN, MALLORY B @ 12 Sep 2017 1336 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1150.
Pt denies SI/HI.
Pt reports the following appts this afternoon: 1200 TMS. No PM programming.

S/O Note Written by VANFOSSEN, MALLORY B @ 12 Sep 2017 1337 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1300.
Pt denies SI/HI.
Pt reports following appts on tomorrow, 13 September: 0900 individual therapy, 1200 TMS.
Pt will return to program tomorrow at regularly scheduled time.

A/P Last Updated by CLOPPER, TAMMY J @ 12 Sep 2017 1306 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.
Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 244

AR 0287

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Disposition Written by POURZAND, MIRIAM @ 13 Sep 2017 1357 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 13 Sep 2017 1357

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29599549 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **12 Sep 2017 1152 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites Refreshed by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 246

AR 0289

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 1152 EDT
TMS

S/O Note Written by GHURANI, SAWSAN @ 12 Sep 2017 1324 EDT

History of present illness

The Patient is a 32 year old male.
A procedural time out was done during which settings and patient was re-identified.
60 minutes.
Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.
Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.
Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos
SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0
Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.
Adjustments were made to accommodate comfort.
This session number 1 ended with 95% MT.

S/O Note Written by BRAGGS, DEBORAH C @ 12 Sep 2017 1349 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed. Up/Down 7.5, Side/Side 1, LLC 1.0, MT .94, SOA 30, AP 10.7, Coil +10.
Procedure: MT 80% up to 95%. TMS Treatment for depression session #1 at non therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 22.04 minutes. A procedural time out was done during which settings and patient was re-identified.
PROGRESS IN MEETING GOALS:
This is session # 1 with MT level at non-therapeutic treatment level for entire session.
Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Last Updated by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 13 Sep 2017 0659

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 248

AR 0291

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29592059 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **12 Sep 2017 0755 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1350 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 249

AR 0292

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 0755 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DONKIN, LAURA G @ 12 Sep 2017 1117 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0900-1000. SM presented in positive mood. SM started off discussing his future career, as he has been pondering this. He feels that his current job with NSA in IT has been very stressful and wonders whether the financial benefit is worth the anxiety. SM said that he loves to cook and wonders if that can be turned into a career. This SW pointed out that a career in computers does not necessarily mean that it will be stressful and that SM is very talented in this field. SM replied that this is true and will give this some more thought. SM said that he will be starting VA medical appointments in about a week for his medical board. We explored the current state of his anxiety and depression. SM is to start TMS treatments for anxiety today at noon. SM said that he has learned some new things about himself while in groups and gave some examples. He mentioned that he talked with estranged sister last Friday and told her that he would like to meet with her and talk about his sexual molestation of her when they were adolescents. SM reported that sister said that she is open to discussion and moving forward. SM is to think about what he would like to focus on in therapy for his final week at PCS. We will meet again on Friday. No SI/Hi plan or intent present.

S/O Note Written by LOWENSTEIN, HELEN T @ 12 Sep 2017 1210 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
Distress Tolerance Group, (1000-1050). Facilitated by Ms. Helen Lowenstein, LCSW and SPC Santiago. Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis. Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.
Topic: Self soothing skills ways to incorporate old and new coping patterns for healthier outcomes. First hand out provided

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 250

AR 0293

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

was Self Soothing Comforting yourself through the five senses and it listed the five as Touch, Hear, See, Taste, & Smell. The 2nd hand out provided was the Road to a Life Worth Living. One side of the pyramid was the problems, and things to decrease, the other side DBT skills and increase. These hand outs sparked lively discussions on ways to incorporate and adopt healthy coping skills in distressing situations.

PARTICIPATION: Pt was an quiet throughout most of the group, however, shared he uses coffee as his go to coping skill because of the taste and smell and food at times especially love of pizza helps him when in distress to calm down. No evidence of SI/HI. Next group to meet 09/19/17 at 1000.

S/O Note Written by HARDY,MARGARET L @ 12 Sep 2017 1216 EDT

Therapy

Intervention This Appointment - Group Therapy.

Intervention This Appointment - Dialectical Behavior therapy (DBT)- emotion regulation.

S/O Note Written by VANFOSSSEN,MALLORY B @ 12 Sep 2017 1328 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0800.

Pt denies SI/HI.

Pt reports following appts this morning: 0900 individual therapy, 1200 TMS, No PM program today.

S/O Note Written by VANFOSSSEN,MALLORY B @ 12 Sep 2017 1329 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1055

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by DONKIN,LAURA G @ 12 Sep 2017 1127 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by POURZAND,MIRIAM @ 13 Sep 2017 1351 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMCM Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 251

AR 0294

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 13 Sep 2017 1351**CHANGE HISTORY**The following A/P Note Was Overwritten by DONKIN, LAURA G @ 12 Sep 2017 1127 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 12 Sep 2017 1127 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES. PER DIEM x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 12 Sep 2017 0757 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 252

AR 0295

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29582912 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Sep 2017 1133 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 253

AR 0296

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3			10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3			28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR			05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 11 Sep 2017 1133 EDT
CRP

S/O Note Written by GHOLSON, GEORICA K @ 11 Sep 2017 1341 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: EXPLORATION OF STIGMA @1230-1320
Facilitators: Georica Gholson, PhD, psychologist and Tammy Buford, psychiatric clinical nurse.
PURPOSE: The purpose of this group is to help patients gain an understanding about mental health stigma. Additionally, the group discusses mental health stigma within the military, their family and friends and in other settings. Also, the group learns about myths and facts related to mental health disorders.
TOPIC: Group discussion centered on internalized mental health stigma. Group members took a quiz to determine the degree of the own internalized mental health stigma. Group discussed thoughts and beliefs they held about their diagnosis as well as ideas that they disagreed with.
PARTICIPATION: SM arrived late to group due to a previous appointment. However, he was actively engaged and offered insightful commentary and suggestions to other group members. Also, SM shared a video on depression with the group that he said helped him explain his mental illness to those around him. No evidence of SI/II. Next group session is 25 September 2017.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1518 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
Reason for Visit
Check in for Afternoon Programming 1230-1430
5 min Check in at: 1135
Program Track:
(x) Comprehensive Recovery Program (CRP)
() Interpersonal Recovery Program (IRP)
() Trauma Recovery Program (TRP)
() Leisure Skills Training (LST)
0 Pain level (0-10)
Psychiatric Exam:
Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1520 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
 -Psychiatric Therapy Group Interview x 1
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 12 Sep 2017 1117**CHANGE HISTORY****The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT:**

The A/P section was last updated by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 11 Sep 2017 1521 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s):
 -Psychiatric Therapy Group Interview x 1
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 11 Sep 2017 1521 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 11 Sep 2017 1521 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 11 Sep 2017 1343 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s):
 -Psychiatric Therapy Group Interview x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 255

AR 0298

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29577207 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Sep 2017 0842 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 12 Sep 2017 1107 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 256

AR 0299

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 11 Sep 2017 0842 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1032 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 11 Sep 2017 1033 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: COMMON CONCERNS GROUP - "0900-0950" Facilitators: This group was co-led by Ms. Lowenstein, LCSW and Ms. Delacie Gardiner.
PURPOSE: The purpose of this group is to allow group members to identify and process common emotional states and how to cope with states using various CPT/DBT techniques. Group members will discuss topics such as anxiety, depression, insomnia, grief, anger, etc, and connect with each other on an emotional level with other group members. This group consists of all three IOP tracks: IRP, CRP, TRP.
TOPIC: Conflict Resolution Tips. Patients were provided a hand out with 12 conflict resolution tips. Each tip was identified and explained in the hand out. Patients were asked to discuss the steps and how they can adopt healthier skills with conflict. This opened up a lively discussion on different ways to handle conflict resolution in a more constructive way.
PARTICIPATION: This group is co-led by two providers to address the high acuity of the group members and to have a staff member available should a group member become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively. SM was quiet throughout the group. SM appeared to be listening as evidenced by head nodding, and direct eye contact. No evidence of S/I or H/I. Next group scheduled for 09/18/17 at 0900.

S/O Note Written by CLOPPER, TAMMY J @ 11 Sep 2017 1057 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Seeking Safety Group: "Taking Good Care of Yourself" 0800-0850
Facilitators: Dr. Gragnani and Tammy Buford, RN.
PURPOSE: The purpose of this group is based on five central ideas (1) safety as the priority of this first-stage-treatment (2) integrated treatment of PTSD and substance abuse (3) a focus on ideals (4) four content areas: cognitive, behavioral, interpersonal, and case management and (5) attention to the therapist processes.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

TOPIC: This group focused on "Taking Good Care of Yourself" in which patients were asked to evaluate whether they are taking good care of themselves. Patients filled out the questionnaire and discussed their answers.

PARTICIPATION: SM attended group, was attentive to facilitators and participated in group discussion. SM reports feeling grumpy d/t being late this morning from 3 car accidents on the way to programming. States his weekend was ok, stating he went to a friend's house and watched a movie and had dinner. States on Sunday he had to go to the VA for an appointment then went on a date. States he also talked to his family. No evidence of SI/HI. Next group 18Sept2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 11 Sep 2017 1130 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1000-1100: Sleep Improvement Group in IOP. Group led by Dr. Deutsch, psychologist. This was the first session of the 4-week sleep improvement series, which meets to address insomnia and nightmares from a CBT-I perspective. Members were introduced to the topic of sleep as a whole, and were given a National Sleep Foundation quiz on their knowledge about sleep. Patients were given handouts on sleep architecture and sleep hygiene. A lively discussion ensued re: the relationship between dreams and anxiety. This SM was attentive and well-engaged throughout. No evidence of SI/HI. Next sleep improvement group will meet in one week.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1147 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-In at :0805

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1147 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-Out at : 1055

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by DONKIN, LAURA G @ 11 Sep 2017 1149 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.
Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by POURZAND, MIRIAM @ 12 Sep 2017 1112 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 12 Sep 2017 1112

CHANGE HISTORY

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 11 Sep 2017 1149 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 11 Sep 2017 1149 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

-> Unassociated Orders, Procedures and Injuries/Accidents <-

INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 11 Sep 2017 1033 EDT.

1. **Major depressive disorder, recurrent, moderate**

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 259

AR 0302

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by GRAGNANI, CYNTHIA T

Encounter ID: BETH-29568630 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Sep 2017 1243 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **GRAGNANI,CYNTHIA**
THERESAReason for Appointment: Written by CLOPPER,TAMMY J @ 08 Sep 2017 1243 EDT
CESAppointment Comments: Written by CLOPPER,TAMMY J @ 08 Sep 2017 1243 EDT
TBS/O Note Written by CLOPPER,TAMMY J @ 08 Sep 2017 1244 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 1000-1030 Registered Nurse met with the patient today for a follow-up Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, and insomnia. The patient was given directions about completing the Alpha-stim session. Before the initiation of the protocol the patient reported that he slept 7 hours interrupted sleep last. The intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The patient was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The patient was scheduled for a follow-up appointment Monday.

A/P Last Updated by CLOPPER,TAMMY J @ 08 Sep 2017 1245 EDT**1. Generalized anxiety disorder**Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
PROVIDER(S): CLOPPER,TAMMY JDisposition Written by GRAGNANI,CYNTHIA T @ 08 Sep 2017 1455 EDT**Released w/o Limitations****Follow up:** with PCM.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GRAGNANI, CYNTHIA T (Physician) @ 08 Sep 2017 1455

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29567981 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2017 1202 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 11 Sep 2017 0817 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 261

AR 0304

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 1202 EDT
CRP

S/O Note Written by CLOPPER, TAMMY J @ 08 Sep 2017 1248 EDT
History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 1202
Afternoon Track: CRP
Appointments Reported this afternoon: None
Pain level Reported (0-10): Denies
Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 08 Sep 2017 1412 EDT
History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1403
Afternoon Track: CRP
Appointments Reported for Monday: None
Pain level Reported (0-10): Denies
Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by MILLER, PENNY E @ 08 Sep 2017 1447 EDT

Reason for Visit

Visit for: (1230-1400) Comprehensive Recovery Program- Recreation Therapy- Facilitators: This writer Penny Miller, recreation therapist, Narcedalia Pratt, social worker and Jessica Shipman, WRNMMC Hospital Recreational Arts Coordinator.

Purpose: This session provided the patients with the opportunity to be creative, self-reflect and apply safe coping skills.

Activity: Patients were introduced to the activity of "Japanese Book Binding". Patients were provided with step-by step instruction in order to complete the process. Steps for book making consisted of cutting, folding, and prepping pages, clamping materials and piercing holes with an awl, and weaving binding thread through to secure pages. Patients were provided with tools, materials, and instructions, and were then given time to independently work. When finished, pts were given the opportunity to share their book with the group and discuss their experience, as well as coping skills used during the process. Patients were encouraged to think about how they can transfer the skills used during the session into their daily lives.

Participation: This patient was actively involved in the book making process. Patient used creative abilities to express thoughts

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 262

AR 0305

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

and emotions in a new way. Patient was focused and concentrated and completed the process. Next Comprehensive Recovery Program, Recreation Therapy session is scheduled for Friday September 22, 2017.

S/O Note Written by PRATT,NARCEDALIA @ 08 Sep 2017 1459 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program- Recreation Therapy (1230-1400) - Staff present: Penny Miller, recreation therapist, Narcedalia Pratt, social worker and Jessica Shipman, WRNMMC Hospital Recreational Arts Coordinator.

Purpose: This session provided the SM with the opportunity to practice creativity and utilize a new outlet for expression.

Activity: "Japanese Book Binding". This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

Participation: SM participated in the book making activity. SM used creative abilities to express thoughts and emotions in a new way.

There was no indication of SI/HI present. The next group session will be held on Friday September 22, 2017.

A/P Last updated by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 11 Sep 2017 0817 EDT

Released w/o Limitations

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 11 Sep 2017 0817

CHANGE HISTORY

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 08 Sep 2017 1248 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29562511 Primary Dx: Insomnia, unspecified

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Sep 2017 0807 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 08 Sep 2017 0945 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 0807 EDT
SLEEP ASSESSMENT

S/O Note Written by LANDE, RAYMOND G. @ 08 Sep 2017 0946 EDT

Reason for Visit

Visit for: Attending Note: SM referred for enhanced sleep assessment.
45 minutes.

History of present illness

The Patient is a 32 year old male.

He reported: Sleep This was a valid study. Total Sleep time = 6 hours and 16 minutes. The pApnea/Hypopnea index = 8.3, Mean oxygen saturation = 94, Mean heart rate = 67, Rapid eye movement (REM) % = 17.93, Deep Sleep % = 4.92, Light Sleep % = 77.16 Wake % = 18.33, Sleep latency (minutes) 23, REM latency (minutes) 174, Number of Awakenings = 11, BMI=23.5, The SM had two REM episodes. The SM appeared to awaken from light sleep.

Objective

Plan: SM has screening evidence for mild breathing problems while asleep. SM has decreased deep sleep and REM sleep latency. Consider referral to sleep clinic.

A/P Written by LANDE, RAYMOND G. @ 08 Sep 2017 0948 EDT

1. Insomnia, unspecified

Procedure(s): -Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time x 1

Disposition Written by LANDE, RAYMOND G. @ 08 Sep 2017 0949 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 08 Sep 2017 0949

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29562379 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2017 0800 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 11 Sep 2017 0806 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 267

AR 0310

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL	UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 0800 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1113 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit
Check in for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-In at :0800

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1114 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit
Check out for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1246 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0900-0945. SM presented in positive mood and was talkative throughout session. SM had just returned from some psychological testing.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 268

AR 0311

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Additional testing for Autism had been requested by this SW. We discussed SM behaviors and whether or not he felt that these behaviors meet the criteria for Autism. SM feels that knowing his diagnosis will be helpful to understand his limitations and to make future plans for his career. In general SM feels that his anxiety has gone down in the past few days. He is not sure if this is due to medications or the lessening of stress, as he is not working. He said that his providers have differing viewpoints as to his future in the military. Dr. Paul is advocating for SM to be separated from military but Dr. Tobar would like SM to continue to get more mental health treatment. Dr. Pourzand entered and joined discussion on treatment for about 10 minutes. We also discussed SM's Irritable Bowel Syndrome. SM reported that he has scheduled weekend plans and is pleased that he will not be isolating. We will meet again on Tuesday. No SI/HI plan or intent present.

S/O Note Written by SMITH, JESSICA ANN @ 08 Sep 2017 1319 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Innovations Group 20 min group-(SM dispersed into individual innovations) facilitated by: Ms. Buford, Ms. Braggs, Dr. Pourzand, Mrs. Smith. During this group the SM were given the opportunity to learn about the various types of innovations offered at PCS to include light therapy, Alpha-Stim CES/MET, Brain Computer Interface, MindFlex, MUSE, and temple massager. SM participated in group. SM engaged in individual innovative activity (see individual encounter in AHLTA). No indication of distress. No indication of SI/HI. Next group Friday.

S/O Note Written by SMITH, JESSICA ANN @ 08 Sep 2017 1517 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH, JESSICA ANN @ 08 Sep 2017 1518 EDT

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. SM reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. SM presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
 -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 ADDITIONAL PROVIDER(S):
 SMITH, JESSICA ANN

Disposition Written by POURZAND, MIRIAM @ 11 Sep 2017 0806 EDT**Released w/o Limitations**

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 11 Sep 2017 0807

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CHANGE HISTORYThe following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 08 Sep 2017 1518 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 08 Sep 2017 1518 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 08 Sep 2017 1256 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 08 Sep 2017 1116 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 08 Sep 2017 1116 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 08 Sep 2017 0822 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-29562639 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **08 Sep 2017 0800 EDT**
Clinic: **PSYCHOLOGY ASSESSMENT
BE**Appt Type: **PROC**
Provider: **BENTON, JIKESHA R****AutoCites Refreshed by BENTON, JIKESHA R @ 08 Sep 2017 1440 EDT****Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING	3 of 3	06 Sep 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985	SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	#0 RF3 TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1			
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1			
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3			
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1			
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2			
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3			
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			

Reason for Appointment:

F/U Testing

Appointment Comments:

CAC

S/O Note Written by BRYANT, JASMINE RESHA E @ 08 Sep 2017 0846 EDT

Objective

Assessment: 2 hours. SM was escorted by writer from PDS lobby to RM 4116 for continued DX testing. Testing was completed 8 DEC 2016. SM was sociable, paranoid, and cooperative during testing AEB asking if he could "get into trouble over testing answers?" SM reported "abusing prescribed medications" in order to "feel high" and stated he was worried about "being honest." SM was redirected and continued with testing. SM stated mood was "anxious, energetic, and content" and his affect was bright and congruent with mood. SM reported 2-3 weeks of increased "anxiety" due to "everyday" triggers. SM reported a "normal" appetite with 1-2 small meal consumption throughout the day. SM reports having chronic IBS and is currently MEDBRD out of the military due to its "discomfort." SM reported a significant weight loss of 12lbs within a 60 day period. SM reports he is refraining from alcohol and it could be his "main contributor" to his recent weight loss. SM reported a "poor" sleep pattern with difficulty staying asleep with a possible sleep disorder. SM reports 6-7 hours of restless sleep per night with a medication aid to "slight" effect and relief. SM reported experiencing sleep paralysis on a "frequent" basis and vivid nightmares about "real life situations." SM denied to clarify. SM is currently awaiting a sleep study with the Sleep Clinic here at Walter Reed. SM reports a 2/10 intestinal pain. SM also has a H/O of headaches/migraines but, did not experience any while testing. SM currently denies any SI/HI/AVH. SM escorted himself back to IOP and was advised to speak with social worker before resuming scheduled activities. Writer informed front desk of SM arrival.

Tests

PAI, AQ completed today

Testing completed 8 DEC 16 MMPI-II, MCMI, RISB

Plan

Limits of confidentiality was explained and understood by SM. Original documentation can be found in BLD 10 7C RM 7131. DX Interview to be scheduled and completed by Dr. Benton.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Psychologic Testing And Report Administered By Technician x 2

Disposition Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.Signed By BENTON, JIKESHA R (Physician/Workstation) @ 08 Sep 2017 1442Note Written by BENTON, JIKESHA R @ 14 Sep 2017 1516 EDT

(Added after encounter was signed.)

Psychological Evaluation Addendum**WALTER REED NATIONAL MILITARY MEDICAL CENTER**

8901 Rockville Pike, Bethesda, Maryland 20889-5600

DEPARTMENT OF BEHAVIORAL HEALTH CONSULTATION AND EDUCATIONAL SERVICES**PSYCHODIAGNOSTIC ASSESSMENT SERVICE**

8901 Wisconsin Ave

Bethesda, MD 20889

PSYCHOLOGICAL EVALUATION ADDENDUM**NAME:** Daniel Anderson (nee Merwin)**SSN:** 20/8503**RANK:** PO2**DATE:** 01AUG17**IDENTIFYING AND REFERRAL INFORMATION:** SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

It should be noted SM received a psychological evaluation conducted by 2LT Hannah Martinez, Doctoral Practicum Student, with PsychoDiagnostic Assessment Services on 02FEB17. This writer served as a covering supervisor for the psychological evaluation. SM was referred for the psychological evaluation by Dr. Sherin Paul, Clinical Psychologist, with Adult Outpatient Behavioral Health for diagnostic clarification. The consult indicated SM has a history of undiagnosed Borderline Personality Disorder and Reactive Attachment Disorder. SM's family history is also significant for Bipolar Disorder.

On 08SEP17, SPC Jasmine Bryant administered the Personality Assessment Inventory (PAI) and Autism Spectrum Quotient (AQ). 2LT Hannah Martinez administered the Minnesota Multiphasic Personality Inventory-2nd edition (MMPI-2), Million Clinical Multiaxial Inventory-Third Edition (MCMI-III), and Rotter Incomplete Sentence Blanks (RISB) on 02FEB17. This writer conducted a collateral interview with Ms. Despina Hangemanole, Social Worker, with Addiction Treatment Services on 13SEP17. Dr. Benton conducted a collateral phone interview with Dr. Sherin Paul, Clinical Psychologist, with Adult Outpatient Behavioral Health on 14SEP17.

Please refer to AHLTA records and the original psychological evaluation for a comprehensive background history.

PSYCHOLOGICAL TEST RESULTS:Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

MMPI-2: The validity indicators suggested that SM endorsed test items in a manner to cry for help. SM is likely to present with extreme somatic problems or chronic pain and to complain of being physically ill although there may not be an organic basis to his problems. He is anxious, tense, nervous, restless, irritable, dysphoric, brooding, and unhappy. He has a loss of initiative. He reported depressed mood, social withdrawal, and reclusiveness. He is self-conscious in talking with others. Doubts about his abilities are common, as is vacillation and indecision about even minor matters. SM is hypersensitive to criticism.

MCMI-III: The validity indicators suggested that SM was being open and honest. SM does not have any close friends, so he tends to remain detached and isolated. There is evidence that SM strongly wishes to be liked and accepted by others on his terms. He is often guarded and experience social situations negatively. SM is apprehensive and nervous in social situation. SM usually avoids relating to others, which forces him to give up the support and affect that the relationship might have brought. Life is experienced as a conflict between taking a risk and accepting the discomfort of forming a relationship or retreating to the unfulfilling safety of isolation.

PAI: The results of the PAI were considered invalid. SM consistently endorsed items that portrayed him in an especially negative or pathological manner. The test results involved considerable distortion and does not reflect an inaccurate reflection of SM's psychological functioning.

AIQ: The Autism Spectrum Quotient is a questionnaire used to determine the extent to which an adult of normal intelligence has the traits associated with Autism spectrum conditions. A content analysis of the AIQ indicated SM elevated on the measure due to his endorsement of social avoidance; he did not endorse the developmental criteria of Autism and Asperger's Disorder.

FINDINGS AND CONCLUSIONS: SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

Given all available information to include psychometric instruments, chart review, diagnostic interview, and collateral interviews, SM does not have Autism or Asperger's Disorder. SM does have relational apathy or a lack of emotional reciprocity but this is not enough to substantiate the disorder. SM has the ability to cultivate age appropriate friends and relationships. Furthermore, there is no impairment in the use of nonverbal behaviors. There is no impairment in communication particularly selective mutism that is commonly found with these disorders. There is no evidence of inflexible adherence to routines or rituals. He has not demonstrated persistent preoccupation with parts of objects. This writer did not observe repetitive motor mannerisms. SM's social detachment and emotional numbness could represent a schizoid adjustment, a neurotic reaction, abuse history, or simply a lifestyle preference yet it is not Autism.

There is evidence from testing of Schizoid Personality traits characterized as lack of interest in social relationships, a tendency towards a solitary or sheltered lifestyle, secretiveness, emotional coldness, detachment, and apathy. There is research to support that Schizoid Personality traits are developed due to an insecure attachment in childhood. This is consistent with his prior history of Reactive Attachment Disorder. However, SM grew up in an environment with physical, sexual, and emotional abuse. He was in a household with a father that had an authoritarian parenting style, which contributed to him being overly controlled, unable to express emotions, and living in fear. SM's emotional development is stunted due to the childhood environment he was reared. SM is emotionally immature; emotionally immature people can be extremely challenging to deal with, because their ability to interpret and react to the variety of life's challenges is often impaired. When emotionally immature people do not get their way, they often respond to their circumstances in ways that are irrational. They need to control and this lack of control motivates them to act out. They pout, whine, cry, manipulate, or violate the object of their obsession, all the whilst believing they are entitled to behave this way.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 274

AR 0317

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SM has mood swings, anger outbursts, hyper sexuality, and suicidal ideations/gestures that can be function of his emotional immaturity. Although these behaviors can be symptoms of Borderline Personality Disorder, psychological test results do not support SM having a personality disorder. The hallmark feature of Borderline Personality Disorder is the fear abandonment. SM does not have a fear of abandonment. SM is introverted, socially withdrawn, and prefers his own company. Typically, SM cuts people off when they become too close to him. This seems to be more of a function of his schizoid personality traits and attachment style. When his personal space is violated, he feels suffocated and desires independence. It should be noted that like individuals with schizoid personality traits, SM is capable of developing relationships when they are based on his terms. His terms do not include emotional intimacy. For example, he desires to connect with his family of origin but with self-imposed boundaries. Additionally, SM indicated he has a relationship with his neighbors in which he can come and go friendly into their home without demands or expectations. This is how he desires all of his interpersonal and romantic relationships. SM is happiest when people place few emotional and intimate demands on him. It is not people that SM wants to avoid, it is the emotions but since there are no emotionless people it is easier to socially withdraw.

RISK ASSESSMENT: SM has a history of suicidal ideation occurring approximately once a month since adulthood. His protective factors include his job, his hobby of creating video games, and wanting to find purpose in his life. SM has low social support, but this does not seem to be a significant stressor. SM does not have a history of attempts and denies access to lethal means. He denied current ideation, plan, or intent. SM is currently assessed at a mild risk for suicide, and should continue to be monitored by his healthcare providers.

DSM-5 Diagnoses:

Given the level of information obtained for this assessment, the following DSM-5 diagnoses are warranted:

Other Specified Trauma and Stressor Disorder
Schizoid Personality Traits
Reactive Attachment Disorder – By History

If there is a need for further discuss of this case, please feel free to contact the undersigned at 301.400.0591.

Jikesha Benton, Psy.D.
Clinical Psychologist

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29555227 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL D
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 07 Sep 2017 1213 EDT
 Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
 Provider: POURZAND, MIRIAM

AutoCites Refreshed by POURZAND, MIRIAM @ 08 Sep 2017 1240 EDT

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 276

AR 0319

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 1213 EDT
CRP

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1238 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 1215 Check in to PCS afternoon program. SM denied SI/Hi. Will attend afternoon groups.

S/O Note Written by DONKIN, LAURA G @ 07 Sep 2017 1414 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 1230-1330. Intensive Sleep Improvement Group for CRP. Facilitator: Laura Donkin, LCSW-C. This bi-monthly group is meant to be an adjunct to the morning Sleep Improvement Group. In this group, members will explore their sleep issues in a more personal and intensive way. We review topics such as: napping, nightmares and sleep hygiene. Today we focused on the physiological and mental benefits of sleep. We discussed sleep hygiene and went around the room asking each group member what they're doing right and how they can improve. Group members discussed benefits of power napping. The group unanimously agreed to practice power napping for last 10 minutes of the group. SM actively contributed to group discussion. We will meet again on 21 September, 2017. No SI/Hi plan or intent present.

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1447 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 1430 Check out of PCS afternoon program. SM denied SI/Hi. Tomorrow, 0800 psychological testing.

S/O Note Written by GHOLSON, GEORICA K @ 07 Sep 2017 1449 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: COMMUNICATION SKILLS
FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician from 1330-1420.
Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.
Intervention: Discuss and identify aspects of "fighting fair/unfair." Discuss elements of what constitutes a conflict and which behaviors can escalate a conflict. Additionally, group discussed how "unfair fighting" can become abuse and which behaviors are

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

considered verbal and emotional abuse. SM participated in group. He discussed how his father's conflict style influenced how he manages arguments. Additionally, he explained that he is passive in arguments and will stockpile. He was able to recognize how stockpiling can damage relationships and expressed how he struggles with confronting others about offenses in the moment

No indication of SI/HI.

Next group scheduled for 21 September 2017.

A/P Last updated by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
-Psychiatric Therapy Individual Approximately 30 Minutes x 2
-Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 08 Sep 2017 1242 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 08 Sep 2017 1242

CHANGE HISTORY

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
-Psychiatric Therapy Individual Approximately 30 Minutes x 2
-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT:

The A/P section was last updated by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 07 Sep 2017 1415 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 278

AR 0321

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1
-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 07 Sep 2017 1415 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 07 Sep 2017 1415 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safer/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1240 EDT.

1. **Generalized anxiety disorder**

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 279

AR 0322

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29546622 Primary Dx: Insomnia, unspecified

Patient: ANDERSON, DANIEL D
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 07 Sep 2017 0649 EDT
 Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
 Provider: LANDE, RAYMOND G.

AutoCites Refreshed by LANDE, RAYMOND G. @ 07 Sep 2017 0706 EDT

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 280

AR 0323

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 0649 EDT
SLEEP ASSESSMENT

S/O Note Written by LANDE, RAYMOND G. @ 07 Sep 2017 0720 EDT

Reason for Visit

Visit for: Attending Note: SM referred for enhanced sleep assessment. 45 minutes.

History of present illness

The Patient is a 32 year old male.

He reported: Sleep SM described sleep as follows. SM goes to bed at 2200 and awakens at 0600. During the night's sleep it takes SM 15 minutes to fall asleep after which SM awakens 2-3 times "noise, bathroom, dreams". SM feels "unrested" upon awakening. SM does not snore, does not talk in sleep and has no morning headaches. SM last use of alcohol two weeks ago. SM uses no nicotine.

Epworth = 18 PreSleep = 13/17 PIRS = 37.

Objective

Plan: SM instructed in proper use of device. Device passed test. SM instructed to return device tomorrow.

A/P Written by LANDE, RAYMOND G. @ 07 Sep 2017 0723 EDT

1. Insomnia, unspecified

Procedure(s): -Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time x 1

Disposition Written by LANDE, RAYMOND G. @ 07 Sep 2017 0723 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C.Psychiatry Continuity Service, WRAMC) @ 07 Sep 2017 0724

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 281

AR 0324

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29546619 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Sep 2017 0648 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 08 Sep 2017 0852 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 282

AR 0325

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL. #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 0648 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 0745 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 0725 Check in to PCS Team A. morning program. SM denied SI/HI. Has 0830 orthodonture appt, which may be short or may be most of the day. He will call and let us know if it lasts more than an hour.

S/O Note Written by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Accountability- sm excused for psych testing.

A/P Last updated by POURZAND, MIRIAM @ 08 Sep 2017 0900 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 283

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Disposition Written by POURZAND, MIRIAM @ 08 Sep 2017 0900 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 08 Sep 2017 0901**CHANGE HISTORY**The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 08 Sep 2017 0859 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 08 Sep 2017 0859 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following S/O Note Was Deleted by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT:**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

The following S/O Note Was Deleted by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT:**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: SM called at 0930 to say he will be at orthodontics longer than expected. He will come to afternoon groups when he is released.

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 07 Sep 2017 1032 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 284

AR 0327

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29542585 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Sep 2017 1355 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1356 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY	0 of 1	06 Sep 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 285

AR 0328

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE ONE CAPSULE BY	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE 2 BY MOUTH EVERY	2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	DAY #0 RF3 RINSE BY MOUTH ONE	NR	09 Aug 2017
		TIME PER DAY FOR 14 DAYS. #0 RF0		
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017
		FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017
		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY	3 of 3	10 May 2017
		DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6	3 of 3	28 Apr 2017
		HOURS FOR CONGESTION #0 RF3		
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG)	1 of 1	28 Apr 2017
		EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1355 EDT
Treatment Plan Update/BHDP Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1356 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Merwin 29 AUG
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):
Overall health reported as: Good
Pain Level (0-10): 3 Currently treated: Yes
Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No
past attempts as of 09/06/2016: 3
Most recent Suicidal Ideation: 2-4 weeks ago
Suicidal Ideation Duration: Fleeting - a few seconds or minutes
Suicidal Ideation Frequency: Once a week
Protective Elements Stopping Suicidal Actions: Family, Fear of failing
Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A
Patient with access to weapons: No ~Recent Outcome Measures (last 30 days)
BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)
PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)
GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)
PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)
PCL-C: N/A
AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 286

AR 0329

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CSI: N/A

ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). No changes in treatment plan.

A/P Last Updated by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1400 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1401 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 06 Sep 2017 1401

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 287

AR 0330

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29537684 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Sep 2017 1035 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 06 Sep 2017 1223 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 288

AR 0331

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 06 Sep 2017 1035 EDT
LST

S/O Note Written by GHOLSON, GEORICA K @ 06 Sep 2017 1515 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)"Golf Clinic" Staff: Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.
Co-facilitator was present to provide support. Co-facilitator ensured the activity and group members were safe, actively participated, and observed and remediated any disruptive behaviors.
Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The objective was to provide an opportunity for patients to recreate and to learn golfing fundamentals in a safe supportive environment. The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water) , golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Today patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post activity a group discussion about the experience they created and coping skills used .
Participation: Pt actively participated throughout the session. Pt ate lunch with the group and was receptive to golf instruction. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted. Next LST Therapeutic Field Exercise (TFX) is scheduled for Wednesday October 4, 2017.

S/O Note Written by SMITH, JESSICA ANN @ 06 Sep 2017 1532 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Reason for Visit
Check in for Afternoon Programming 1230-1430
5 min Check in at: 1115
Program Track:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

- (x) Comprehensive Recovery Program (CRP)
 () Interpersonal Recovery Program (IRP)
 () Trauma Recovery Program (TRP)
 0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 06 Sep 2017 1542 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at: 1400

Plan for Next Day of Programming

x() Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by MILLER,PENNY E @ 06 Sep 2017 1759 EDT**Reason for Visit**

Visit for: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)"Golf Clinic" Staff: this writer Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.

Objective: To provide an opportunity to recreate and learn golfing fundamentals in a safe supportive environment.

Activity: Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water) , golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post participation this writer Penny Miller, recreation therapist facilitated a group discussion about the experience created and coping skills applied during the process.

Participation: Pt actively participated throughout the session. Pt ate lunch with the group, socialized with peers and demonstrated willingness to be actively involved. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted.

The next LST Therapeutic Field Exercise (TFX) planned by this writer Penny Miller, recreation therapist is scheduled for Wednesday October 4, 2017.

A/P Last updated by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 290

AR 0333

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Procedure(s): -Psychiatric Therapy Group Interview x 1
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S):
 SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 07 Sep 2017 1247 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 07 Sep 2017 1247**CHANGE HISTORY***The following S/O Note Was Deleted by MILLER,PENNY E @ 06 Sep 2017 1801 EDT:***Reason for Visit**

Visit for: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)*Golf Clinic* Staff: this writer Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.

Objective: To provide an opportunity to recreate and learn golfing fundamentals in a safe supportive environment.

Activity: Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water), golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post participation this writer Penny Miller, recreation therapist facilitated a group discussion about the experience created and coping skills applied during the process.

Participation: Pt actively participated throughout the session. Pt ate lunch with the group, socialized with peers and demonstrated willingness to be actively involved. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted.

The next LST Therapeutic Field Exercise (TFX) planned by this writer Penny Miller, recreation therapist is scheduled for Wednesday October 4, 2017.

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT - see above.Previous Version of A/P section was entered/updated by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT - see above.Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 06 Sep 2017 1224 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 291

AR 0334

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29535723 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**

Date: **06 Sep 2017 0930 EDT**
Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR, EDEN @ 06 Sep 2017 0949 EDT

Allergies
•No Known Allergies

Vitals
No Vitals Found.

Appointment Comments:
ett/phq9/gad7

Note Written by TOBAR, EDEN @ 06 Sep 2017 1135 EDT

Followup Note

Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #12

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male

Military Data:

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

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Page 292

Medical Record

Anderson, Daniel Dennis

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DoD ID: 1286180538

Created: 30 Oct 2017

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. We last met four weeks ago, at which time pt was waiting to find out if his command would allow him to attend IOP. Since that time he was accepted into the program and started it last week. He has been feeling more depressed and anxious and says his phq9 and gad7 scores are higher today because he is answering the questions more honestly now. He has felt increasingly upset with his command as he finds them very unsupportive. He cites as examples that they tried to separate him for his ATS enrollment, calling it a treatment failure even though he self-referred. His ATS counselor contacted his command to intervene. He also states there was an 'all-hands' meeting about him in which the reasons his clearance were revoked and other topics were discussed per pt in front of 150 service members without his knowledge, supposedly to minimize gossip about him. WE discussed these episodes as triggers for his increased depression and anxiety symptoms. HE states his MEB referral for IBS was accepted, which he is pleased about. He is not sure if Effexor xr is helpful. He still has cravings to drink despite taking naltrexone and feels tired all the time. He has a sleep study coming up. He has cut out all caffeine and has been having headaches, about which I encouraged him to speak to his PCM. HE states he has a number of medical conditions he wants documented in his chart for his medical board. He admits he had a thought over the weekend of jumping off a building while sitting on the toilet but denies intent to act.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

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Page 293

AR 0336

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way
Few or several days**Anxiety** - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

06SEP17 phq9= 19 (#9=1); gad7= 19

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda

Anderson, Daniel Dennis

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Page 294

AR 0337

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Medications:

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING 3 Ordered 06 Sep 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 0 Refill
 VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY DAY 0 Active 06 Sep 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 2 Active
 Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. 0 Active 09 Aug 2017@0001

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
 Active 06 Jun 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS 2 Active 18 May 2017@0001

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN 3 Active
 10 May 2017@0001

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 295

AR 0338

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in casual clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: fair

Speech: talkative

Mood: dysphoric

Affect: full

Thought Process: circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight: fair

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	

Anderson, Daniel Dennis

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Page 296

AR 0339

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcl	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcl	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcl	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcl	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcl	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcl	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcl	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcl	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)

Anderson, Daniel Dennis

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Page 297

AR 0340

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

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Page 298

AR 0341

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Intervention: increase Effexor to 225 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will abstain from drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Consider adding acamprosate in future as pt reports continued cravings, though he has not relapsed. Normal b12 panel drawn after July 2017 visit.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 06 Sep 2017 1137 EDT

1. Generalized anxiety disorder

Medication(s):

-VENLAFAXINE XR-PO 75MG CPSR 24H - TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #30 RF3 Ordered By: TOBAR, EDEN

Ordering Provider: TOBAR, EDEN T

2. Major depressive disorder, single episode, unspecified

Disposition Written by TOBAR, EDEN @ 06 Sep 2017 1137 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 06 Sep 2017 1138

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 299

AR 0342

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29531948 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Sep 2017 0739 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 06 Sep 2017 0825 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Loading...

Reason for Appointment:Written by CHELLAPPA, MARY R @ 06 Sep 2017 0739 EDT
 IOP

S/O Note Written by DONKIN, LAURA G @ 06 Sep 2017 0935 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Positive Psychology Group 0800-0900 facilitated by Laura Donkin, LCSW-C and Ms. Gardiner. The purpose of this group is to assist patients in viewing themselves and their situations based on their strengths, rather than weaknesses or symptoms, with the aim of helping them flourish and live a fulfilling life. Today's group was focused on reviewing the factors identified by Dr. Martin Seligman, which are present in people who describe themselves as happy. Today's discussion was centered on Accomplishment and how this factor can enhance one's feelings of happiness. SM actively participated in group discussion. The next group will be held @ 0800 on Wednesday, 13 September. No SI/HI plan or intent present.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 300

AR 0343

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by SMITH, JESSICA ANN @ 06 Sep 2017 1358 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0745

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH, JESSICA ANN @ 06 Sep 2017 1403 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :0900

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH, JESSICA ANN @ 06 Sep 2017 1413 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by POURZAND, MIRIAM @ 07 Sep 2017 1124 EDTHistory of present illness

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

1000-1020 met with sm for follow up he reports he went to Dr. Tobar for scheduled follow up since appointment was already made. Sm reports notified Dr. Tobar anxiety and depression measures have increased therefore Effexor increased from 150 mg daily to 225 mg daily. Sm reports no side effects. Also discussed TMS and starting treatment for anxiety next week.

FOLLOW UP PLANS

end of the week

.....

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 301

AR 0344

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

MEDICATION RECONCILIATION AND COMPLIANCE

[x]...Medication reconciliation completed. Risks, benefits, major/common side effects, and alternatives reviewed with patient who stated an understanding and agreement with plan.

[x] Yes.....[] No.....Compliant with medications.....Comments:

Current medication

CURRENT MEDICATIONS and OTCs/Supplements/Herbals

MEDICATION TRACKING

Date Effexor 225 mg daily Comments- for mood

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal. Full range, stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Last updated by POURZAND, MIRIAM @ 07 Sep 2017 1128 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN
-Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND, MIRIAM @ 07 Sep 2017 1129 EDT

Released w/o Limitations

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 302

AR 0345

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 07 Sep 2017 1129

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 07 Sep 2017 1128 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 07 Sep 2017 1128 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

The following A/P Note Was Overwritten by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT:

The A/P section was last updated by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 06 Sep 2017 0826 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 303

AR 0346

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29523988 Primary Dx: Generalized anxiety disorder

Patient: ANDERSON, DANIEL D
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 05 Sep 2017 1223 EDT
 Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
 Provider: POURZAND, MIRIAM

AutoCites Refreshed by POURZAND, MIRIAM @ 05 Sep 2017 1324 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 304

AR 0347

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Sep 2017 1223 EDT
IRP

S/O Note Written by DONKIN, LAURA G @ 05 Sep 2017 1405 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Anger Management Group 1230-1330. 5 September, 2017. Facilitator: Laura Donkin, LCSW-C, and Ms. Gardiner
Purpose: The purpose of this group is to help people understand the effect that anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the triggers and precipitants that lead to anger and frustration.
Topic(s): "Anger Thermometer" Group began with a discussion of personal experiences with anger. A worksheet with a thermometer was used for members to rate their experiences with feelings of anger, and to measure their reactions on a scale from 1 to 10. We then reviewed positive coping skills for stress relief and anger management. Patient participated in group activity and discussion. No indications of suicidal/homicidal ideation, intent, or plan present. Next group will be held on 11 September, 2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1439 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 05 Sep 2017 1443 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Crisis Management Group (1330-1420) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW
PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.
TOPIC: Today's group began with introductions and what they did over the holiday weekend. All patients participated. Patients were then

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

introduced to today's topic/handout, "Definition of a Crisis" to provide increased awareness about what a crisis is, symptoms of distress and stages of a crisis reaction. Patients also discussed things that helped and hinder during crisis. Each group member was provided with a worksheet outlining the aforementioned.

PARTICIPATION: Patient actively participated in the small and large group discussion. There was no indication of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/12/17.

S/O Note Written by VANFOSSSEN,MALLORY B @ 05 Sep 2017 1504 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1210.
Pt denies SI/HI.
Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSSEN,MALLORY B @ 05 Sep 2017 1504 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1430.
Pt denies SI/HI.
Pt reports following appts on tomorrow, Wednesday 6 September: 0930 outpatient behavioral health.
Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by PRATT,NARCEDALIA @ 05 Sep 2017 1507 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Crisis Management Group (1330-1420) - Staff Present: Narcedalia Pratt, LCSW-C and Penny Miller, CTRS, LCSW-C.
PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.
TOPIC: Today's group began with introductions and what they did over the holiday weekend. All patients participated. Patients were then introduced to today's topic/handout, "Definition of a Crisis" to provide increased awareness about what a crisis is, symptoms of distress and stages of a crisis reaction. Patients also discussed things that helped and hinder during crisis. Each group member was provided with a worksheet outlining the aforementioned. This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

PARTICIPATION: Patient actively participated in the small and large group discussion. There was no indication of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/12/17.

A/P Last updated by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

Disposition Written by POURZAND,MIRIAM @ 06 Sep 2017 1254 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 06 Sep 2017 1254

CHANGE HISTORY

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 05 Sep 2017 1325 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 307

AR 0350

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29516510 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **05 Sep 2017 0808 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 05 Sep 2017 0824 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 308

AR 0351

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Sep 2017 0808 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 0859 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Emotion Regulation (0800-0900) Facilitated by Anne-Marie Deutsch, Ph.D
Purpose: To introduce patients to Emotion Regulation strategies as ways to: understand the emotions they experience (correctly identify and label emotions); work to reduce emotional vulnerability by increasing pleasant emotions; work to decrease emotional suffering by letting go of painful emotions; and change painful/unpleasant emotions by acting in the opposite manner.
The content for this session focused on a structure to use in managing emotions, specifically a handout entitled "Recovery Action Plan". Group members answered questions such as "What do I notice when I am not doing well?" and others related to maintaining good emotional balance. SM was late to group – he was quiet throughout the session and there were no concerns regarding SI/HI, intent or plan. The next emotional regulation group will be in one week. SM released without limitations to attend 0900 group.

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1047 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 05 Sep 2017 1058 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Distress Tolerance Group, (1000-1050). Facilitated by Ms. Helen Lowenstein, LCSW.
Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis.
Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.
Topic: Distress Tolerance Cheat Sheet Hand out was discussed and discussed self soothing techniques for coping skills in distressing situations and the importance of practicing coping skills when not in distress to incorporate them into ones life. Patients were then asked to come up with a list of coping skills either they tried in the past that were positive and worked or ones they would like to try in the future. Each patient was provided turns to act or draw a coping skill and tell when it is good to use and why. The rest of the group was able to guess what the coping skill was. This sparked discussion on adopting healthy new coping skills and

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Page 309

AR 0352

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

behavior.

PARTICIPATION: PT was an active participant throughout the group. PT drew his coping skill and explained why it is important. No evidence of SI/HI. Next group to meet 09/12/17 at 1000.

S/O Note Written by DONKIN, LAURA G @ 05 Sep 2017 1114 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual note. SW met with SM for individual 1:1 session from 0900-0955. SM described Labor Day holiday as generally difficult and said that he is not drinking but "it was really hard." SM admitted to spending a lot of the time in bed. SM said that he has been reading excerpts from his mother's journal over the period of his childhood to help him refresh his memory of abuse from father and to clarify his emotions towards his father. SM read this SW from the journal and we used these passages as talking points. As SM was sharing incidents of childhood with this SW, he segued into discussion about sister who was diagnosed as bipolar and acted out in childhood and adolescence. SM admitted to sexually molesting sister when he was age 15 and she was 15. He said that father found out and called it "rape" and used it against him. He was punished for 1 year. SM did not share his feelings about this incident, but says that he and this sister do not communicate. SM also said that due to abuse from father, he was in Foster Care for a few weeks and that both sisters had attempted suicide. SM stated that he has had almost no contact with father over more than 10 years. This SW explored what SM his hoping for from father. SM would like some sort of apology for abuse, but at the same time knows that he will never get this. We also discussed his ambivalence towards father, as he is still hoping for recognition even though he says that he hates father. SM will think more about maintaining this emotional connection to father and why he finds it so difficult to let go of his need for love from him. SM admitted to fleeting suicidal ideation over the weekend but said that it was over in a few minutes. SM currently denies SI/HI plan or intent. We will meet again on Friday.

S/O Note Written by POURZAND, MIRIAM @ 05 Sep 2017 1326 EDT

History of present illness

The Patient is a 32 year old male.

SUICIDE RISK ASSESSMENT

Suicide Risk Factors Review:

Suicide Plan: N

Suicide Preparation: N

Suicide Rehearsal: N

History of Suicidality: Y, passive intermittent

Single Attempts: Y, during childhood

Multiple Attempts: N

Current Intent: N

Impulsivity: Y

Substance abuse: Y

Significant Loss: N

Interpersonal Isolation: N

Relationship problems: Y

Burden to others: N

Health problems: N

Physical pain: N

Legal problems: N

Shame: N

Patient's Overall Suicide Risk: low.

S/O Note Written by VANFOSSEN, MALLORY B @ 05 Sep 2017 1503 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0805.

Pt denies SI/HI.

Pt reports following appts this morning: none.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 310

AR 0353

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

S/O Note Written by VANFOSSEN, MALLORY B @ 05 Sep 2017 1503 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1050.

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by DONKIN, LAURA G @ 05 Sep 2017 1131 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by POURZAND, MIRIAM @ 06 Sep 2017 1249 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 06 Sep 2017 1249**CHANGE HISTORY****The following A/P Note Was Overwritten by DONKIN, LAURA G @ 05 Sep 2017 1131 EDT:**

The A/P section was last updated by DONKIN, LAURA G @ 05 Sep 2017 1131 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1048 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1048 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1048 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 05 Sep 2017 0825 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 311

AR 0354

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29498947 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: Outpatient

Date: 31 Aug 2017 1234 EDT
Clinic: PSYCH DAY HOSP BE

Appt Type: FTR
Provider: POURZAND, MIRIAM

AutoCites Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1421 EDT

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 313

AR 0356

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 31 Aug 2017 1234 EDT
IRP

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 1401 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Life Skills Group 1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "Treatment Expectations Survey." Patients filled out survey for their treatment expectations and the most important expectations were discussed by patients. SM actively participated in group discussion. The next group will be held on 7 September.

No SI/Hi plan or intent present.

S/O Note Written by GHOLSON, GEORICA K @ 31 Aug 2017 1435 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: FORGIVENESS RELATIONSHIP SKILLS 1330-1420
FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician
Purpose: Explore and discuss components of healthy relationships, including peers, family, and friends. The group aims to guide patients into identifying maladaptive and adaptive relationship behaviors. Furthermore, the group aims to help patients apply concepts to their daily lives to strengthen their relationships, cultivate new relationships, and to improve discernment about relationships that may be beneficial or harmful to their recovery process.
Group task: Group members defined and discussed the concept of forgiveness. Group members described situations in which they forgave others. Additionally, they discussed barriers and challenges to forgiveness. Participation: SM participated in group discussion

Assessment: No indication of distress. No indication of SI/Hi

Plan: Next group scheduled for Thursday 7 September 2017.

A/P Last updated by POURZAND, MIRIAM @ 01 Sep 2017 1422 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND, MIRIAM @ 01 Sep 2017 1423 EDT

Released w/o Limitations

Follow up: 5 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1424

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 01 Sep 2017 1422 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 01 Sep 2017 1422 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 31 Aug 2017 1435 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s):

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON, GEORICA K @ 31 Aug 2017 1427 EDT:

The A/P section was last updated by GHOLSON, GEORICA K @ 31 Aug 2017 1427 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 31 Aug 2017 1403 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s):

-Psychiatric Therapy Group Interview x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 315

AR 0358

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29491837 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 31 Aug 2017 0805 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: POURZAND, MIRIAMAutoCites Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1400 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 31 Aug 2017 0805 EDT CES**Appointment Comments:** Written by CLOPPER, TAMMY J @ 31 Aug 2017 0805 EDT TB**S/O Note** Written by CLOPPER, TAMMY J @ 31 Aug 2017 1126 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 0800-0830 Registered Nurse met with the patient today for a follow-up Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, and insomnia. The patient was given directions about completing the Alpha-stim session. Before the initiation of the protocol the patient reported that he slept 6 hours interrupted sleep last with nightmares. Reports taking a 3 hour nap in the evening as well. The intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The patient was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The patient was scheduled for a follow-up appointment tomorrow.

A/P Last Updated by CLOPPER, TAMMY J @ 31 Aug 2017 1133 EDT**1. Generalized anxiety disorder**

Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
PROVIDER(S): CLOPPER, TAMMY J

Disposition Written by POURZAND, MIRIAM @ 01 Sep 2017 1400 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1400

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29491169 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 31 Aug 2017 0741 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: POURZAND, MIRIAMAutoCites Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1352 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 31 Aug 2017 0741 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0838 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 0740 Check in to PCS Team A. SM denied SI/HI. 0800 appt with Ms. Donkin.

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 0935 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 31 Aug 2017 1343 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: (1000-1050) - Recreation Therapy- "This group was facilitated by Penny Miller, recreation therapist and Helen Lowenstein, social worker LCSW.
Purpose: To provide an opportunity for healthy communication, problem-solving, encourage teamwork and compromise. Patients were divided into 4 teams two teams played Uno and provided coping skills they utilized in the past that were healthy ones when needed when it was their turn or ones they want to try in the future. This was a way patients could recreate yet utilize skills to help in distressing situations. The other two two teams played games and shared coping skills.
TOPIC: Leisure planning and recreation. The ice breaker was an activity to get the patients to recreate and learn to work together. The game musical chairs was played and the group worked together in removing chairs from tables and supporting each other if they didn't make it to the next round. Then a hand out was provided discussing leisure planning and they were asked to get a partner and share their healthy plans for this weekend. Two additional hand outs were providing for coping skills list to prepare them in case stressful situations arise over the weekend.
Participation: PT was an active participant throughout the group. No evidence of SI/I or HI. Next session is scheduled for 9/07/17, 1000.

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 1412 EDT

History of present illness

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 319

AR 0362

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0810-0900. SM presented in positive mood and was talkative throughout session. This was SM's first individual session and we explored some areas that we will focus on for treatment. SM described himself as very OCD and described some of his behaviors. SM would like to learn to be more flexible in his behaviors and in thought processes. He has difficulty deciding if he is an introvert or extravert and said that he vacillates in between the two. SM said that he has always had difficulty forming lasting friendships which also disturbs him. We spent much of session discussing his relationship with his father, who was generally physically and emotionally abusive during most of childhood. SM did not recognize that he was being abused until later in high school and realized how manipulative father is. He worries that he has many of the same negative qualities as father. He admits to having fleeting thoughts of suicidal ideation for 30 seconds a few days ago, but currently denies this. SM would also like to form intimate relationships which are not co-dependent, as most have been in past. He is currently working on being more strict with himself on sleep hygiene. No SI/Hi plan or intent present. We will meet again on 5 September.

S/O Note Written by POURZAND, MIRIAM @ 01 Sep 2017 1353 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1000-1020- met with sm for follow up reports adapting well to program. Discussed alternative treatment, sm reports using alpha-stim device. No other changes to treatment plan. No SI/Hi. Plan follow up next week.

A/P Last updated by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):
 -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Therapy Individual Approximately 30 Minutes x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
 -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND, MIRIAM @ 01 Sep 2017 1355 EDT

Released w/o Limitations

Follow up: 5 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1355

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 31 Aug 2017 1422 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 320

AR 0363

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

- INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
- Psychiatric Therapy Individual Approximately 30 Minutes x 1
- Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 31 Aug 2017 0936 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 31 Aug 2017 0936 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

- Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 31 Aug 2017 0812 EDT.

1. **Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29490746 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **31 Aug 2017 0718 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0719 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG,	Active	TAKE 2 BY MOUTH EVERY	3 of 3	06 Jun 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985 SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
CAPSULE, ORAL				DAY #0 RF3	
PROBIOTIC (VSL#3) DS-PO PACK	Active			TAKE ONE PACKET BY 1 of 1	06 Jun 2017
				MOUTH EVERY DAY #0 RF1	
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active			CHEW 1 TABLET BY MOUTH 2 of 2	18 May 2017
				FOUR TIMES A DAY AS	
				NEEDED FOR GAS #0 RF2	
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active			DISSOLVE 1 TABLET 3 of 3	10 May 2017
SUBL, SUBLINGUAL				UNDER TONGUE EVERY	
				EIGHT HOURS AS NEEDED	
				FOR ABDOMINAL PAIN #0	
				RF3	
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active			TAKE ONE SCOOP EVERY 3 of 3	10 May 2017
				DAY MIXED IN LIQUID.	
				AFTER TWO WEEKS	
				INCREASE TO TWICE	
				EVERY DAY #0 RF3	
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active			DRINK 10ML EVERY 6 3 of 3	28 Apr 2017
				HOURS FOR CONGESTION	
				#0 RF3	
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active			DRINK 20ML (400MG) 1 of 1	28 Apr 2017
				EVERY FOUR HOURS FOR	
				BASELINE PAIN CONTROL	
				#0 RF1	
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active			NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active			NR	05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0718 EDT
Treatment Plan Update Team A/BHDP

S/O Note Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0719 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
Daniel Anderson
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):
Overall health reported as: Good
Pain Level (0-10): 3 Currently treated: Yes
Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No
past attempts as of 09/06/2016: 3
Most recent Suicidal Ideation: 2-4 weeks ago
Suicidal Ideation Duration: Fleeting - a few seconds or minutes
Suicidal Ideation Frequency: Once a week
Protective Elements Stopping Suicidal Actions: Family, Fear of failing
Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A
Patient with access to weapons: No
Recent Outcome Measures (last 30 days)
BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)
PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)
GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)
PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)
PCL-C: N/A
AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)
CSI: N/A
ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)
BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)
TREATMENT PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, Ms. Buford and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

medication list). This SM was admitted t his week. Treatment was reviewed and there were no changes to present plan.

A/P Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0720 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0720 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 31 Aug 2017 0721

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29489550 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Aug 2017 1605 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1605 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 325

AR 0368

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED]	1985 SSN: [REDACTED]	DoD ID: 1286180538	Created: 30 Oct 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2			18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3			10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3			10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3			28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1			28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR			14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR			05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1605 EDT
Treatment Plan Update Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1607 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Merwin 29 AUG
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 3

Currently treated: Yes

Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No

past attempts as of 09/06/2016: 3

Most recent Suicidal Ideation: 2-4 weeks ago

Suicidal Ideation Duration: Fleeting - a few seconds or minutes

Suicidal Ideation Frequency: Once a week

Protective Elements Stopping Suicidal Actions: Family, Fear of failing

Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A

Patient with access to weapons: No

Recent Outcome Measures (last 30 days)

BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)

PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)

GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)

PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)

PCL-C: N/A

AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

CSI: N/A

ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT

PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, Ms. Buford and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). SM was admitted 29 AUG No changes in treatment plan.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1609 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1609 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 30 Aug 2017 1609

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29484711 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Aug 2017 1251 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1400 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 328

AR 0371

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 30 Aug 2017 1251 EDT
LST

S/O Note Written by SMITH, JESSICA ANN @ 30 Aug 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
Reason for Visit
Check in for Afternoon Programming 1230-1430
5 min Check in at: 1230
Program Track:
(x) Comprehensive Recovery Program (CRP)
() Interpersonal Recovery Program (IRP)
() Trauma Recovery Program (TRP)
0 Pain level (0-10) 0
Psychiatric Exam:
Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by VANFOSSSEN, MALLORY B @ 30 Aug 2017 1514 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist; and Maggie Hardy, LCSW-C, Social Worker. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. Pts were provided with a topic, and then instructed to create the corresponding artwork based upon thoughts and images that came to mind in response. The artwork directive was to "make a drawing containing a door". Pts were asked to consider how the topics of opportunity, obstacles, inside, outside, and functionality could be related to the topic. Pts were also asked to think about how the imagery of a door could depict a theme as a symbol or a metaphor, and focus on making meaning from the image. Ultimately, pts were encouraged to make their own meaning from the topic, and set their own intention for how they would like to communicate this. 2D materials were used, consisting of pastels, pencils, markers, or chalks. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of viewing the door as a barrier versus an opportunity, the nature of having to choose between multiple paths, if keeping things out also functions to keep things in and whether or not this is ideal, doors relating to protection, and who if anyone- including us- are able to pass through the door we have depicted. There was no indication of SI/HI. Next art therapy session will be held 31 August, 2017.

S/O Note Written by HARDY, MARGARET L @ 30 Aug 2017 1523 EDT

History of present illness

The Patient is a 32 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Art Therapy (1230-1400) Facilitated by: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist;

Co-facilitated by Margaret Hardy, LCSW-C, Social Worker

OBJECTIVE- This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding.

SUMMARY OF PROMPT- Group instruction was to create something using any of the materials in the art room with a door. Pts were encouraged to not only consider the subject matter (what is actually drawn- colors, lines, shapes, symbols) but their approach to the materials (the process of artmaking, technique, organization, apprehension or openness) as being meaningful, and able to provide them with insight.

This writer co-facilitated art therapy in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations. There was no indication of SI/HI. Next Art Therapy session will be Thursday, 31 AUG 2017.

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1532 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by POURZAND,MIRIAM @ 31 Aug 2017 1401 EDT**1. Generalized anxiety disorder:** 1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.**Competency/Risk:**

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY,MARGARET L; VANFOSSEN,MALLORY B

Disposition Written by POURZAND,MIRIAM @ 31 Aug 2017 1401 EDT**Released w/o Limitations****Follow up:** 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1401

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 31 Aug 2017 1401 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 31 Aug 2017 1401 EDT - see above. Previous Version of A/P section was entered/updated by

HARDY, MARGARET L @ 30 Aug 2017 1525 EDT.

1. Generalized anxiety disorder F41.1

Procedure(s): -(90853) Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY, MARGARET L; VANFOSSEN, MALLORY B

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29481531 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 30 Aug 2017 1031 EDT
Clinic: PSYCH DAY HOSP BEAppt Type: FTR
Provider: POURZAND, MIRIAMAutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 30 Aug 2017 1031 EDT
CES

Appointment Comments: Written by CLOPPER, TAMMY J @ 30 Aug 2017 1031 EDT
TB

S/O Note Written by CLOPPER, TAMMY J @ 30 Aug 2017 1215 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 0950-1020 Registered Nurse met with the SM today for an initial Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, & sleep problems. The pt was given directions about completing the Alpha-Stim session. Before the initiation of the protocol, SM reported 7 hours of interrupted sleep last night with one nightmare, depression 8/10, anxiety 10/10, 1/10 pain in stomach, 1/10 anger at this time. During the initial stages of the Alpha-Stim session the intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The pt was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The pt was scheduled for a follow-up appointment tomorrow.

A/P Last Updated by CLOPPER, TAMMY J @ 30 Aug 2017 1216 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
PROVIDER(S): CLOPPER, TAMMY J

Disposition Written by POURZAND, MIRIAM @ 31 Aug 2017 1354 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1354

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29476160 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Aug 2017 0741 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1312 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
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VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 30 Aug 2017 0741 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1025 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800-0850: Positive Psychology group, cofacilitated by Dr. Deutsch, psychologist, and Ms. Gardner, psychiatric technician. This group is designed to help members learn ways to increase well-being, meaning, and joy in their lives using research-based methods of positive psychology. Today's group was based on the acronym PERMA as developed by Seligman: Positive Emotion, Engagement, Positive Relationship, Meaning, Accomplishment. Today's discussion focused on relationships and life meaning. Members discussed what constitutes a relationship and appreciating the value that they bring to our lives. We then moved to exploring what brings purpose to our lives. This SM was attentive and well engaged in the discussion. There was no evidence of SI/HI. Next Positive Psychology group meets in one week. SM released without limitations.

S/O Note Written by MILLER, PENNY E @ 30 Aug 2017 1121 EDT

Reason for Visit

Visit for: (0900 - 0930) Sensible Thinking Group This group is facilitated by Jessica Smith, social worker and supported by this writer Penny Miller, recreation therapist

Purpose: This group teaches the principles of cognitive behavioral therapy and helps patients to reexamine their thoughts and core beliefs in order to exhibit more positive behaviors.

Activity: CBT concepts were presented focusing on cognitive distortions. Pt's discussed how to cope with irrational thinking in the military and civilian structure using CBT concepts. This writer served as a support to the group therapy process.

participation: Pt participated in the group process. Pt left around 0930 and did not return due to being called out of the session by Dr. Pourzand, nurse practitioner. Next Sensible Thinking group is scheduled for Wednesday September 6, 2017. No indications of suicidal or homicidal ideation, intent, or plan.

(This note was written by Penny Miller, CTRS, LCSW-C recreation therapist).

S/O Note Written by SMITH, JESSICA ANN @ 30 Aug 2017 1329 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Jessica Smith LCSW and Penny Miller, CTRS LCSW

Purpose: To provide psycho education on cognitive behavioral therapy, cognitive distortions, and application to current situations. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Intervention: Handout provided on common cognitive distortions. Facilitated discussion of negative thinking patterns such as generalization, black and white thinking, personalization, etc and how those thinking patterns influence emotions. Discussed how thinking patterns can be challenged and adjust to create different emotional responses. Participation: Patient was attentive throughout psycho education and participated in group discussion. Patient was receptive to peer feedback.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1335 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0740

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x)
) No.**S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1349 EDT****History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x)
) No.**S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1401 EDT****History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT**1. Generalized anxiety disorder:** 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.**Competency/Risk:**

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 336

AR 0379

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 31 Aug 2017 1347 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1347

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT - see above. Previous Version of A/P section was entered/updated by SMITH,JESSICA ANN @ 30 Aug 2017 1401 EDT.

1. Generalized anxiety disorder

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN
 -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29468286 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **29 Aug 2017 1202 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM**AutoCites Refreshed by POURZAND, MIRIAM @ 30 Aug 2017 1359 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 29 Aug 2017 1202 EDT
CRPS/O Note Written by DONKIN, LAURA G @ 29 Aug 2017 1353 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Intensive Anger Group 1230-1320 29 August, 2017 Facilitator: Laura Donkin, LCSW-C and Ms. Gardiner

Purpose: The purpose of this group is to help people understand the effect that anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the triggers and precipitants that lead to anger and frustration.

Topic: "I Know You Are But What Am I?" Patients were asked to draw a picture that best describes their character when they are angry. They were then asked to explain their drawings and the characteristics of the animal they chose, to the group. Group members reacted positively to this exercise, and lively discussion ensued. Patient drew a picture of a cub and a bear. He said that when he becomes angry, the cub turns into a bear. Next group will be held on next Tuesday, 5 September. No indications of

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

suicidal/homicidal ideation, intent, or plan present.

S/O Note Written by LOWENSTEIN, HELEN T @ 29 Aug 2017 1442 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Stress Management Group (1330-1430) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW.

PURPOSE: The purpose of this group is for patients to discuss possible stress triggers as well as strategies or plans to cope with them. This group focuses on methods patients can implement in their lives to reduce stress in short-term and long term situations.

TOPIC: Today's group focused on "Self-Care Assessment" that explores stress reduction methods consisting of avoid, alter, accept and adapt. This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

PARTICIPATION: This writer served as an observer to help with any patients that may be in distress. No evidence of distress. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/5/2017.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1458 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:

Pt checked in to afternoon programming at 1200.

Pt denies SI/HI.

Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1459 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

TEAM A AFTERNOON CHECK OUT:

Pt checked out from afternoon program at 1430.

Pt denies SI/HI.

Pt reports following appts on tomorrow, Wednesday 30 August: 1100 VA appt in Bldg 11.

Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by PRATT, NARCEDALIA @ 29 Aug 2017 1510 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Stress Management Group (1330-1430) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW.

PURPOSE: The purpose of this group is for patients to discuss possible stress triggers as well as strategies or plans to cope with them. This group focuses on methods patients can implement in their lives to reduce stress in short-term and long term situations.

TOPIC: Today's group began with introductions and identifying a self-care thing that they have done this week to take care of themselves. All service members participated. Service members were introduced to the "Self-Care Assessment", exploring 3 out of the 6 areas of self-care: physical, psychological, emotional, spiritual, relationship and workplace self-care. Patients filled in a worksheet for each of the aforementioned domains rating tasks according to how well they think they were doing each. A discussion was facilitated regarding how often each patient participates in each task. Beliefs, values, and barriers to self-care were explored.

PARTICIPATION: SM actively participated by completing the worksheet and in the group discussion.

No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/5/17.

A/P Last updated by POURZAND, MIRIAM @ 30 Aug 2017 1359 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 339

AR 0382

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

Disposition Written by POURZAND,MIRIAM @ 30 Aug 2017 1400 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 30 Aug 2017 1400

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 30 Aug 2017 1359 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 30 Aug 2017 1359 EDT - see above.Previous Version of A/P section was entered/updated by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT.

1. Generalized anxiety disorder

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT - see above.Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 29 Aug 2017 1355 EDT.

1. Generalized anxiety disorder

Procedure(s):

-Psychiatric Therapy Group Interview x 1

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29464176 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Aug 2017 0933 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis		DOB: [REDACTED] 1985 SSN: ***-**-****	DoD ID: 1286180538	Created: 30 Oct 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3		28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT
TESTING

S/O Note Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Merwin 29 AUG
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):
Overall health reported as: Good
Pain Level (0-10): 3 Currently treated: Yes
Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No
past attempts as of 09/06/2016: 3
Most recent Suicidal Ideation: 2-4 weeks ago
Suicidal Ideation Duration: Fleeting - a few seconds or minutes
Suicidal Ideation Frequency: Once a week
Protective Elements Stopping Suicidal Actions: Family, Fear of failing
Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A
Patient with access to weapons: No
Recent Outcome Measures (last 30 days)
BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)
PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)
GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)
PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)
PCL-C: N/A
AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)
CSI: N/A
ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)
BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017).

A/P Last Updated by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0935 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

1. Generalized anxiety disorder

Procedure(s): -Psychologic Testing And Report Administered By Computer x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0935 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 29 Aug 2017 0935

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29460247 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Aug 2017 0715 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **SPEC**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 30 Aug 2017 1337 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 29 Aug 2017 0715 EDT
INTAKE

S/O Note Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0906 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 29 Aug 2017 1143 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Distress Tolerance Group 1000-1050 facilitated by Ms. Helen Lowenstein LCSW.
Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis. Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.
Topic: Patients were provided a hand out titled Things that influence Stress Tolerance Level. It listed five categories: Support network, sense of control (internal vs external), attitude and outlook, ability to deal with your emotions (Recognition and recovery), and Knowledge and preparation. The patients were asked to identify ones they have been utilizing in their life already for positive coping, and areas they may need to incorporate. Patients went around the room and shared what they have been or need to start to do and what areas cause them more distress than others. This is to help empower patients that they may have or will have a tool box of coping skills to pull from when in distress and adopt healthier coping patterns and behaviors.
PARTICIPATION: PT was an active throughout the group. PT shared that having set routines is helpful for him with feeling in control and goals. No evidence of SI/HI. Next group to meet 09/05/17 at 1000.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1248 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:
Pt is new intake this morning for Team A.
Pt checked out from morning programming at 1045.
Pt denies SI/HI.
Pt will return after lunch.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by DONKIN, LAURA G @ 29 Aug 2017 1518 EDT**Personal history****PT CONTACT INFORMATION**

Contact #: [REDACTED]
 Email Address:
 Unit/Command: NSA, Ft Meade
 Command Telephone #: 443-479-6067
 CO/OIC/Supervisor: CDR Yuskoe

OCCUPATIONAL / SPECIAL / MILITARY HISTORY

Branch of Service: Navy E-5, recently demoted from E-6
 Status: ☒ Active Duty ☐ Retired ☐ Family Member
☐ Other
 Job Description (MOS / AFSC): Network security
 Special Duty:
☐ ...PRP, SCI, or PSP (describe):
☐ ...Active Flying Status
☐ ...Diving Duty
☐ ...SMOD
☐ ...Other

DEPLOYMENT HISTORY

of Deployments: 0
 Locations:
 Total time deployed:
 Job during deployment:

SUBSTANCE USE AND TREATMENT HISTORY

Tobacco and other Nicotine products: denies

Alcohol: Patient currently seen at ATS at WRNMMC. Pt admits to alcohol consumption starting in Middle School. Pt has already had significant alcohol treatment including inpatient at Ft. Belvoir.

Caffeine: Pt denies recent consumption of coffee or other stimulants.

Illicit / prescription drug abuse: denies

SOCIAL / DEVELOPMENTAL / SPIRITUAL HISTORY

Pt is 32 yo single Caucasian male with almost 12 yrs TIS, Navy E-5 (recently demoted from E-6), MOS cyber security. Pt reports that he was born in California to very young, unmarried parents, who later married and then divorced. Pt reports that he has 2 sisters, who are ages 30 and 29. He also has a half brother, and half sister who he does not have contact with. Pt reports that father had custody for most of childhood, and mother had to pay support. Both parents were physically abusive. Father was on welfare and frequently negligent of his parental duties. Pt states that father's excessive discipline was to make them fearful. Pt reports 2 incidents of sexual trauma from unwanted contact. Once by older cousin and another time in middle school with friend grabbing him. Pt was moved numerous times during childhood. Pt said that there were times when he was living in a ghetto due to father living off welfare and spending all their money. Pt appears to currently have emotional support from mother and sisters. He has a very contentious relationship with father, thus recently changing his name. Pt said that he barely passed high school, and had a 2.2 GPA. He attributes this to his struggle with IBS, excessive running schedule and not doing homework. He joined the Navy immediately following high school. He has difficulty with relationships and is not currently in one. He denies religious affiliation.

LEGAL / DISCIPLINARY / FINANCIAL / OTHER STRESSORS & PROBLEMS

Pt reports recent demotion due to accusation of social media harassment of another SM. Pt also admits to serious financial debt due to excessive spending.

SEXUAL HISTORY

Pt reports history of hypersexuality, but reports Effexor is currently helpful with this. He states that he does not like being touched in certain ways and has trouble emotionally connecting with partners.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Family history**FAMILY PSYCHIATRIC, SUBSTANCE USE AND MEDICAL HISTORY**

Mother is diagnosed with Bipolar disorder. Younger sister also diagnosed with Bipolar disorder. Youngest sister diagnosed with depression. Both sisters have had multiple suicide attempts. Maternal grandmother also Bipolar.

S/O Note Written by POURZAND, MIRIAM @ 30 Aug 2017 1358 EDT**History of present illness**

The Patient is a 32 year old male.
He reported: Feeling tired (fatigue).
Drowsiness.
Insomnia.

MEDICATION RECONCILIATION AND COMPLIANCE

☒ ...Medication reconciliation completed. Risks, benefits, major/common side effects, and alternatives reviewed with patient who stated an understanding and agreement with plan.

☒ Yes..... ☐ No.....Compliant with medications.....Comments:

SUICIDE RISK ASSESSMENT:**WARNING SIGNS:**

☒ Yes ☐ No Suicidal ideation:
☒ Yes ☐ No Suicidal plans: childhood via hanging
☐ Yes ☒ No Suicidal intent:
☐ Yes ☒ No Suicidal communication:
☐ Yes ☒ No Access to lethal means:
☐ Yes ☒ No Seeking access to lethal means:
☐ Yes ☒ No Preparations for suicide:
☒ Yes ☐ No Substance abuse: hx of ETOH to include detox hx
☐ Yes ☒ No Hopelessness:
☐ Yes ☒ No Purposelessness:
☐ Yes ☒ No Anger:
☒ Yes ☐ No Reckless/Impulsive:hx of risky behavior
☐ Yes ☒ No Feeling trapped:
☐ Yes ☒ No Social withdrawal:
☒ Yes ☐ No Anxiety:
☒ Yes ☐ No Mood changes:
☒ Yes ☐ No Sleep disturbance:
☒ Yes ☐ No Guilt or shame:

Comments:

HOMICIDAL OR VIOLENT THOUGHTS OR ACTIONS

☐ Yes ☒ No Past homicidal thoughts:
☐ Yes ☒ No Past homicidal actions:
☐ Yes ☒ No Current homicidal thoughts:
☐ Yes ☒ No Past violent episodes:
☐ Yes ☒ No Current violent thoughts / urges:
☐ Yes ☒ No Intent to act on thoughts / urges:

COMMENT ON RISK OF HARM TO OTHERS:**CONTRIBUTING RISK FACTORS:**

☒ Yes ☐ No Family h/o suicide attempts: siblings attempted
☒ Yes ☐ No Family h/o mental illness:
☐ Yes ☒ No Loss (loved one, relative, relationship, status):
☐ Yes ☒ No Suicide of relative/peer/famous person:
☐ Yes ☒ No Stressful life event (acute):
☐ Yes ☒ No Chronic stressors (financial, legal, etc.):
☐ Yes ☒ No Psychological trauma (current):

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 347

AR 0390

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

☒ Yes ☐ No Childhood trauma (sexual, emotional, physical):
☐ Yes ☒ No Stressful medical condition:
☐ Yes ☒ No Chronic pain:
☐ Yes ☒ No Physical functional impairment:
☒ Yes ☐ No Military related stress:

Comments:

PROTECTIVE:

☒ Yes ☐ No Good social support system:
☒ Yes ☐ No Positive personal traits:
☒ Yes ☐ No Access to health care:

Comments:

Review of systems**Systemic:** No recent weight loss and no recent weight gain.**Head:** No headache.**Eyes:** No blurry vision.**Gastrointestinal:** Appetite not decreased. No diarrhea.**Endocrine:** No decreased libido.**Musculoskeletal:** No muscle aches, no localized joint pain, and no limb pain.**Neurological:** No dizziness, no motor disturbances, and no tremor. No gait abnormality. No sensory disturbances.**Psychological:** No nightmares and no bulimic episodes. No social isolation.**Skin:** No rash.**Assessment****ASSESSMENT AND DIAGNOSIS**

Patients strengths: resilient

Potential obstacles to treatment: anxiety d/o

Prognosis: ☐ Excellent..... ☐ Good..... ☐ Fair..... ☒ Guarded..... ☐ Poor

PROFILE STATUS: reports in process of MEB

Visit is not deployment-related.

Plan**TREATMENT GOALS AND OBJECTIVES**

Patients goals

1. Figure out how to cope with prior life events
2. Move on from things

Treatment objectives

1. Improve psychological functioning
2. Decrease number of episodes of trichotillomania
3. Reduction in symptoms as evidence by self reported measures BHDP by 20% post completion of program

TREATMENT PLAN AND STRATEGY

Medication: Effexor 150 mg daily

Psychotherapy: 2 x per week

Referrals: watch pad sleep study, Alpha-Stim, BFA

Estimated Frequency and Duration of Treatment: 4 wks

Other:

- ☒ Treatment Options and Education: Diagnosis and treatment options - including risks, benefits, side effects, and choice to decline treatment, were discussed with the patient who expressed an understanding of the diagnosis and plan.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 348

AR 0391

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

[x] Treatment plan was collaboratively discussed with the patient.

[x] Yes [] No...Patient agrees with plan? If not, what part?

DATE: 8/29/17

S/O Note Written by CLOPPER, TAMMY J @ 30 Aug 2017 1414 EDTChief complaint

The Chief Complaint is:

Continued stress and anxiety.

Reason for Visit

NEW EVALUATION.

The Patient was seen by a staff member.

(0900-1000): Present at intake: Dr. Pourzand, Mrs. Donkin, LCSW-C, Ms. Buford, RN.

General overall feeling - Fair.

Difficulty doing work, taking care of things at home, or getting along with other people - Very difficult.

Limits of confidentiality reviewed with the patient who verbally expressed an understanding, signature was obtained. (See [Add Note] for any scanned in documents.)

Referred here

Appointment is voluntary.

....

Patient was not escorted.

Referred here by - Other.

Source of information was self.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

HISTORY OF PRESENT ILLNESS:

Pt is a 32 y/o single Caucasian male ADN E5 with almost 12 years TIS, HDS: Ft. Meade, MOS: Network Intelligence, referred to PCS by outpatient provider at WRNMMC d/t continued symptoms of anxiety and depression. SM reports he has not worked in one month, has lost access to the building, and was demoted from E6 to E5 in 7/2017 d/t social media sexual harassment sent to a female co-worker. SM reports having anxiety symptoms as far back as childhood d/t his father. In 2008, SM started picking his scalp (neurotic excoriation) while deployed aboard a ship d/t stress and anxiety. SM also developed MRSA. SM reports in 2010 he had a bad 2 year relationship breakup with a woman whom was an alcoholic and taking medication. SM states in 2012 he started seeing behavioral health d/t having suicidal ideation, being discontent with life, and the bad breakup. SM endorses guilt, decreased appetite and fear of gaining weight and losing 10 lbs. in the last month (stating he does not want to look like his father as well as end up with diabetes as he has), states feels as though he has sleep paralysis and at times sleeps too much but other times difficulty falling and staying asleep, +anxiety and worrying, reports being hypersexual stating he could have intercourse daily as well as ejaculate three times a day, +anger/irritability, +isolation, states does not like sun exposure, fantasizes about life-space things, watches television a lot which in turn creates increased anxiety (example: watches Game of Thrones and Walking dead but does not look at it as just a TV show, fantasizes that it is real). SM states he works on computer gaming and enjoys cooking. Reports he was in debt for \$35,000 but sold one of his homes and now debt has decreased to \$19,000. States his debt was from buying his brother a car and giving his family money. SM denies AVH and OCD.

ADDITIONAL HPI

SM has no religious preference. SM was deployed near Japan on a ship from 3/2006-4/2009 denying combat exposure and stating he felt safe. SM reports fleeting SI with no plan/intent, currently denying active SI/HI. SM to attend both IOP/CRP programs.

PHYSICAL PAIN SEVERITY 3/ 10.

PAIN ASSESSMENT

Location: stomach (IBS)

Duration:

Quality:

Factors that correlate with onset:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 349

AR 0392

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Frequency:
Average level:
Worst level:
Least level:
What makes it better:
What makes it worse:

... Patient IS NOT currently in a situation where he/she is being verbally or physically hurt, threatened, or made feel afraid.

LEARNING / NEEDS ASSESSMENT

Date Updated:

What is your preferred method of learning?..... ☐ Verbal..... ☐ Written..... ☐ Visual..... ☒ Other (Specify): hands-on
Preferred Language (written or spoken):..... ☒ English..... ☐ Other:
☐ Yes... ☒ No... Learning disability, language barrier, hearing/vision deficit.. (If Yes, Specify):
☐ Yes... ☒ No... Cultural or religious beliefs that may affect care..... (If Yes, Specify):
☐ Yes... ☒ No... Patient or a family member is in the EFMP Program (If Yes, Specify):
☐ Yes... ☒ No... Patient using community resources (e.g. chaplain, family services, etc.) (If Yes, Specify):
☐ Yes... ☒ No... Needs help obtaining more community resources/support. If yes, specify:
☐ Yes... ☒ No... Patient would like family members involved in care.
☐ Yes... ☒ No... Advance Directives completed?
☐ Yes... ☒ No... Copy of the Advance Directive in the record?

NUTRITIONAL ASSESSMENT

Date Updated:

☐ Yes... ☒ No... Illness or condition has led to a change in kinds or amounts of food or made it hard to eat
☒ Yes... ☐ No... Fewer than two meals per day
☐ Yes... ☒ No... Unintended loss of ten or more pounds in the last six months

Personal history**PAST MEDICAL HISTORY**

IBS; PRK; tonsillectomy; childhood asthma; neurotic excoriation (scalp picking);
PSYCHIATRIC HISTORY

Suicide attempt as a child by taking bottle of aspirin d/t conflict with father, vomited but no treatment; age 17 suicide attempt via consuming large quantity of alcohol, no treatment; 6/16/2014 Integrated Health WRNMMC x 2 visits d/t anxiety; 8/2014-10/2014 WRNMMC outpatient BH d/t anxiety; 4/2015-11/2015 WRNMMC outpatient BH d/t depression/anxiety, also attended CBTI group; 8/2016 Integrative Health WRNMMC d/t mood swings/anxiety x 1 visit; 9/2016 started seeing outpatient BH WRNMMC d/t mood swings/anxiety. MEDICATIONS HAVE BEEN RECONCILED to include current medications, OTC, and supplements. Previously trialed meds: Zoloft (increased fatigue), melatonin, lexapro (felt flat), Unisom, Wellbutrin XL (increased anxiety), and Lunesta (ineffective). SM currently taking: Effexor 150 mg daily and Naltrexone 50 mg daily.

A/P Last updated by POURZAND, MIRIAM @ 30 Aug 2017 1357 EDT

1. Generalized anxiety disorder:

32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 350

AR 0393

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Diagnostic Evaluation Initial x 1
 -Psychiatric Diagnostic Evaluation With Medical Evaluation And Management x 1

Disposition Last Updated by POURZAND, MIRIAM @ 30 Aug 2017 1359 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 0742**CHANGE HISTORY***The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 30 Aug 2017 1357 EDT:*

The A/P section was last updated by POURZAND, MIRIAM @ 30 Aug 2017 1357 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 29 Aug 2017 1516 EDT.

1. Generalized anxiety disorder

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Diagnostic Evaluation Initial x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 29 Aug 2017 1516 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 29 Aug 2017 1516 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0907 EDT.

1. Generalized anxiety disorder

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 351

AR 0394

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

22 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29388088 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 22 Aug 2017 0800 EDT
 Clinic: ATS ADULT BE

Appt Type: FTR
 Provider: HANGEMANOLE, DESPINA C

Reason for Appointment:
 f/u

Appointment Comments:
 ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 22 Aug 2017 1004 EDT

History of present illness

The Patient is a 32 year old male.

Focus Of Session: Realizations

S) SM reported that he wanted to drink on Friday due to stress from command. He stated that command had a legal representative notify him that they were counting his referral as a command referral and he was at risk for administrative separation due to this being his second referral. Treatment failure processes were reviewed with SM who acknowledged understanding. SM stated he would prefer to continue treatment at WR ATS as opposed to transferring to WNY SARP due to continuity of care and integration of care. SM stated that he went home on Friday and watched a movie and the cravings dissipated. SM discussed his weight loss, decrease in IBS symptoms and financial gains since he quit drinking. SM also stated he is developing a closer relationship with his family now that he is sober. SM reported that he did not go to a meeting last week but committed to attending one this week. SM also stated he would begin making a gratitude list daily to see if this helped to ground him in the present in order to decrease his anxiety. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP. SM would benefit from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker in three weeks.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 22 Aug 2017 0852 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 22 Aug 2017 0856 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in 3 weeks. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 22 Aug 2017 1004

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

22 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29408977 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Aug 2017 0700 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 23 Aug 2017 1141 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 12
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used:** CBT**Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he continues to have issues with his command and is concerned about returning to the environment post IOP. He stated that he learned that his department had an all-hands meeting regarding him and why his clearance was removed. He feels that other sailors now have a negative impression of him and has noticed that they interact with him differently. Therapist and patient processed his feelings about this. Patient stated that he has been working on socializing and getting out of his home. Patient relayed recent outings. Therapist expressed concern regarding an outing that patient had with another sailor. Therapist encouraged patient to be mindful of social interactions with others in his department related to all the concerns they've had about his boundaries and behavior. Patient agreed that this was not a positive outlet for socialization. Further conversation focused on patient's re-investment into his family relationships. He stated that he is working on trying to build normal healthy relationships even though he does not feel innately warm and secure in these relationships. Therapist and patient discussed how to balance internal growth and relationship growth. Patient is identifying future oriented plans. Patient has no suicidal plan or intent but fleeting ideation. Patient will start IOP next week.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 354

AR 0397

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 355

AR 0398

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Resilience: Yes
 Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.
 This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High
 Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 22 August 2017

Reviewed with patient on: 22 August 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 23 Aug 2017 1144 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 23 Aug 2017 1144 EDT

Released w/o Limitations

Follow up: 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 23 Aug 2017 1144

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

14 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29328694 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **14 Aug 2017 1500 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN**Note Written by PAUL, SHERIN @ 15 Aug 2017 1545 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 11
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: CBT

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he received updated IOP start date that is command approved. Patient is looking forward to this. Therapist and patient discussed this further. Patient stated that he received a call from MEB lawyer regarding his case. Patient will follow up as needed with lawyer. He stated that he is going to additional GI appointments to try other treatments. Further conversation focused on patient's isolation. He stated that he feels better staying at home and to himself as he's afraid of making mistakes or being misunderstood. Therapist and patient discussed how recent events have made the patient mistrust himself. Therapist and patient discussed next steps. He stated that he wants to focus on building his family relationships and identified ways that he is strengthening those bonds. Patient is identifying future oriented plans. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 359

AR 0402

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 360

AR 0403

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 361

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 15 Aug 2017 1547 EDT

1. **Generalized anxiety disorder**
2. **Major depressive disorder, recurrent, moderate**
3. **Alcohol dependence, uncomplicated**
Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 15 Aug 2017 1548 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 15 Aug 2017 1548

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

14 Aug 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29304076 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **14 Aug 2017 1006 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **DELSESTO, BARBARA SUE**

Call Back Phone: [REDACTED]

AutoCites Refreshed by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT**Allergies**

*No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Telephone Consult: Written by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT
Case ManagementTelephone Consult Comments: Written by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT
IOP coordinationS/O Note Written by DELSESTO, BARBARA SUE @ 14 Aug 2017 1014 EDTAnderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Subjective

Spoke with Ms. Lisa Banks-Williams at the Intensive Outpatient Program and received a new start date for this patient for 29 August at 0700. Patient accepted this date and verbalized an understanding to call CM if any issue comes up. Dr. Paul and patient's Command also informed of the new date- CDR Yusko. All parties have CM information.

A/P Written by DELSESTO, BARBARA @ 14 Aug 2017 1014 EDT

1. Encounter for other administrative examinations

Disposition Written by DELSESTO, BARBARA @ 14 Aug 2017 1014 EDT

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 14 Aug 2017 1014

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

14 Aug 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-29337561 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 Aug 2017 0800 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **DELEON,PATRICK D.**

Reason for Appointment:

f/u

Appointment Comments:

jbf

S/O Note Written by DELEON,PATRICK D. @ 16 Aug 2017 1130 EDT**History of present illness**

The Patient is a 32 year old male.

S: Individual follow-up session with this SW as SM's primary ATS counselor Ms. Hangemanole is on leave this week. SM reports ongoing sobriety, acknowledges occasional thoughts of drinking but able to abstain and expressed pride that he has more than a month of sobriety. SM reports recent weight loss which he's pleased with, entirely due to stopping alcohol and caffeine as he reports his IBS prevents him from exercising and he hasn't significantly changed his diet. SM discussed fleeting passive suicidal thoughts, not presently having them and convincingly able to assure of his safety and no intent to act on them. SM reports they are generally sparked by existential questions about finding meaning and purpose in life, more recently connected to thinking about what he'll do after the Navy, discussed both the excitement but primarily the fear that comes with the idea that he could study a new field, could do anything, and this is both a great opportunity and overwhelming. SM reports increased isolation, stemming from two people in recovery who relapsed following a breakup or tension with SM, which he rationally recognizes is not his fault but nevertheless lessens his motivation to connect with others.

O: Client arrived on time to session. Alert and oriented x 3.

Appearance: Appropriate

Behavior: Appropriate

Speech: Within Normal Limits

Thoughts: Logical, linear, goal-directed

Mood: Depressed

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: Convincingly denied

Med/Pain Issues: Irritable Bowel Syndrome

A: SM reports significant depressive symptoms, appears motivated to maintain sobriety

P: Next individual session w/ Ms. Hangemanole 22 Aug, start PCS 29 Aug.

A/P Written by DELEON,PATRICK D. @ 16 Aug 2017 1131 EDT**1. Alcohol dependence, uncomplicated** F10.20

Procedure(s): -(90837) Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by DELEON,PATRICK D. @ 16 Aug 2017 1131 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic. - Comments: Next individual session w/ Ms. Hangemanole 22 Aug, start PCS 29 Aug**Signed By DELEON, PATRICK D.** (Social Work Case Manager) @ 16 Aug 2017 1131

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

10 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29272515 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**

Date: **10 Aug 2017 0801 EDT**
Clinic: **ATS ADULT BE**

Appt Type: **T-CON***
Provider: **HANGEMANOLE, DESPINA C**

Call Back Phone: [REDACTED]

S/O Note Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0803 EDT

Subjective

Tcon with client to notify him of PCS intake date. Intake will be on 29 August and client was aligned with this date. SM also agreed to check in with Patrick Deleon while this writer is on leave next week.

A/P Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0805 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0805 EDT

Follow up: as needed in the ATS ADULT BE clinic.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 10 Aug 2017 0805

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

09 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29260181 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 09 Aug 2017 0800 EDT
Clinic: ATS ADULT BEAppt Type: FTR
Provider: HANGEMANOLE, DESPINA C**Reason for Appointment:**

f/u

Appointment Comments:

jbf

S/O Note Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0742 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Depressive Symptoms

S) SM reported that he spent the weekend watching movies and sleeping. SM stated that he did talk with his sister and his mother and examined with them some of the reasons for living. SM stated he has hopes of moving down to where they live and buying a plot of land to live on together. SM stated that his MEB is moving forward for his IBS. SM denied having an intake date with PCS right now. SM reported that he is still depressed and often thinks about his reasons for living. SM reported he went to one AA meeting but didn't really like it because there was "drama" and he didn't feel he got anything out of it. SM reported that he was triggered to drink one time after hearing people talk about craft beer on the radio. SM stated that he turned the radio off and the feeling passed. He stated that he thought about suicide over the weekend but did not have a plan or intent to harm himself. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP. SM would benefit from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker in two weeks.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0921 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0921 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0916 EDT**Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 18 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

Alcohol use disorder

Reason for Request:

32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahita to reach pt. Thank you.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 10 Aug 2017 0742

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Aug 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29245054 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Aug 2017 0930 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 08 Aug 2017 0949 EDT**Allergies**

•No Known Allergies

VitalsVitals Written by JONES, ANDRUW JOHNBRUCE @ 08 Aug 2017 0927 EDT

BP: 127/86, HR: 78, WT: 160 lbs, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

VitalsVitals Written by JONES, ANDRUW @ 08 Aug 2017 0927 EDT

BP: 127/86, HR: 78, WT: 160 lbs, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR, EDEN @ 09 Aug 2017 1400 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #11

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we increased Effexor xr to 150mg every morning for mood and anxiety. Pt says today he thinks the dose increase is helpful for his IBS symptoms. He isn't sure about impact on anxiety. We discussed that has not been on for long. He remains abstinent from alcohol and coffee and is participating in ATS program. HE has not had his sleep study yet. Review normal B12 lab. He is not having suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:**

Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14

DAYS. 0 Active 09 Aug 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 1 Active

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY

DAY 1 Active 09 Aug 2017@0001

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR

14 DAYS 0 Expired 06 Jun 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 3 Active

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 370

AR 0413

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
 Active 06 Jun 2017@0001
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY
 AS NEEDED FOR GAS 2 Active 18 May 2017@0001
 HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL DISSOLVE 1 TABLET UNDER
 TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN 3 Active
 10 May 2017@0001
 Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED
 IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May
 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4
 Tobacco/e-cigs: none PPD Equivalent:
 Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.
 Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 371

AR 0414

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure
 Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)
 Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None
 Patient denies treatment team needs to be aware of specific ethnic/cultural issues.
 Learns best by: Pictures. Learning is adversely affected by: None.
 Patient would not like family members involved in care.
 Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.
 Behavior/Orientation: Polite, and cooperative.
 Abnormal Movements: normal gait. No abnormal movements apparent.
 Rapport: fair
 Speech: talkative
 Mood: anxious
 Affect: full
 Thought Process: somewhat circumstantial
 Thought Content: denies current suicidal intent/HI/AVH
 Judgment: fair
 Insight: fair
 Impulsivity: none at time of interview
 Cognition: grossly intact
 Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Hepatic Function Panel				
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Basic Metabolic Panel				
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
CBC W/Diff				
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

RBC	BLOOD	4.86	x10(6)/mcl	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcl	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcl	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcl	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcl	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcl	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcl	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Lyme Disease Ab Total Screen	SERUM	Negative <i>	(See-Below)	

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonic Acid	SERUM	170	nmol/L	0-378

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cyanocobalamin)	SERUM	293 <i>	pg/mL	(211-946)

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Comprehensive Metabolic Panel				
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Aspartate Aminotransferase SERUM 20 U/L (0-40)

ETG/ETS, UA (250 Cut-Off) Site/Specimen 02 Feb 2016 1406 Units Ref Rng
Ethyl Glucuronide URINE Negative <i> ng/mL Cutoff=250

Drug Abuse Screen Site/Specimen 02 Feb 2016 1406 Units Ref Rng

Amphetamines	URINE	NEGATIVE <i>	(Negative)
Barbiturates	URINE	NEGATIVE <i>	(Negative)
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)
Cocaine	URINE	NEGATIVE <i>	(Negative)
Opiates	URINE	NEGATIVE <i>	(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High
Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: continue Effexor to 150 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 374

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. continue. have discussed adverse effects of alcohol on mood and sleep. Will be referred for sleep study in July. Normal b12 panel drawn after July 2017 visit.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 09 Aug 2017 1507 EDT1. **Generalized anxiety disorder:** Med management 15 minutes; supportive therapy 15 minutes.

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -VENLAFAXINE XR-PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY #30 RF1

Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

-NALTREXONE-PO 50MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 09 Aug 2017 1508 EDT

Released w/o Limitations

Follow up: 4 week(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR, EDEN @ 08 Aug 2017 1001 EDT

Additional A/P Information:

Discontinued VENLAFAXINE XR-PO 75MG CPSR 24H -

Signed By TOBAR, EDEN (Physician/Workstation) @ 09 Aug 2017 1508

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 375

AR 0418

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

07 Aug 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN

Encounter ID: BETH-29226745 Primary Dx: Major depressive disorder, single episode, moderate

Patient: MERWIN, DANIEL DENNIS Date: 07 Aug 2017 0845 EDT Appt Type: FTR
 Treatment Facility: WALTER REED Clinic: INT MED CL F MEDICAL HOME Provider: LINKER, MARTIN R
 NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: Outpatient

AutoCites Refreshed by JASLIN, ALFREDO E @ 07 Aug 2017 0845 EDT**Allergies**

•No Known Allergies

Reason for Appointment:

IBS-D Follow up

Appointment Comments:

Appt self-booked via TOL

VitalsVitals Written by JASLIN, ALFREDO E @ 07 Aug 2017 0842 EDT

BP: 123/80, HR: 81, RR: 12, T: 98.1 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,
 BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 3/10 Mild, Pain Scale Comments: Stomach

S/O Note Written by LINKER, MARTIN R @ 07 Aug 2017 1718 EDT**Chief complaint**

The Chief Complaint is: Follow up on irritable bowel syndrome.

History of present illness

The Patient is a 32 year old male.

32 m presents today in follow up to IBS. Patient states he is currently having a flare.

Alert and oriented x 3 with no signs of distress. Vital signs within normal limits. No complaints of nausea vomiting diarrhea.

<<Note accomplished in TSWF-CORE>>

Spasms today. Expects unscheduled bowel movements today. States he does not eat much because he has abdominal cramps and diarrhea when the products of digestion reach and are in his colon. But also states that he eats enough to maintain his weight. He is unsure whether or not he is making psychological progress. Continues to participate in BH visits. Taking same dose of venlafaxine. No nausea. Unclear when intensive outpatient treatment will begin. Discussed writing of a letter to amend or clarify NAVMED 6100/5 in order to excuse him from company-level PT and allow him to participate in PT at his own pace. Spoke last week with gastroenterologist and with psychiatrist. Patient is to make follow-up appointment in GI Clinic. His BH follow-up visits are scheduled. Not drinking.

Discussed many issues. Has good insight. Calmer. Less despondent.

Bloating, abdominal pain, and diarrhea.

Anxiety, emotional lability, depression, sleep disturbances ...Thinks that he sleeps too much..., and decreased functioning ability.

Visit is not deployment-related.

Pain assessment

Location: stomach

Duration: intermittent

Quality: spasm

Pain Severity 3/10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 07 August 2017

NKDA

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Current medication

Medications as of 07 August 2017

Probiotic one packet po daily
 Simethicone 80 mg po qid prn
 Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 Naltrexone 50 mg po daily
 Venlafaxine XR 150 mg po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history
 IBS-D
 Generalized anxiety disorder
 Major depressive disorder
 ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 Photorefractive keratectomy
 Jaw surgery

Personal history

Social history reviewed Tobacco – none

Alcohol – none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history

M – Well

F – DM. MI / stent at age 40. Melanoma.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Cardiovascular:** No palpitations.**Pulmonary:** No shortness of breath.**Gastrointestinal:** Appetite not normal. No early satiety.**Genitourinary:** No urinary symptoms.**Musculoskeletal:** No limb swelling.**Neurological:** No fainting.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Lungs:

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard. • No rales/crackles were heard.

Cardiovascular:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Heart Rate And Rhythm: ° Normal.
 Heart Sounds: ° Normal S1 and S2. ° No gallop was heard.
 Murmurs: ° No murmurs were heard.
 Edema: ° Not present.

Abdomen:

Visual Inspection: ° Abdomen was not distended.
 Auscultation: ° Bowel sounds were normal.
 Palpation: ° Abdominal tenderness ...Tender over approximate course of colon.. ° Abdomen was soft.

Psychiatric:

• Exam: ...Discussed many issues. Has good insight. Less anxious. Less despondent.. ° No impairment in social interaction.
 ° No impairment in communication.
 Appearance: ° Abnormal.
 Demonstrated Behavior: ° Behavior demonstrated abnormalities.
 Affect: ° Normal.
 Thought Processes: ° Not impaired.
 Thought Content: ° Revealed no impairment.

Test conclusions

Medication list was updated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

A/P Written by LINKER, MARTIN @ 07 Aug 2017 1708 EDT

1. **Major depressive disorder, single episode, moderate:** Today seems somewhat improved. Continuing BH interventions.
2. **Generalized anxiety disorder:** Today seems somewhat improved. Continuing BH interventions.
3. **Alcohol dependence, uncomplicated:** In sobriety.
4. **Irritable bowel syndrome with diarrhea:** He will make appointment to be seen in GI Clinic.

Disposition Written by LINKER, MARTIN @ 07 Aug 2017 1708 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic. - Comments: To return after GI Clinic visit.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By LINKER, MARTIN (Contractor, MD) @ 07 Aug 2017 1721

CHANGE HISTORY

The following S/O Note Was Overwritten by LINKER, MARTIN @ 07 Aug 2017 0919 EDT:

S/O Note Written by JASLIN ALFREDO E @ 07 Aug 2017 0838 EDT

Chief complaint

The Chief Complaint is: Follow up on irritable bowel syndrome.

History of present illness

The Patient is a 32 year old male.
 32 m presents today in follow up to IBS. Patient states he is currently having a flare.

Alert and oriented x3 with no signs of distress. Vital signs within normal limits. No complaints of nausea vomiting diarrhea.
 <<Note accomplished in TSWF-CORE>>

Visit is not deployment-related.

Pain Severity 3/10.

Pain assessment

Location: stomach

Duration: intermittent

Quality: spasm

Patient has NOT received other care since their last visit with this clinic.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 7/27/17

NKDA

Current medication

Medications as of 27 July 2017

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 150 mg po daily

MVI one po daily

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 378

AR 0421

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history M -- Well

F -- DM, MI / stent at age 40. Melanoma.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 379

AR 0422

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

31 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29166858 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 31 Jul 2017 0900 EDT
Clinic: ATS ADULT BEAppt Type: FTR
Provider: HANGEMANOLE, DESPINA CS/O Note Written by HANGEMANOLE, DESPINA C @ 01 Aug 2017 1111 EDTHistory of present illness

The Patient is a 32 year old male.
 Focus Of Session: Passive Suicidal Ideation
 S) SM reported that he spent the weekend watching movies and sleeping. SM stated that he found himself wanting to sleep the weekend away to pass the time. SM reported that he has been feeling depressed and hopeless. He stated that he thought about suicide over the weekend but did not have a plan or intent to harm himself. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.
 O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.
 A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP.
 Alcohol Use D/O, Severe
 P) Case will be reviewed with treatment team. SM will follow up with social worker next week.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 01 Aug 2017 0723 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 01 Aug 2017 0724 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.
 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 01 Aug 2017 1112

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29135457 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Jul 2017 1400 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

f/u

Appointment Comments:

dei

Note Written by PAUL, SHERIN @ 27 Jul 2017 1502 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 10
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: CBT****Pain: 0/10**

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he decided not to pursue a court marital and instead accepted an NJP which resulted in loss of rank and half month's pay. Therapist and patient processed his feelings about the results. He stated that he's glad that they don't want to "kick me out" and knows that he has an opportunity to regain rank should he not be medically separated. Patient stated that he wrote a personal statement which he provided to his CO and read to his command. Patient read this in session. Patient stated that he wanted his command to know where he was coming from and provide context. Therapist provided positive reinforcement for this. Patient stated that he is focusing on next steps for care and recovery from the past several months. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: [] None [X] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 382

AR 0425

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 383

AR 0426

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low (X) Intermediate () High

Harm to Others: (X) Not Elevated () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: (X) Outpatient () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would NOT like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 384

AR 0427

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 27 Jul 2017 1504 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 27 Jul 2017 1504 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 27 Jul 2017 1505

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 385

AR 0428

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

27 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN

Encounter ID: BETH-29125975 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Jul 2017 0915 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **FTR**
Provider: **LINKER, MARTIN R**AutoCites Refreshed by WESLEY, LATASHA @ 27 Jul 2017 0905 EDT**Allergies**
•No Known Allergies**Reason for Appointment:**

med board

Appointment Comments:

kpg

VitalsVitals Written by WESLEY, LATASHA @ 27 Jul 2017 0902 EDTBP: 118/78, HR: 86, RR: 18, T: 98.0 °F, HT: 69 in, WT: 171 lbs, SpO₂: 100%, BMI: 25.25,

BSA: 1.933 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Weight with shoes.

S/O Note Written by LINKER, MARTIN R @ 27 Jul 2017 1813 EDT**Chief complaint**

The Chief Complaint is: Anxiety. Depression.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Has IBS-D. Triggers include certain foods (high FODMAPS), eating at certain times (breakfast time more so than lunch time) certain smells (e.g., perfume), physical activity, anxiety, stress.

Stools vary. Can have temporally closely spaced multiple stools. Lots of abdominal cramping preceeding bowel movements. Sometimes feels like he should go to the ED because of severe cramping pain. Has been evaluated in GI Clinic and given various treatments, all of which he states were unhelpful. Last GI Clinic visit cited in AHLTA was on 13 April 2017.

Has lots of stress and anxiety.

Taking venlafaxine. Was taking 75 mg daily. Dose increased today to 150 mg. Venlafaxine caused nausea. Nausea now resolved.

IOP planned – start date not clarified.

Recent lost access to the building that he was working in. Now performs analysis on a computer – lower stress. Recent reduction in pay grade. His mother and sisters live in SC, and he thinks that he will be better mentally if he were in SC and could develop his relationship with them.

Excellent general overall feeling /health.

Gastrointestinal symptoms See HPI.

Psychological symptoms See HPI.

Pain assessment 7/27/17

Location:

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 386

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Least level:

What makes it better:

What makes it worse:

Pain Severity 0/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated 7/27/17

NKDA

Current medication

Medications as of 27 July 2017

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 75 mg po daily, to be increased to 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco – none

Alcohol – none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history M – Well

F – DM. MI / stent at age 40. Melanoma.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 387

AR 0430

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Neurological:

• Not oriented to time, place, and person.

Psychiatric:

• No impairment in social interaction.

Affect: • Normal.

Test conclusions

Medication list was updated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

A/P Written by LINKER, MARTIN @ 27 Jul 2017 1816 EDT**1. Irritable bowel syndrome with diarrhea:** Consider interplay between GI and psychiatry problems. Discuss case with gastroenterologist.**2. Generalized anxiety disorder:** Consider interplay between GI and psychiatry problems. Discuss with psychiatrist and psychologist.**3. Major depressive disorder, single episode, moderate:** Consider interplay between GI and psychiatry problems. Discuss with psychiatrist and psychologist.**Disposition Written by LINKER, MARTIN @ 27 Jul 2017 1817 EDT****Released w/o Limitations****Follow up:** 2 week(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By LINKER, MARTIN (Contractor, MD) @ 27 Jul 2017 1817****CHANGE HISTORY***The following S/O Note Was Overwritten by LINKER, MARTIN @ 27 Jul 2017 1018 EDT:**S/O Note Written by WESLEY, LATASHA @ 27 Jul 2017 0852 EDT***Chief complaint**

The Chief Complaint is: Med board forms.

History of present illness

The Patient is a 32 year old male.

He reported: Excellent general overall feeling /health.

Pain Severity 0/ 10.

Pain assessment 7/27/17

Location:

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

.....
Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.**Allergies**

Allergies Verified and Updated 7/27/17

NKDA

animal dander.

Current medication

MVI one po daily

Effexor 37.5 mg po daily (started on July 11, 2017)

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS Naltrexone 15 mg po daily (started July

11, 2017)

verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 388

AR 0431

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK
 Jaw surgery

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐

Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of CRC. Breast CA.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 389

AR 0432

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

27 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29123896 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Jul 2017 0800 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 27 Jul 2017 0830 EDT**Allergies**

•No Known Allergies

VitalsVitals Written by WONG, CHARMIN A @ 27 Jul 2017 0736 EDT

BP: 128/79, HR: 76, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

VitalsVitals Written by WONG, CHARMIN A @ 27 Jul 2017 0736 EDT

BP: 128/79, HR: 76, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR, EDEN @ 27 Jul 2017 2205 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #10

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 390

AR 0433

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we increased Effexor xr to 75mg every morning for mood and anxiety as pt reported increasing distress surrounding facing a DRB the week of July 3rd for charges of allegedly sexually harassing a coworker. Pt says today he thinks the dose increase is helpful for his IBS symptoms. He isn't sure about impact on anxiety. We discussed that he is still on a low dose and hasn't been on it for long. HE is having trouble sleeping and is taking unisom at night but still struggles with sleep maintenance. He feels tired all the time. HE has been abstinent from alcohol for 18 days and is not drinking caffeine. He had an intake with ATS and is doing breathalyzers. HE decided not to challenge his NJP and has been reduced in rank to E5. HE is not having suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 391

AR 0434

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Effexor xr 75 mg po qam, naltrexone 50 mg po daily, unisom

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY

DAY 1 Active 27 Jul 2017@0001

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 392

AR 0435

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE 1/2 TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY 0 Active 27 Jul 2017@0001

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY MORNING 1 Ordered 18 Jul 2017@0001

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS 0 Expired 06 Jun 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 3 Active
PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1

Active 06 Jun 2017@0001
SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS 2 Active 18 May 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Dentes self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
Asthma during childhood
Allergic response to pets
Recurrent intestinal pain (possibly lactose intolerance)
PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure
 Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)
 Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None
 Patient denies treatment team needs to be aware of specific ethnic/cultural issues.
 Learns best by: Pictures. Learning is adversely affected by: None.
 Patient would not like family members involved in care.
 Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.
 Behavior/Orientation: Polite, and cooperative.
 Abnormal Movements: normal gait. No abnormal movements apparent.
 Rapport: pt more guarded today
 Speech: constricted
 Mood: dysphoric
 Affect: constricted
 Thought Process: focused on MEB referral
 Thought Content: denies current suicidal intent/HI/AVH
 Judgment: fair
 Insight: fair
 Impulsivity: none at time of interview
 Cognition: grossly intact
 Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	Date	Time	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM 49	04 Jan 2017	1232	U/L	(10.0-71.0)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Hepatic Function Panel		04 Jan 2017	1232		
Albumin	SERUM 4.9			g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM 58			U/L	(40-129)
Alanine Aminotransferase	SERUM 34			U/L	(0-41)
Aspartate Aminotransferase	SERUM 24			U/L	(0-40)
Bilirubin	SERUM 0.3			mg/dL	(0.15-1.2)
Bilirubin Direct	SERUM <0.2			mg/dL	(0.0-0.3)
Protein	SERUM 7.6			g/dL	(6.6-8.7)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Basic Metabolic Panel		22 Jun 2016	1240		
Urea Nitrogen	SERUM 14.8			mg/dL	(6-20)
Carbon Dioxide	SERUM 28			mmol/L	(22-29)
Chloride	SERUM 98			mmol/L	(98-107)
Creatinine	SERUM 1.00			mg/dL	(0.7-1.2)
Glucose	SERUM 89			mg/dL	(74-106)
Potassium	SERUM 4.5			mmol/L	(3.5-5.1)
Sodium	SERUM 139			mmol/L	(136-145)
Calcium	SERUM 10.1			mg/dL	(8.6-10.2)
Anion Gap	SERUM 13			mmol/L	(7-16)
GFR Calculated Non-Black	SERUM 99.8			mL/min	(60->=60)
GFR Calculated Black	SERUM 115.4			mL/min	(60->=60)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
CBC W/Diff				
WBC BLOOD	5.6 x10(3)/mcL	(3.6-10.6)		
RBC BLOOD	4.86 x10(6)/mcL	(4.21-5.92)		
Hemoglobin	BLOOD 15.1 g/dL	(12.8-17.7)		
Hematocrit	BLOOD 44.4 %	(37.5-50.9)		
MCV BLOOD	91.4 fL	(79.5-96.8)		
MCH BLOOD	31.1 pg	(26.2-33.1)		
MCHC BLOOD	34.1 g/dL	(32.6-35.0)		
RDW CV BLOOD	12.9 %	(12.0-16.2)		
Platelets BLOOD	272 x10(3)/mcL	(162-427)		
MPV BLOOD	9.0 fL	(7.0-10.9)		
Neutrophils	BLOOD 59.4 %	(40.7-76.4)		
Lymphocytes	BLOOD 29.8 %	(15.9-47.8)		
Monocytes	BLOOD 8.9 %	(4.5-11.8)		
Eosinophils	BLOOD 1.5 %	(0.3-7.1)		
Basophils BLOOD	0.4 %	(0.2-1.2)		
ABS Neutrophils	BLOOD 3.3 x10(3)/mcL	(1.8-7.5)		
ABS Lymphocytes	BLOOD 1.7 x10(3)/mcL	(1.0-3.1)		
ABS Monocytes	BLOOD 0.5 x10(3)/mcL	(0.2-0.8)		
ABS Eosinophils	BLOOD 0.1 x10(3)/mcL	(0.0-0.5)		
ABS Basophils	BLOOD 0.0 x10(3)/mcL	(0.0-0.4)		
Differential Review	BLOOD MANUAL DIFF NOT PERFORMED			

	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Lyme Disease Ab Total Screen				
Borrelia burgdorferi Ab	SERUM Negative <i>	(See-Below)		

	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab				
Treponema pallidum Ab	SERUM Negative <i>	(Negative)		
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170 nmol/L	0-378		

	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab				
HIV-1/O/2 Ab	SERUM Negative <r>			

	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cyanocobalamin)				
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL (211-946)		

	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine				
Homocysteine	SERUM 8.9 <i>	mcmol/L (4.0-15.4)		

	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Comprehensive Metabolic Panel				
Albumin	SERUM 4.7 g/dL	(3.5-5.2)		
Alkaline Phosphatase	SERUM 53 U/L	(40-129)		
Alanine Aminotransferase	SERUM 17 U/L	(0-41)		
Bilirubin	SERUM 0.4 mg/dL	(0.15-1.2)		
Urea Nitrogen	SERUM 13.8 mg/dL	(6-20)		
Calcium	SERUM 9.7 mg/dL	(8.6-10.2)		
Carbon Dioxide	SERUM 29 mmol/L	(22-29)		
Chloride	SERUM 98 mmol/L	(98-107)		
Creatinine	SERUM 0.96 mg/dL	(0.7-1.2)		
Glucose	SERUM 89 mg/dL	(74-106)		
Potassium	SERUM 4.4 mmol/L	(3.5-5.1)		
Protein	SERUM 7.6 g/dL	(6.6-8.7)		
Sodium	SERUM 141 mmol/L	(136-145)		
Anion Gap	SERUM 14 mmol/L	(7-16)		

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 395

AR 0438

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	
Barbiturates	URINE	NEGATIVE <i>	(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)	
Cocaine	URINE	NEGATIVE <i>	(Negative)	
Opiates	URINE	NEGATIVE <i>	(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)	
Cannabinoids	URINE	NEGATIVE <i>	(Negative)	
Methadone	URINE	NEGATIVE <i>	(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: increase Effexor xr to 150 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 396

AR 0439

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.
 Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Again discussed ATS referral which pt agreed to today. have discussed adverse effects of alcohol on mood and sleep. Will refer for sleep study. Orderd b12 panel.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 27 Jul 2017 2208 EDT

1. **Generalized anxiety disorder:** Med managemnet 25 minutes, supportive therapy 20 mnutes

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -VENLAFAXINE XR-PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY #14 RF1

Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Laboratory(ies): -B12+FOLATE PANEL (Routine) Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Consult(s): -Referred To: SLEEP DISORDERS MTF BE (Routine) Specialty: SLEEP DISORDERS Clinic: SLEEP (PULM) CL BE Provisional Diagnosis: R/o obstructive sleep apnea

Disposition Written by TOBAR, EDEN @ 27 Jul 2017 2208 EDT

Released w/o Limitations

Follow up: 2 to 3 week(s) or sooner if there are problems.

Administrative Options: Consultation requested

Signed By TOBAR, EDEN (Physician/Workstation) @ 27 Jul 2017 2209

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

25 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29097351 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **25 Jul 2017 0900 EDT**
Clinic: **ATS ADULT BE**Appt Type: **SPEC**
Provider: **HANGEMANOLE, DESPINA C****Reason for Appointment:**

Intake

Appointment Comments:

aga

S/O Note Written by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1155 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Intake Assessment

S) SM and this writer completed intake assessment. SM acknowledged that he understood the evaluation process and levels of care. SM reviewed alcohol use history. SM reported that he was referred after disclosing to his BH provider that he was drinking on medications. SM stated he isn't sure if he has an alcohol problem, despite being in treatment before. SM reported abuse of asthma inhaler while in high school and use of marijuana one time while in high school. SM reported some pain related to IBS. SM denied current SI/HI.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative during assessment. SM appears ambivalent about treatment related to his AUD. SM seems to be more comfortable relating his alcohol use to his depression and anxiety, and may not see it as a standalone issue.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1125 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1126 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 25 Jul 2017 1156

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 398

AR 0441

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29051489 Primary Dx: Encounter for other administrative examinations

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 20 Jul 2017 0848 EDT
Clinic: PSYCHIATRY BEAppt Type: FTR
Provider: DELSESTO, BARBARA SUEAutoCites Refreshed by DELSESTO, BARBARA @ 20 Jul 2017 0849 EDT**Allergies**
•No Known Allergies**Active Medications**

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF1	1 of 1	18 Jul 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	10 Jul 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 20 Jul 2017 0848 EDT
Case ManagementAppointment Comments: Written by DELSESTO, BARBARA @ 20 Jul 2017 0848 EDT
Care Coordination/Command Contact

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 399

AR 0442

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by DELSESTO, BARBARA SUE @ 20 Jul 2017 1344 EDT**Reason for Visit**

Visit for: Case Management. Spoke with this patient and his Commander- CDR Yusko:443-479-6067. Discussed the referral to WRNMMC's IOP. The patient had a start date for 7 August but the Commander is requesting a start date for after the Labor Day holiday so the legal issues for this patient can be worked out. CM notified Ms. Lisa Bank-Williams at the PCS clinic to request a new start date. Will let the patient know when it can be scheduled.

History of present illness

The Patient is a 32 year old male.

He reported: Military service Profile Type: Patient was recently placed on LIMDU for IBS and GAD. MEB was recommended by the PCM. Paperwork taken to bldg 17 to the MEB office and MEB set to proceed. His Commander was given a copy of the LIMDU.

Discussed the IOP program with the Commander and recommended that the patient be allowed to attend. Spoke with patient regarding his legal issues and he will schedule a time to talk with the Commander about the process. CM information provided to all parties and will keep working with both to get patient into the IOP and provide support through his legal issue.

A/P Written by DELSESTO, BARBARA @ 20 Jul 2017 1350 EDT**1. Encounter for other administrative examinations****Disposition** Written by DELSESTO, BARBARA @ 20 Jul 2017 1350 EDT**Released w/o Limitations****Signed By** DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 20 Jul 2017 1350

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 400

AR 0443

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29028197 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **18 Jul 2017 1330 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 18 Jul 2017 1344 EDT**Allergies**

•No Known Allergies

VitalsVitals Written by FOX, THOMAS JOSEPH @ 18 Jul 2017 1312 EDT

BP: 112/66, HR: 74, RR: 18, T: 97.1 °F, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Reason for Appointment:

follow up

Appointment Comments:

ajj

VitalsVitals Written by FOX, THOMAS J @ 18 Jul 2017 1312 EDT

BP: 112/66, HR: 74, RR: 18, T: 97.1 °F, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR, EDEN @ 19 Jul 2017 1532 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #9

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we started Effexor xr 37.5 mg every morning for mood and anxiety as pt reported increasing distress surrounding facing a DRB the week of July 3rd for charges of allegedly sexually harassing a coworker. Pt says he sent her pictures of himself with his dogs without his shirt on, and of his dogs licking a piece of meat, and that this was misconstrued to be sexually suggestive. Pt says today he has been having stomach upset and hasn't noticed an impact from the Effexor yet. We discussed it is too early for it to have an impact and right now we are gradually tapering it up to a therapeutic dose to ensure tolerability. He states he has been sober 9 days. HE has had some suicidal ideation without intent because he says his plan would be too expensive (buying a helium vent and gassing himself on helium). He continues to take naltrexone and thinks it is helpful for reducing alcohol use and maybe even his mood. His command wanted to NJP him and reduce him in rank to E-5, which he refused. He states they told him others find him narcissistic and hard to interact with. They told him he was 'unsalvageable'. Pt is consulting with a lawyer. Command states they are going to ad sep him under a general discharge. Pt wants to get out of the Navy but he wants an MEB. He took the limdu Dr Paul wrote and gave it to his PCM, who incorporated it into an MEB referral for that and IBS. I advised pt the Convening Authority for Behavioral Health, CDR Carr, contacted me about it as no behavioral health provider had signed it. I advised pt I agree with limdu referral but not MEB referral at this point as I don't believe he has exhausted all options for treatment; for example he is starting IOP on 07AUG. Pt voiced disappointment but said he would talk to PCM about resubmitting form. HE denies current suicidal intent.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Page 402

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen

Rating scales:

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)

☒ Male

☐ History of family/friend suicide

☐ Chronic medical conditions

☒ Impulsivity

☒ History of abuse

☐ Chronic pain

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Page 403

AR 0446

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

PROTECTIVE FACTORS (Strengths):

- ☐ Married, children ☒ Active treatment engagement
☐ Good coping/problem solving skills ☒ Hopefulness present
☐ Faith/religion commitment ☐ Positive future orientation

Allergies: nkda**Medications:** none**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 404

AR 0447

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:pt more guarded today

Speech:constricted

Mood:dysphoric

Affect:constricted

Thought Process: focused on MEB referral

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcl	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcl	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 405

AR 0448

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

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Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcl	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcl	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcl	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcl	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcl	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcl	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

Anderson, Daniel Dennis

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Page 406

AR 0449

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

ETG/ETS, UA (250 Cut-Off) Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Ethyl Glucuronide URINE Negative <i> ng/mL Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: increase Effexor xr to 75 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 407

AR 0450

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Again discussed ATS referral which pt agreed to today. have discussed adverse effects of alcohol on mood and sleep

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one week

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 19 Jul 2017 1534 EDT**1. Generalized anxiety disorder**

Medication(s): -VENLAFAXINE XR--PO 75MG CPSR 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING
#30 RF1 Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T
Consult(s): -Referred To: BEHAVIORAL HEALTH MTF BE (Routine) Specialty: Clinic: RM BEH HLTH BE
Provisional Diagnosis: Alcohol use disorder

Disposition Written by TOBAR, EDEN @ 19 Jul 2017 1534 EDT**Released w/ Work/Duty Limitations****Follow up:** 2 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requestedNote Written by TOBAR, EDEN @ 18 Jul 2017 1407 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING

Signed By TOBAR, EDEN (Physician/Workstation) @ 19 Jul 2017 1534

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

18 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29045775 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **18 Jul 2017 0800 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN**Note Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE**Patient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 9
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: Treatment Planning

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he received the results of the DRB and he chose to pursue a court martial as he did not want to admit wrong doing to the extent which was recorded. He acknowledged that his behavior may have had unintentional negative impact but he does not agree with the presentation of his behavior as malicious or himself as manipulative. Patient became very despondent that others thought of him that way. He stated that although he understands that he struggles with empathy and caring for others, he never purposely would harm anyone. He expressed stress at financial strain that an admin sep will place and the potential to lose medical coverage. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: [] None [X] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Recurrent, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Page 411

AR 0454

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017*Reviewed with patient on:* 13 June 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 412

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT

1. **Major depressive disorder, recurrent, moderate**

2. **Generalized anxiety disorder**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 19 Jul 2017 1426

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

13 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28978906 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **13 Jul 2017 1015 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **FTR**
Provider: **RODAK, COLLEEN M****Reason for Appointment:**

irritable bowel syndrome

Appointment Comments:

mjs

Vitals**Vitals** Written by BANGURA, JOHN A @ 13 Jul 2017 1002 EDTBP: 124/82, HR: 78, RR: 18, T: 98.3 °F, HT: 69 in, WT: 78.6 kg, SpO₂: 95%, BMI: 25.59,
BSA: 1.944 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 2/10 Mild, Pain Scale Comments: STOMACH**Questionnaire AutoCites** Refreshed by BANGURA, JOHN A @ 13 Jul 2017 1007 EDT**Questionnaires**

Falls Risk Screening (Outpatient) Taken On: 13 Jul 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient patient a falls risk?: No

Anxiety & Depression Screening Taken On: 13 Jul 2017

Questionnaire Notes: PATIENT BEEN SEEN BY PSYCH

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Nearly every day
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Several days

S/O Note Written by RODAK, COLLEEN M @ 14 Jul 2017 1223 EDT**Chief complaint**

The Chief Complaint is: LIMDU and IBS.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and has been started on naltrexone since his last visit; he presents today requesting a LIMDU that with a request (question on LIMDU) to start a med board process.a.

Good general overall feeling /health.

Abdominal pain and diarrhea.

Visit is not deployment-related.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 414

AR 0457

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

What makes it better:
 What makes it worse:

.....
 Pain Severity 2 / 10.

Patient reports that they are compliant with medications.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

MVI one po daily

Effexor 37.5 mg po daily (started on July 11, 2017)

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS Naltrexone 15 mg po
 verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Jaw surgery

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

Annual Questions Date: 19Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

Systemic: No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 415

AR 0458

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Head: No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Heartburn and nausea. No vomiting, no bright red blood per rectum, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety, emotional lability, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.**Skin:** No rash.

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

The patient DID NOT experience illness during the trip.

Physical findings**General:**

- Physical examination Not indicated for visit / administrative visit.

Vital Signs:

- Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

- ° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Test conclusions

Medication list was updated at the beginning of the visit.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Note Written by MINOR, TIFFANY @ 13 Jul 2017 1020 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. 7/13/17 at 10:20

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me

Note Written by BROWER, CARLA @ 13 Jul 2017 1428 EDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 7/13/17 Patient Name: Daniel Dennis Anderson Patient SSN: [REDACTED]
 Proposed start date for limited duty: 7/13/17 Proposed end date (< 6 months): 12/13/2017

This period of limited duty is for: (Select one)

- ☒ 1st LIMDU (< 6 months) Estimated ADSM (no referral to service headquarters necessary).
☐ 2nd LIMDU (< 6 months) Estimated ADSM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.
☐ 1st LIMDU (< 6 months) Officer ADSM (referral to service headquarters necessary).
☐ 2nd LIMDU (< 6 months) Officer ADSM (referral to service headquarters necessary).
☐ 3rd or subsequent LIMDU periods on Navy and Marine ADSM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "dissemination review").
☒ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) IBS - D/P ICD-9 CM Code K57.0
 (2) GAD ICD-9 CM Code 296.32
 (3) MOD resistant med ICD-9 CM Code

Circumstances of Injury/Illness:

The patient is a 32-year-old male who has anxiety, depression, and combat-related PTSD. He has been on multiple medications and has been in the hospital for several weeks. He has been on a 30-day leave of absence from his unit. He has been on a 30-day leave of absence from his unit. He has been on a 30-day leave of absence from his unit.

Treatment plan:

He returned to ICD command health center for a multiple band. He is on a 30-day leave of absence from his unit. He has been on a 30-day leave of absence from his unit. He has been on a 30-day leave of absence from his unit.

SECTION 2: PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Commanding Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my standing provider.

Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARD OFFICER

The following actions have been completed:

- ☐ Completion of Patient Information Sheet
☐ Notification to PCS/Personnel Office
☐ LODD Requested from Parent Command (if LODD required)
☐ Entry into MedBOLTT
☐ Briefing to Patient on Limited Duty/MEB
☐ Notification to MTF LIMDU Coordinator
☐ Notification to Parent Command

Patient Administration Officer/Medical Board Officer Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEBR Case File, and PERC-6021 or M489N-4

NAVJAG 60206 (Rev. 06-2004)
PREVIOUS EDITIONS OBSOLETE

A/P Written by RODAK, COLLEEN M @ 14 Jul 2017 1231 EDT

1. Encounter for other administrative examinations: See add notes

Disposition Written by RODAK, COLLEEN M @ 14 Jul 2017 1231 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 14 Jul 2017 1231

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 13 Jul 2017 1107 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 13 Jul 2017 1016 EDT

Chief complaint

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 417

AR 0460

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

The Chief Complaint is: LIMDU and IBS.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it will be starting IOP he presents today to obtain a 30 day SIQ.

Feeling tired (fatigue).

Abdominal pain and diarrhea.

Patient is a 32 yo male AD/SM that presents with pain to his stomach 2/10 today. patient reports he would like limdu today for the IBS. patient reports no other concerns.

Good general overall feeling /health.

Abdominal pain and diarrhea.

Visit is not deployment-related.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

.....

Pain Severity 2 / 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

FISH OIL, MULTIVITAMIN, EFFEXOR, NALTREXONE

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): [x] English [] Other:

Preferred method of learning? [] Verbal [] Written [] Visual [] Other (Specify):

Learning disability, language barrier, hearing/vision deficit? [] Yes [x] No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? [] Never []

Rarely [] Sometimes [] Often [] Always

Advance directives completed? [] Yes [x] No

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 418

AR 0461

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact preference:
 PCM:

Annual Questions Date: 19Jun2017.

Family history

Family medical history Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.
 Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.

Review of systems

Systemic: No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.
Head: No headache.
Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.
Cardiovascular: No chest pain or discomfort.
Pulmonary: No dyspnea and no cough.
Gastrointestinal: No nausea, no vomiting, no bright red blood per rectum, and no constipation.
Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.
Musculoskeletal: No back pain.
Neurological: No lightheadedness.
 The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.
 Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.
 The patient HAS NOT traveled outside of the country in the past 90 days.
 The patient DID NOT experience illness during the trip.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

*The following S/O Note Was Overwritten by MINOR TIFFANY @ 13 Jul 2017 1020 EDT:**S/O Note Written by BANGURA JOHN A @ 13 Jul 2017 1002 EDT***Chief complaint**

The Chief Complaint is: LIMDU.

History of present illness

The Patient is a 32 year old male.
 He reported: Good general overall feeling /health.
 Visit is not deployment-related.

Pain Severity 2 / 10.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

FISH OIL, MULTIVITAMIN, EFFEXOR, NALTREXONE

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 419

AR 0462

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital
 IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.
 Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

Annual Questions Date: 19Jun2017.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient DID NOT experience illness during the trip.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 420

AR 0463

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Jul 2017 at WRNMMC, Integrative Hlth & Well BE by THOMAS, LAUREN A

Encounter ID: BETH-28963629 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 12 Jul 2017 0845 EDT
Clinic: INTEGRATIVE HLTH & WELL BE
Appt Type: FTR
Provider: THOMAS, LAUREN A**Reason for Appointment:**

IBS diet

Appointment Comments:

Ist

Screening Written by THOMAS, LAUREN A @ 12 Jul 2017 0910 EDT**Reason For Appointment:** IBS diet**Reason(s) For Visit (Chief Complaint):** Patient Education - Dietary Counseling And Surveillance (New) ;**Vitals**Vitals Written by THOMAS, LAUREN A @ 12 Jul 2017 0910 EDT

HT: 69 in, WT: 178 lbs, BMI: 26.29, BSA: 1.966 square meters, Tobacco Use: No, Alcohol Use: No

S/O Note Written by THOMAS, LAUREN A @ 12 Jul 2017 0923 EDT**History of present illness**

The Patient is a 32 year old male.
The SM was referred for medical nutrition therapy for IBS-D. BMI=26., LDL-C=140 mg Trig=262. PMH=Anxiety, depression. Is currently under a medical board. The SM states that he has had GI problems for many years. Also has a family hx of high cholesterol. Has decreased intake of red meat from 3x-1x/week. Triglycerides are likely elevated due to excessive alcohol intake. The SM states he has not lost weight but in fact has gained weight but that maybe from drinking alcohol. He stopped drinking 3 days ago and also stopped caffeine intake then too. He reports following the low FODMAP diet 1 1/2 years ago. Stopped following it and also was not completely following it. Started following it again 5 weeks ago. He states it has helped his symptoms. He reports 1 Bm/day that is watery, painful. He states that garlic and onion bother him as do cruciferous vegetables. He stated that no matter what I eat, I feel pain, discomfort. Diet recall reveals the patient is following the low FODMAP diet but is eating bread products with gluten. He states he doesn't feel gluten bothers him. B: none or Glucerna shake L: 3-4 oz chicken breast, 1/2 cup brown rice, water S: Jello D: Chicken/ turkey, rice or turkey burger on a potato roll, water. Supplements: Centrum Silver, Fish Oil, Probiotic.

Current medication

Including OTCs, vitamins, herbals, supplements, etc.

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GA.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Reported:

Medical: Reported medical history IBS-D

GAD / depression

HX of ETOH abuse (previous inpatient treatment)

HPV genital.

Lab Result Cited by THOMAS, LAUREN A @ 12 Jul 2017 0924 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 421

AR 0464

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

A/P Written by THOMAS, LAUREN A @ 12 Jul 2017 0934 EDT**1. Irritable bowel syndrome with diarrhea:** Nutrition Diagnosis: Altered GI function RT stress, excessive alcohol, depression AEB patient symptoms

Intervention #1:

1. Discussed 2nd phase of FODMAP diet which includes gradual addition of some foods from one food group
2. Discussed returning to low FODMAP before adding foods from another group
3. Recommended patient make an appointment with IHWS Mind-Body therapist to learn skills for stress reduction/relaxation/mediation

Barriers: Limited ability to exercise

Monitoring/Evaluation

Goals:

1. Add in 1/2 banana then see how symptoms are
 2. Add in another fruit from fruit group to assess tolerance
 3. Next add in grains in similar way
 4. Make an appt with Mind-Body therapist
 5. F/u recommended- patient declined
- Monitor symptoms with food journal
RD and clinic contact information given for follow-up, questions

Procedure(s): -Medical Nutrition Therapy Initial Assessment, Intervention x 3

Disposition Written by THOMAS, LAUREN A @ 12 Jul 2017 0937 EDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the INTEGRATIVE HLTH & WELL BE clinic.

45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By THOMAS, LAUREN A (Registered Dietitian, Walter Reed National Military Medical Center) @ 12 Jul 2017 0937

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-28936747 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **10 Jul 2017 1231 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **ACUT**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 10 Jul 2017 1249 EDT**Allergies**

•No Known Allergies

Vitals

No Vitals Found.

Reason for Appointment: Written by TOBAR, EDEN @ 10 Jul 2017 1231 EDT
ED follow up**Vitals**Vitals Written by TOBAR, EDEN @ 10 Jul 2017 1056 EDT

BP: 130/86, HR: 81, T: 98.8 °F

Comments: vitals taken by clinic enlisted staffNote Written by TOBAR, EDEN @ 11 Jul 2017 2212 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #9

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 423

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for acute ED follow-up appt after being referred to the ED on 06JUL for reporting suicidal thoughts to his command that day. Pt states he faced a DRB last week. He has been having legal trouble at his command for allegedly sexually harassing a coworker. Pt says he sent her pictures of himself with his dogs without his shirt on, and of his dogs licking a piece of meat, and that this was misconstrued to be sexually suggestive. Pt says he has been having increasing suicidal ideation over the past couple of months because of the legal situation. He started researching ways to kill himself on a website called helpme.org and thought about carbon monoxide poisoning or shooting himself with a shotgun, although he doesn't own one and denies plan to buy one. He says he told a coworker last week who told his command who referred him to ED, where he was evaluated and released to outpatient. Pt says he wouldn't act on these thoughts due to his family and sister. He says after stopping his medications (Lexapro, Lunesta and Naltrexone) around the beginning of May he became increasingly depressed and started drinking more, up to a liter and a half a week of vodka. He also drank up to 3 coffees per day. Pt states he thinks he felt better on medication and would like to go back on a medication for his mood. He states he stopped drinking alcohol two days ago. He learned more about his family psychiatric history since we last met, specifically that both grandparents are on venlafaxine and find it helpful for their mood. Grandmother also is on Risperdal for bipolar disorder. Pt reports when he is programming, watching TV or movies he finds they are an escape and he does not feel tired. However, he otherwise feels tired much of the time. He felt tired on past trials of SSRIs as well.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 424

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

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SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation

Anderson, Daniel Dennis

DOB: [REDACTED]

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Page 425

AR 0468

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Allergies: nkda**Medications:** none**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 426

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:mildly pressured

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Hepatic Function Panel				
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Basic Metabolic Panel				
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
CBC W/Diff				
WBC	BLOOD 5.6	x10(3)/mcl	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcl	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD 44.4	%	(37.5-50.9)	
MCV	BLOOD 91.4	fL	(79.5-96.8)	
MCH	BLOOD 31.1	pg	(26.2-33.1)	
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD 12.9	%	(12.0-16.2)	

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Page 427

AR 0470

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM Negative <i>		(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM Negative <i>		(Negative)	

Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <r>			

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL	(211-946)	

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L	(4.0-15.4)	

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM 4.7	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 53	U/L	(40-129)	
Alanine Aminotransferase	SERUM 17	U/L	(0-41)	
Bilirubin	SERUM 0.4	mg/dL	(0.15-1.2)	
Urea Nitrogen	SERUM 13.8	mg/dL	(6-20)	
Calcium	SERUM 9.7	mg/dL	(8.6-10.2)	
Carbon Dioxide	SERUM 29	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 0.96	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.4	mmol/L	(3.5-5.1)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	
Sodium	SERUM 141	mmol/L	(136-145)	
Anion Gap	SERUM 14	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 105.6	mL/min	(60->=60)	
GFR Calculated Black	SERUM 122.1 <i>	mL/min	(60->=60)	
Aspartate Aminotransferase	SERUM 20	U/L	(0-40)	

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE NEGATIVE <i>		(Negative)	

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

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Page 428

AR 0471

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Barbiturates	URINE	NEGATIVE <i>	(Negative)
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)
Cocaine	URINE	NEGATIVE <i>	(Negative)
Opiates	URINE	NEGATIVE <i>	(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will resume medication

Intervention: start Effexor xr 37.5 mg po qam with plan to increase to 75 mg poq am in one week if tolerated, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: restart naltrexone 25 mg po q day x 3 days, then increase to 50 mg po daily. Discussed ATS referral but he declines at this time. have discussed adverse effects of alcohol on mood and sleep

Measure: self-report, lab results

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 429

AR 0472

Medical Record

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Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one week

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Last Updated by TOBAR, EDEN @ 11 Jul 2017 2210 EDT**1. Generalized anxiety disorder**

Procedure(s): -Psychiatric Therapy For Crisis Intervention x 1

Medication(s): -VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING
 #14 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T
 -NALTREXONE--PO 50MG TAB - T1/2 TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN
 INCREASE TO ONE TABLET BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR,EDEN Ordering
 Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR, EDEN @ 11 Jul 2017 2211 EDT**Released w/o Limitations****Follow up:** 1 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 12 Jul 2017 1513

CHANGE HISTORY*The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by TOBAR,EDEN @ 12 Jul 2017 1511 EDT:***Signed TOBAR, EDEN T (Physician/Workstation) @ 11 Jul 2017 2213**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 430

AR 0473

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-28931074 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS** Date: **10 Jul 2017 0918 EDT** Appt Type: **FTR**
 Treatment Facility: **WALTER REED** Clinic: **PSYCHIATRY BE** Provider: **DELSESTO, BARBARA SUE**
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

AutoCites Refreshed by DELSESTO, BARBARA @ 10 Jul 2017 0919 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 10 Jul 2017 0918 EDT

Case Management

Appointment Comments: Written by DELSESTO, BARBARA @ 10 Jul 2017 0918 EDT

Care Coordination/Command Contact

S/O Note Written by DELSESTO, BARBARA SUE @ 10 Jul 2017 1133 EDT**Reason for Visit**

Visit for: Case Management. Patient was seen in the ED on 6 July and saw Dr. Paul this am at 0800. He was taken by his Command for a safety check/eval. He denies any safety concerns today. He will see his PCM for LIMDU paperwork and start the MEB process this week. Dr. Paul has written a temporary LIMDU for BH while patient continues to receive treatment. Both medical and BH conditions to be added to the permanent LIMDU.

History of present illness

The Patient is a 32 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 431

AR 0474

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Spoke with patient's Commander- CDR Yusko regarding the Intensive Outpatient Program in the PCS clinic. Confirmed date to start is 7 August. Informed Command that the program is M-F /0700-1500 for at least 4 weeks. She stated that she can NOT commit to support this treatment at this time. I requested that she get back to me in the next 2 weeks regarding this treatment. The patient is currently pending some legal action for misconduct and his anxiety is elevated. He reports his IBS is causing some pain, more trips to the bathroom daily and he is picking his scalp until he bleeds and has sores develop. I discussed with the Commander that this patient should be bringing the LIMDU paperwork this week and the MEB action does not stop the legal action. Advocated that patient attend this IOP and continue with treatment. His condition is exacerbated by the legal action and the conflict at work but his condition was noted and treated well before this legal action occurred. He feels that he has had a good service record and has 11 years TIS. He has sought treatment around his work schedule and has tried to remain fit for duty. His record supports a permanent LIMDU and the medical board process will decide his fitness for duty going forward.

A/P Written by DELSESTO, BARBARA @ 10 Jul 2017 1148 EDT

1. Encounter for other administrative examinations: CM to follow this patient. CM information provided to this patient for questions/issues

Disposition Written by DELSESTO, BARBARA @ 10 Jul 2017 1149 EDT

Released w/o Limitations

Follow up: as needed in the PSYCHIATRY BE clinic. - Comments: f/u scheduled with Dr. Paul and Dr. Tobar 45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 10 Jul 2017 1149

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 432

AR 0475

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28954544 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **10 Jul 2017 0800 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 11 Jul 2017 1319 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 8
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: Treatment Planning

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he completed his Disciplinary Review Board which was a stressful experience. Patient described feeling overwhelmed by the accusations and assumptions on his character. He expressed confusion that he had not been previously told about any inappropriate behavior and offered corrective instruction. Patient stated that anxiety and IBS symptoms have risen. He acknowledged the interrelated nature of the two conditions. Patient is working with CDR Del Sesto to follow up with getting support with his command on behavioral health issues. Patient's command has not provided IOP approval as of yet. Patient expressed anxiety about the future and outcome of his career. Therapist and patient worked on coping skills to manage anxiety/depression.

Response to treatment: ☐ None ☒ **Some** ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 434

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Recurrent, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 435

AR 0478

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017*Reviewed with patient on:* 13 June 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 436

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 11 Jul 2017 1319 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 11 Jul 2017 1320 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 11 Jul 2017 1320

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 437

AR 0480

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

07 Jul 2017 at WRNMMC, Psychiatry Be by WISE, JOSEPH E

Encounter ID: BETH-28914234 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Jul 2017 0816 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **WISE, JOSEPH EDWARD**

Call Back Phone: [REDACTED]

AutoCites Refreshed by WISE, JOSEPH E @ 07 Jul 2017 0817 EDT**Allergies**

•No Known Allergies

VitalsVitals Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0927 EDTBP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,

BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0927 EDTBP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,

BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0927 EDTBP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,

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Vitals Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0927 EDTBP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,

BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0902 EDTBP: 127/82, HR: 86, RR: 20, T: 98.3 °F, HT: 69 in, WT: 180.7 lbs, SpO₂: 97%, BMI: 26.68,

BSA: 1.978 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0902 EDTBP: 127/82, HR: 86, RR: 20, T: 98.3 °F, HT: 69 in, WT: 180.7 lbs, SpO₂: 97%, BMI: 26.68,

BSA: 1.978 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Vitals Written by PROVENCIO, ELISHA S. @ 07 Jun 2017 1006 EDT

BP: 129/75, HR: 75, RR: 16, HT: 69 in, WT: 168 lbs, BMI: 24.81, BSA: 1.918 square meters, Tobacco Use: No, Alcohol Use: No,

Pain Scale: 0 Pain Free

Comments: no anti-histamines in last 7 days or moreS/O Note Written by WISE, JOSEPH EDWARD @ 07 Jul 2017 0819 EDT**Subjective**

Record reviewed, in response to ER last night. I liaised with those providers. I called the pt; message left about psychiatric appointment options for earlier than 18 JUL, if needed. (note, he does have another appointment with his therapist prior to that.) We will await his call back.

A/P Last Updated by WISE, JOSEPH E @ 07 Jul 2017 0819 EDT**1. Generalized anxiety disorder**Disposition Last Updated by WISE, JOSEPH E @ 07 Jul 2017 0819 EDT

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 438

AR 0481

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By WISE, JOSEPH E (Physician/Psychiatrist, Walter Reed NMMC) @ 07 Jul 2017 0820

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by MEADOR, KRISTINE P

Encounter ID: BETH-28914272 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS** Date: **07 Jul 2017 0815 EDT** Appt Type: **T-CON***
 Treatment Facility: **WALTER REED** Clinic: **INT MED CL F MEDICAL HOME** Provider: **MEADOR, KRISTINE P**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient** Call Back Phone: **(410)-562-5345x1**

Reason for Telephone Consult: Written by MEADOR, KRISTINE P @ 07 Jul 2017 0815 EDT

PCM: RODAK

Telephone Consult Comments: Written by MEADOR, KRISTINE P @ 07 Jul 2017 0815 EDT

F/U FOR ER VISIT; DEPRESSION

Note Written by MEADOR, KRISTINE P @ 07 Jul 2017 0818 EDT

32 yo M Navy AD sent from Ft Meade for SI. Has had increasing SI for past 3 weeks. Attempted x 2 while in HS.

A/P Last Updated by SMITH, MICKALYNN J @ 10 Jul 2017 0747 EDT**1. Encounter for other administrative examinations**

Procedure(s): -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1

Disposition Last Updated by MEADOR, KRISTINE P @ 10 Jul 2017 0912 EDT**Released to Self Care**Note Written by MEADOR, KRISTINE P @ 07 Jul 2017 1113 EDT

32 yo M seen in ED on 06Jul2017 for SI. F/u appt scheduled for psychiatry and PCP (see below). Left general message for pt to return call to Team Fox River.

PSYCHIATRY BE/WRNMMC PAUL, SHERIN 10Jul2017@0800 FTR/60 PENDING
 Arrive 15 min early

INT MED CL F MEDICAL/WRNMMC RODAK, COLLE 17Jul2017@0745 FTR/30 PENDING
 Arrive 15 min early BPAD WEA

Note Written by SMITH, MICKALYNN J @ 10 Jul 2017 0743 EDT**RN note**

Pt returned RN phone call. States he has f/u with PCP already scheduled and will talk with provider about ER visit at that meeting. TCON closed.

Signed By MEADOR, KRISTINE P (Physician) @ 10 Jul 2017 0913

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Jul 2017 at WRNMMC, Psychiatry Consult Liaison Be by WORKS, LINDSAY K

Encounter ID: BETH-28912169 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS	Date: 06 Jul 2017 2027 EDT	Appt Type: ACUT
Treatment Facility: WALTER REED	Clinic: PSYCHIATRY CONSULT	Provider: WORKS, LINDSAY KAY EMIL
NATIONAL MILITARY MEDICAL CNTR	LIAISON BE	
Patient Status: Outpatient		

Reason for Appointment: Written by WORKS, LINDSAY K @ 06 Jul 2017 2027 EDT
safety check**Note** Written by WORKS, LINDSAY K @ 06 Jul 2017 2027 EDT**Impression:**

32yo single Caucasian AD USN E6 male with past psychiatric history of GAD, MDD, Adj disorder who presented at the request of command for safety eval due to recent suicidal thoughts. Biologically, the patient self-discontinued his Lexapro a few months ago, with noticeable worsening of symptoms since discontinuing. He has a history of heavy alcohol use, but denies recent binge use. He suffers from poor sleep as well. Psychologically, the patient struggles with chronic depression and suicidality. He has poor coping skills and turns to alcohol for relief. He is isolative but engaged in treatment. He is at times impulsive, as evidenced by self-discontinuing effective medications. Socially, the patient has a couple of close friends which he trusts and confides in. He also has a good therapeutic relationship with his outpatient provider.

Risk factors include prior suicide attempts, mental illness, acute stressors of job/finance/relationship, and family history. Protective factors include future orientation, interest in treatment, help-seeking, no access to guns, roommate. Hospital admission was discussed with the patient at length. He refused admission at this time and does not require involuntary admission for safety as he is not currently suicidal or homicidal and is able to care for self. He is chronically suicidal and trusts his outpatient provider enough that he called her on his way in and she made an appointment on Monday.

Dx: GAD, Adjustment D/O

Recommendations/Plan:

- Patient to be discharged from ED with outpatient BH follow-up
- BH psychology apt on Monday 0800
- emailed WRNMMC BH staff to arrange for psychiatric follow-up within 1 week
- return to the ED or call 911 if suicidal thoughts worsen or if you feel unsafe

D/w Dr. Molchan- staff psychiatrist

-

HPI:

Patient presented to the ED at the request of command due to expressing suicidal thoughts yesterday. Patient reports he has chronic suicidal thoughts "off and on" and that last night he was having thoughts and was "sort of researching different ways online" and told this to a civilian co-worker. That co-worker was concerned and reported it to his command, who then sent the patient to the ED. On the way into the ED, the patient contacted his therapist and told

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

her what was happening and she scheduled him for Monday 0800 appointment.

At the time of the evaluation, the patient denied any current suicidal thoughts. He stated that he was irritated that his friend reported him but understands that suicide is taken seriously. He denies that his thoughts are worse than usual but does admit that researching different ways is "not common but not rare". He denies any specific plan.

Yesterday the patient went before the DRB for misconduct and is facing separation or demotion as punishment. This was particularly upsetting to him and "stressed him out". He also self-discontinued his psychiatric medication (Lexapro) in April and since then has noticed an increase in depression and anxiety. He is interested in resuming the medication and would like to meet with his prior provider Dr. Tobar to discuss. The medication was stopped due to making him feel sleepy, but he feels the benefits out way the cost. Also, since being more stressed his IBS has increased which has caused more pain and has decreased appetite.

The DRB is in regards to accusations of sexual misconduct in regards to social media posts and conversations with a couple of female colleagues. The patient denies any misdoing.

Psych ROS

Depression: endorses poor sleep with early morning awakenings, guilt, hopeless and helpless at times, anhedonia (prior enjoyed gaming, less pleasure from it now). Chronic SI without plan or intent.

Anxiety: more anxious since stopping Lexapro, nervously picks at scalp to the point of having a bald patch. Endorses general anxiety, all day every day over small things.

Mania: denies

Psychosis: denies

PTSD: has thoughts of past abuse and at times feels uneasy around men, but denies overt avoidance/nightmares/flashbacks.

Psych History

Prior diagnosis: ETOH abuse, GAD, MDD

Prior suicide attempt: x2 in adolescence via alcohol and aspirin

Inpatient substance abuse treatment at ft. Belvoir April 2015

Currently in therapy and sees Dr. Tobar for medications.

Prior Lexapro 20mg qd, stopped in April

PMHx/PSHx:

Childhood asthma

IBS

HPV

PRK (2011)

Current Meds:

GasX

Fish Oil

Probiotic

Family History:

Sisters: suicide attempts, bipolar, substance abuse

Anderson, Daniel Dennis

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Page 442

AR 0485

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

MGMA- bipolar

Developmental/social Hx:

Born in CA, oldest of 3 siblings. Born to an intact union, divorced at age 3. Contentious divorce. Father won custody. Patient was bullied in school and abused by dad. Involved in track. Graduated HS with average grades. Went on to business school, dropped out and joined the military. Patient is straight, currently single. He recently ended a relationship, found out recently that following the break-up she began using drugs, which makes the patient feel guilty.

Military history:

11yrs TIS

USN E6

No deployments

Currently working on Med Board.

ETOH: has decreased use to 1-2 drinks per night, last few weeks less than 1 per night

Tobacco: denies

Illicit Drugs: denies

Allergies:

NKDA

Objective Findings

Vital Signs: HR 73, BP 144/94, R 16, Temp 97.9

MSE:

General: Caucasian male with orange hair, fair skin, appearing stated age. Well-nourished, well-groomed.

Behavior: calm and cooperative, good eye contact

Speech: regular rate, rhythm, volume, tone

Mood: "ok"

Affect: reactive, euthymic, smiling at times

Thought Process: logical, linear, goal directed, easy to follow

Thought Content: denies SI/HI, no evidence of hallucinations/delusions

Judgement: fair

Insight: fair

Impulse Control: Intact during interview

Labs: largely wnl

Time spent face to face with patient: 60minutes

A/P Last Updated by WORKS,LINDSAY K @ 06 Jul 2017 2028 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Disposition Last Updated by WORKS,LINDSAY K @ 06 Jul 2017 2030 EDT

Released w/o Limitations

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 443

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Follow up: with PCM and/or in the PSYCHIATRY BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By **WORKS, LINDSAY KAY EMIL** (Physician) @ 06 Jul 2017 2030

Co-Signed By **MOLCHAN, SUSAN E** (Psychiatrist) @ 10 Jul 2017 1555

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-28903549 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **06 Jul 2017 1030 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **DELSESTO, BARBARA SUE**AutoCites Refreshed by DELSESTO, BARBARA @ 06 Jul 2017 1032 EDT**Allergies**
•No Known Allergies**Active Medications**

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 06 Jul 2017 1030 EDT

Case Management

Appointment Comments: Written by DELSESTO, BARBARA @ 06 Jul 2017 1030 EDT

Care Coordination

S/O Note Written by DELSESTO, BARBARA SUE @ 07 Jul 2017 1045 EDT**Reason for Visit**

Visit for: Case Management. Spoke with this patient regarding his referral to the Intensive Outpatient Program. I spoke with him about the situation at his unit-he is having some legal issues with his unit and is awaiting the outcome from this. He feels he is being mistreated by his Command and reached out to CM to talk with them about moving his duty assignment or a PCS LIMDU. The legal issues will need to be complete before he can PCS. CM to talk with his Commander about reducing this patient's stress level as it is making him more symptomatic with his IBS, anxiety, etc.

History of present illness

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 445

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The Patient is a 32 year old male.

The start date for IOP is 7 August per Ms. Banks-Williams. Patient verbalized an understanding and CM will continue to try to contact his Commander for confirmation of support for the IOP and discuss his work environment.

A/P Written by DELSESTO, BARBARA @ 07 Jul 2017 1052 EDT

1. Encounter for other administrative examinations

Disposition Written by DELSESTO, BARBARA @ 07 Jul 2017 1052 EDT

Released w/o Limitations

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 07 Jul 2017 1052

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

27 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28841296 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Jun 2017 1500 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

f/u

Appointment Comments:

ra

Note Written by PAUL, SHERIN @ 28 Jun 2017 1125 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 7
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he has received negative feedback from his command regarding LimDu and IOP. Patient expressed concerns that they think he is "faking" his behavioral health issues in order to "get out of trouble". Patient stated that he is well aware that despite neutral intentions, his behavior towards others related to sexual harassment allegation had a negative impact on the women it was directed to. Patient stated that he has been trying to "keep things going" despite regular daily stressors from Navy demands negatively impacting his mental and physical health (IBS). He stated that he is recognizing that he cannot keep going forward without further injuring himself. Therapist noted that his previous notes indicated that he experienced significant stress deciding to re-enlist and shortly after felt that he made an error in returning to Navy stressors. Patient feels that Navy demands are detrimental to his behavioral and physical health. Patient is following up with potential MEB with other providers. Patient indicated impulsive drive to "turn in my badge" because he just wants to get out of the department. However, he is concerned about how this will impact him long term. Therapist provided patient with contact info for NCM CDR Del Sesto to discuss his current situation and receive support.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 448

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
Alcohol Abuse Disorder
Axis II: Diagnosis deferred on Axis II
Axis III: Deferred
Axis IV: Financial stress, lack of social support
Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Frustration Tolerance Limited
 Resilience: Yes
 Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 450

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL SHERIN @ 28 Jun 2017 1126 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL SHERIN @ 28 Jun 2017 1127 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 28 Jun 2017 1127

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by FINK, CAITLIN M

Encounter ID: BETH-28769305 Primary Dx: Epidermal cyst

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Jun 2017 1203 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **PROC**
 Provider: **FINK, CAITLIN M**

AutoCites Refreshed by DIBLASI, DANIEL R @ 21 Jun 2017 1528 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS-PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

S/O Note Written by DIBLASI, DANIEL ROBERT @ 21 Jun 2017 1535 EDT**Chief complaint**

The Chief Complaint is: Excision.

History of present illness

The Patient is a 32 year old male.

32 y/o male presents for excision of scrotal cysts.

In the Navy and currently on active duty.

No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI.

Allergies

No known drug allergies.

Current medication

Current medications reviewed, confirmed and reconciled with patient.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Past medical/surgical history**Diagnoses:**

- No basal cell carcinoma of the skin
- No squamous cell carcinoma of the skin.
- No malignant melanoma of the skin

Personal history

Behavioral: No tobacco use.

Alcohol: Alcohol use.

Family history

- No malignant melanoma of the skin.

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value
Pain level by numeric rating scale	0

General Appearance:

- ° Well developed. ° Well nourished. ° In no acute distress. ° Not acutely ill.

Neurological:

- ° Oriented to time, place, and person.

Skin:

- Skin: On exam the following lesions were identified and examined:
Multiple round subcutaneous cysts on the scrotum. • Complexion type II.

A/P Last Updated by DIBLASI, DANIEL R @ 21 Jun 2017 1540 EDT

1. **Epidermal cyst:** 32 y/o male with multiple EICs on the scrotum. 3 lesions excised. Patient tolerated the procedure. Follow up as needed.

Staffed with Dr. Fink

Procedure(s):

-Excision Of Lesion Trunk Benign Up to .5cm x 1 ADDITIONAL PROVIDER(S): FINK, CAITLIN M - Universal protocol was followed in compliance with WRNMMC standards. Patient's identification was checked (name and DOB). Procedure site(s) and side matches the consent form. The biopsy report and slide (if available) were reviewed. The site was marked and anesthetized with [2] mL of lidocaine 1% with epinephrine. The area was then prepped and draped in a sterile fashion. The lesions were then excised. Estimated blood loss was 1mL. Superficial skin opposition was achieved using 5-0 fast gut sutures. The wound was cleaned, Vaseline placed. Patient was instructed on wound care. The patient was instructed to return to clinic sooner for signs of symptoms of infection to include erythema, draining fluid or pain to palpation.

Lesion Management:
Initial size: [4]mm Margins: [0]mm Size of lesion with margins : [4]mm
Final length of incision [0.5]cm

Laboratory(ies):

-TISSUE EXAM (Routine) Ordered By: DIBLASI, DANIEL R Ordering Provider: DIBLASI, DANIEL ROBERT

Disposition Last Updated by DIBLASI, DANIEL R @ 21 Jun 2017 1541 EDT**Released w/o Limitations**

Follow up: as needed in the DERMATOLO CL BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by FINK, CAITLIN M @ 21 Jun 2017 1545 EDT

Agree with above assessment and plan. Note reviewed and in compliance with WRNMMC and JCAHO standards.

Signed By FINK, CAITLIN M (Physician, Staff Dermatologist) @ 21 Jun 2017 1545

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

19 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28732393 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS** Date: **19 Jun 2017 0915 EDT** Appt Type: **FTR**
 Treatment Facility: **WALTER REED** Clinic: **INT MED CL F MEDICAL HOME** Provider: **RODAK, COLLEEN M**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient**

Reason for Appointment:

Follow up for IBS. Notify the doctor of Physical Training and Smell trigger

Appointment Comments:

Appt self-booked via TOL

VitalsVitals Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87 Left Arm, Adult Cuff, HR: 81 Regular, Radial Artery, RR: 20, T: 98.5 °F Oral, HT: 69 in Stated, WT: 178.5 lbs,

SpO₂: 97%, BMI: 26.36, BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes,

Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Questionnaire AutoCites Refreshed by GRIFFIN, GERALDINE @ 19 Jun 2017 0935 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 19 Jun 2017

Questionnaire Notes: Patient reports that he does not have any suicidal ideation and that he is being seen by Counselors from IBHS.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Nearly every day
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: More than half the days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Several days

Falls Risk Screening (Outpatient) Taken On: 19 Jun 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient a falls risk?: No

S/O Note Written by GRIFFIN, GERALDINE @ 19 Jun 2017 0910 EDT**Chief complaint**

The Chief Complaint is: IBS Information update 3/10 19Jun2017.

History of present illness

The Patient is a 32 year old male.

He reported: Good general overall feeling /health.

Pain assessment 3/10

Location: Abdomen

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level: 6/10

Worst level: 10/10

Least level: 0/10

What makes it better: diet change, not eating

What makes it worse: food, smells of food, eating

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Allergies

Allergies Verified and Updated 19Jun2017

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your

doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

Annual Questions Date: 19Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

S/O Note Written by RODAK, COLLEEN M @ 21 Jun 2017 1552 EDT**Chief complaint**

The Chief Complaint is: IBS information update.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it will be starting IOP he presents today to obtain a 30 day SIQ.

Feeling tired (fatigue).

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Abdominal pain and diarrhea.

Pain Severity 2/10.

Current medication

June 19 2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS
verified CMR**Past medical/surgical history****Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No systemic symptoms and no generalized pain. No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort and no palpitations.**Pulmonary:** No dyspnea, no cough, and no wheezing.**Gastrointestinal:** Appetite not decreased. No dysphagia and no pain on swallowing. Heartburn. No nausea, no vomiting, no hematemesis, no bright red blood per rectum, and no constipation.**Genitourinary:** No hematuria, no change in urinary frequency, and no feelings of urinary urgency. No dysuria and no testicular symptoms were present. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety, emotional lability, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.**Physical findings****General:**

• Physical examination NA for today's visit.

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Note Written by MINOR, TIFFANY @ 19 Jun 2017 0921 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. 6/19/17 at 09:21

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

A/P Written by RODAK, COLLEEN M @ 21 Jun 2017 1601 EDT

1. Encounter for other administrative examinations: See add notes

Disposition Written by RODAK, COLLEEN M @ 21 Jun 2017 1601 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by DUVALL, MICHAEL R @ 20 Jun 2017 0945 EDT

WRKATHILMEDCENINST 6320.1E

QUARTERS/LIGHT DUTY LIST
WFORMC 6320/6 (REV 1/9)
INSTRUCTIONS TO PATIENT:

WALTER REED NATIONAL MILITARY MEDICAL CENTER
BETHESDA, MD 20889-5000

1. FOR ALL PERSONNEL - PRIOR TO LEAVING THE HOSPITAL AREA. TAKE THIS FORM TO THE PRIMARY CARE HEALTH CENTER TO BE PLACED ON THE QUARTERS/LIGHT DUTY LIST.
2. ENLISTED PERSONNEL - RETURN TO YOUR SERVICE AND SHOW THIS FORM TO YOUR SUPERVISOR.
3. OFFICERS - NOTIFY YOUR SERVICE TEAM LEADER OR IMMEDIATE SUPERVISOR IN YOUR CHAIN OF COMMAND.

INFORMATION: DURING THE PERIOD OF TIME IN A QUARTERS PATIENT STATUS, YOU WILL REMAIN IN THE CONFINES OF YOUR QUARTERS, UNLESS RELEASED BY THE MEDICAL OFFICER AND/OR YOUR SUPERIOR IN THE CHAIN OF COMMAND. MARRIED PERSONNEL AND THOSE LIVING ASHORE MAY BE PERMITTED TO GO HOME UPON OBTAINING PERMISSION FROM THE MEDICAL OFFICER AND/OR YOUR SUPERIORS IN YOUR CHAIN OF COMMAND. ALL PERSONNEL WILL RETURN TO THE PRIMARY CARE HEALTH CENTER ON THE TIME AND DATE INDICATED FOR POSSIBLE RETURN TO DUTY, EXTENSION IS A QUARTERS PATIENT STATUS, OR ADMISSION TO THE SICK LIST.

DATE: 6/19/17 TIME: 1005 am
FROM: MILITARY SICK CALL EMERGENCY ROOM ✓ in

TO: COMMANDER/COMMANDING OFFICER

(NAME OF COMMAND TO WHICH MEMBER IS ATTACHED)

1. REQUEST THAT THE BELOW NAMED MEMBER BE PLACED IN THE FOLLOWING STATUS:

 QUARTERS PATIENT STATUS FOR DAYS ✓ LIGHT DUTY STATUS FOR 30 DAYS

MEMBER IS TO RETURN TO CLINIC FOR FOLLOW-UP AND FURTHER DISPOSITION ON (DAY OF THE WEEK)

RESTRICTIONS:

✓ NO LIFTING/BENDING
 NO PFT/EXERCISING

 NO PROLONGED STANDING OR WALKING
 NO SHAVING

OTHERS:

DIAGNOSIS

MEDICAL OFFICER SIGNATURE

IMPRINT PATIENT DATA

Andrew Daniel
DoD 1286180538

PATIENT ADDRESS WHILE IN QUARTERS/LIGHT DUTY STATUS

PATIENT PHONE NUMBER WHILE IN QUARTERS/LIGHT DUTY STATUS

WHITE COPY: MEMBER'S HEALTH RECORD

YELLOW COPY: MEMBER'S SUPERVISOR

PINK COPY: NEMC

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 21 Jun 2017 1602**CHANGE HISTORY***The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 21 Jun 2017 1600 EDT:**S/O Note Written by MINOR, TIFFANY JOHNETTA @ 19 Jun 2017 0912 EDT***Chief complaint**

The Chief Complaint is: IBS information update.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it has been recommended that the patient start IOP mental health / LIMDU

He presents today to update me on his mood and to discuss his sleep disturbances / IBS-D symptoms and its negative impact on his QOL / ability to perform work duties due to severity / frequency of symptoms.

Patient is an 32 yo male AD/SM that's presents with pain 2/10 today in his stomach. patient reports 10/10 is the worst due to eating food. patient reports not eating or changing foods help the pain.

Feeling tired (fatigue).

Abdominal pain and diarrhea.

Pain Severity 2/ 10.

Current medication

Medication Reconciled 12Jun2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No systemic symptoms and no generalized pain. No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no bright red blood per rectum, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 458

AR 0501

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by NICHOLAS, LUKE C

Encounter ID: BETH-28722514 Primary Dx: Anogenital (venereal) warts

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER-MEADE
 Patient Status: **Outpatient**

Date: **16 Jun 2017 0930 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **NICHOLAS,LUKE C**

Reason for Appointment:

Anogenital (venereal) warts

Appointment Comments:

MJ/IRMAC

S/O Note Written by DIBLASI,DANIEL ROBERT @ 16 Jun 2017 1154 EDT**Chief complaint**

The Chief Complaint is: Genital warts.

History of present illness

The Patient is a 32 year old male.

32 y/o male presents for evaluation/treatment of genital warts. Have been there for about 1 year. Has treated topically and with LN2 in the past and lesions have not resolved. Patient also c/o cysts on the scrotum.

In the Navy and currently on active duty.

No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI.

Allergies

No known drug allergies.

Current medication

Current medications reviewed, confirmed and reconciled with patient.

Past medical/surgical history**Diagnoses:**

- No basal cell carcinoma of the skin
- No squamous cell carcinoma of the skin.
- No malignant melanoma of the skin

Personal history

Social history.

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value
Pain level by numeric rating scale	0

General Appearance:

- ° Well developed. ° Well nourished. ° In no acute distress. ° Not acutely ill.

Neurological:

- ° Oriented to time, place, and person.

Skin:

- Skin:: On exam the following lesions were identified and examined:
 Small skin colored papules in the pubic region and on the proximal penile shaft
 Multiple round, subcutaneous cysts on the scrotum. • Complexion type II.

A/P Last Updated by DIBLASI,DANIEL R @ 16 Jun 2017 1247 EDT

1. Anogenital (venereal) warts: 32 y/o male with genital warts. Did not improve with topical or destructive therapies in the past. Recommended repeat treatment with LN2 and then regular follow up every 4-6 weeks for repeat treatment until clear. Patient verbalized understanding.

Seen and staffed with Dr. Nicholas

Procedure(s):

-Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent received, and cryo applied to lesions in standard fashion. Therapy was applied in a pulsed fashion to minimize collateral tissue injury. Patient was instructed to use Vaseline ointment to the area(s) until healed. Patient tolerated the procedure well and left in stable condition.

2. Epidermal cyst: Multiple scrotal EICs. Can schedule for excision. AHLTA and Outlook calendar unavailable at the time of encounter, so will contact patient to schedule.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT**Released w/o Limitations****Follow up:** in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: I saw the patient with the resident and agree with the above assessment and plan.**Note Written by** DIBLASI,DANIEL R @ 16 Jun 2017 1154 EDT**Consult Order****Referring Provider:** RODAK, COLLEEN M**Date of Request:** 19 May 2017**Priority:** Routine**Provisional Diagnosis:**

Anogenital (venereal) warts

Reason for Request:

32 to with penile lesions Previously treated for genital warts with topicals and cryosurgery by dermatology; on PE -> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology please evaluate additional question is if this patient she undergo an anal PAP thank you

Signed By NICHOLAS, LUKE C (Physician-WRNMMC, Dermatologist) @ 19 Jun 2017 1241**CHANGE HISTORY***The following Disposition Note Was Overwritten by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT:*

The Disposition section was last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT - see above. Previous Version of Disposition section was entered/updated by DIBLASI,DANIEL R @ 16 Jun 2017 1248 EDT.

Released w/o Limitations**Follow up:** in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 460

AR 0503

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28672871 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **13 Jun 2017 0858 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 13 Jun 2017 1000 EDT**Subjective**

Provider was contacted by patient's command Chief Schooley regarding statements that patient made the previous day. Chief Schooley indicated that patient admitted to suicidal ideation and stated that the reason that he did not follow through with this was because he could not think of a painless way to die. Chief Schooley stated that the patient then followed up with stating that he was not thinking of hurting himself and no imminent risk was indicated. Chief Schooley indicated that he was concerned about the patient's safety. With expressed verbal permission of the patient, this provider indicated that patient had been seen this morning and screened for safety. Provider notified the caller that if in the future this or other sailors indicated suicidal harm, he has the option to recommend them for an immediate safety screen. Again with expressed verbal permission of the patient, this provider indicated that the patient will be placed on Limdu for behavioral health diagnoses. Further, patient is expected to start intensive outpatient program.

A/P Last Updated by PAUL, SHERIN @ 13 Jun 2017 1000 EDT

1. **Generalized anxiety disorder**
2. **Major depressive disorder, recurrent, moderate**

Disposition Last Updated by PAUL, SHERIN @ 13 Jun 2017 1000 EDT**Follow up:** in the PSYCHIATRY BE clinic.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 13 Jun 2017 1001

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28695800 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **13 Jun 2017 0700 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

Follow up

Appointment Comments:

DCM

Note Written by PAUL, SHERIN @ 14 Jun 2017 1245 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE**Patient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 6
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that since previous session he was provided more information regarding sexual harassment allegation against him. He expressed frustration that his actions were perceived negatively and no one talked to him about it in person. He stated that he never meant to hurt anyone or make anyone feel uncomfortable. However, he agreed that some of the engagement on social media seems inappropriate. Patient expressed frustration that he does not have a good understanding of social norms. He noted that he has been feeling suicidal related to increase in stress. Patient expressed concern about his well-being. He is amenable to intensive outpatient program and LimDu. Therapist and patient completed this paperwork. Patient was also notified that provider had been contacted by Chief Schooley and plans on contacting him later in the day. Patient provided verbal consent for provider to present information regarding patient's treatment plan.

Response to treatment: ☐ None ☒ **Some** ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 463

AR 0506

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Recurrent, Moderate
 Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 464

AR 0507

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High
 Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 465

AR 0508

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 14 Jun 2017 1246 EDT

1. Major depressive disorder, recurrent, moderate

2. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 14 Jun 2017 1246 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 14 Jun 2017 1247

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 466

AR 0509

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28655557 Primary Dx: <No description for K58.2 in Medcin database>

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **12 Jun 2017 0845 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **FTR**
Provider: **RODAK, COLLEEN M****Reason for Appointment:**

Depression and Anxiety

Appointment Comments:

G G

Vitals**Vitals Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0902 EDT**BP: 127/82 Left Arm, Adult Cuff, HR: 86 Regular, Radial Artery, RR: 20, T: 98.3 °F Oral, HT: 69 in Stated,
WT: 180.7 lbs Upright Scale, Actual, With Shoes, SpO₂: 97%, BMI: 26.68, BSA: 1.978 square meters,
Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild, Pain Scale Comments:
Abdomen.**Questionnaire AutoCites Refreshed by GRIFFIN, GERALDINE @ 12 Jun 2017 0906 EDT****Questionnaires**

Anxiety & Depression Screening Taken On: 12 Jun 2017

Questionnaire Notes: Patient reports that he is being seen by Counselors from IBHS.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Nearly every day
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

Falls Risk Screening (Outpatient) Taken On: 12 Jun 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. Physical appearance: **No concerns;**
4. Balance: **No concerns with balance;**
5. Is the patient patient a falls risk?: No

S/O Note Written by RODAK, COLLEEN M @ 13 Jun 2017 0943 EDT**Chief complaint**

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it has been recommended that the patient start IOP mental health / LIMDU

He presents today to update me on his mood and to discuss his sleep disturbances / IBS-D symptoms and its negative impact on his QOL / ability to perform work duties due to severity / frequency of symptoms.

Good general overall feeling /health.

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 467

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Metamucil one capsule daily
 Peridex wash
 Motrin 800 mg po twice daily prn
 MVI one po daily
 RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
 OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY
 PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS
 verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
 Alcohol - 3 drinks a week
 single / no children / CTN at fort Mead.
 Behavioral: No tobacco use history.
 Alcohol: Alcohol use AUDIT-C Date:
 History ANNUAL QUESTIONS
 Preferred language (written or spoken): ☒ English ☐ Other:
 Preferred method of learning? ☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):
 Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):
 (SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your
 doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always
 Advance directives completed? ☐ Yes ☒ No
 Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact preference: [REDACTED]
 PCM:

Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.

Review of systems

Systemic: No fever and no chills.
Cardiovascular: No palpitations.
Pulmonary: No cough and no wheezing.
Gastrointestinal: Appetite not decreased. No dysphagia, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no hematemesis. Abdominal pain and diarrhea. No constipation.
Genitourinary: No hematuria and no change in urinary frequency. No dysuria and no testicular symptoms were present. No abnormal urethral discharge.
Endocrine: No inadequacy of penile erection.
Psychological: Anxiety, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.

Skin: No rash.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 468

AR 0511

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Lymph Nodes:

° Inguinal lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Back:

° No costovertebral angle tenderness.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Neurological:

° Not oriented to time, place, and person.

Psychiatric:

° Exam: anxious / sad effective but has insight into his mood and how the physiological symptoms are exacerbated by his mood state--> severe pain & explosive diarrhea. He is requesting a med board.

Mood: ° Dysthymic.

Affect: ° Abnormal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[3] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[] 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Test conclusions

Medication list was updated at the beginning of the visit.

Note Written by MINOR, TIFFANY @ 12 Jun 2017 0857 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. 08:58 on 6/12/17

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

CBC W/o Diff	Site/Specimen	12 Apr 2017 1147
WBC	BLOOD	6.0
RBC	BLOOD	4.58
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	42.3
MCV	BLOOD	92.4

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 469

AR 0512

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	262
RDW CV	BLOOD	13.1
MPV	BLOOD	8.7

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Basic Metabolic Panel	Site/Specimen	12 Apr 2017 1147
Urea Nitrogen	SERUM	16.0
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.88
Glucose	SERUM	112 (H)
Potassium	SERUM	4.9
Sodium	SERUM	140
Calcium	SERUM	9.9
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	113.7
GFR Calculated Black	SERUM	131.4 <i>

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Hemoglobin A1c	Site/Specimen	18 May 2017 0835
Hemoglobin A1c	BLOOD	5.2 <i>

A/P Last Updated by RODAK, COLLEEN M @ 13 Jun 2017 0949 EDT

1. Mixed irritable bowel syndrome: anxious / sad effective but has insight into his mood and how the physiological symptoms are exacerbated by his mood state—> severe pain & explosive diarrhea. He is requesting a med board for his condition; he is currently in the process of entering an IOP of his depression / anxiety. He will FU in 2 weeks with a log of his symptoms and we will evaluate his symptoms / treatment / level of disability and the status of his mental health.

Disposition Last Updated by RODAK, COLLEEN M @ 13 Jun 2017 0950 EDT**Released w/o Limitations**

Follow up: as needed in 2 week(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 13 Jun 2017 0950

Note Written by DUVALL, MICHAEL R @ 13 Jun 2017 1129 EDT

(Added after encounter was signed.)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 470

AR 0513

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 06-13-2017 Patient Name: Daniel Dennis Marvin Patient SSN: [REDACTED]

Proposed start date for limited duty: 06-14-2017 Proposed end date (< 6 months): 12-13-2017

The period of limited duty is for: (Select one)

☒ 1st LMDU (< 6 months) Entitled ADSDM (no referral to service headquarters necessary).

☐ 2nd LMDU (< 6 months) Entitled ADSDM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.

☐ 1st LMDU (< 6 months) Officer ADSDM (referral to service headquarters necessary).

☐ 2nd LMDU (< 6 months) Officer ADSDM (referral to service headquarters necessary).

☐ 2nd or subsequent LMDU periods on Navy and Marine ADSDM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").

☐ Placement on LMDU if the patient is not already in a LMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) Generalized Anxiety Disorder ICD-9 CM Code 300.02

(2) Major Depressive Disorder, Recurrent, Moderate ICD-9 CM Code 296.32

(3) BIP-O ICD-9 CM Code K88.0

Circumstances of injury/illness:

The patient is a 32-year-old male who presents with anxiety, depression, and co-morbid medical conditions that negatively impact his ability to function in home, work, and in social settings. The co-morbid BIP-O is of such severity that it daily interferes with military ADLs.

Treatment plan:

PT referred to JCP (mental health). He has on multiple group medications and his BIP-O severely impacts his ability to function in all settings.

Limitations from full duty (including whether transfer/TEMU for treatment is indicated, and any PRT limitations):

Access to all medical appointments. Ensure opportunity for 8 consecutive hours of sleep every 24 hour period. The patient should not have access to weapons. The patient should not POC, deploy, or be placed in austere environments.

PAUL SPERIN, MD, RESERVE

Medical Officer Member and Signature Date

[Signature]
CAPT, MC, USMC

Patient CA Mission and Signature Date

SECTION 2: PATIENT INFORMATION TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Counseling Activity, and that the MTF will report this LMDU action to my current command. I understand I may be referred to duty after the date appearing above on my clinical condition warrants and upon action by my attending provider.

Patient Signature Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- ☐ Completion of Patient Information Sheet
- ☐ Briefing to Patient on Limited Duty/EMJIS
- ☐ Notification to PEO/Personnel Office
- ☐ Notification to MTF LMDU Coordinator
- ☐ ODD Requested from Patient Command (if LOOD required)
- ☐ Notification to Patient Command
- ☐ Entry into HMDOLIT

Patient Administration Officer/Medical Boards Officer Signature and Date

ROUTING: Original to Patient Health Record; copies to Patient, Patient Command, PEO, MESA Case File, and PERS-421 or MMSR-4

NAVED 6100 (Rev. 08-2004)
Approved Services Officer etc.

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 12 Jun 2017 0942 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 12 Jun 2017 0905 EDT

Chief complaint

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male.

This is my first visit with this 32 yo male ADSDM with a HX of IBS-d/ pain, GAD/depression, EIOh abuse and genital warts. He presents today with concerns about his allergies and possible asthma asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patients reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Patient is a 32 yo male ADSDM that present with 3/10 stomach pain that been on going since he was young. Patient reports he is here to discuss mental health issues and concerns.

Good general overall feeling /health.

Pain Severity 3/10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 471

AR 0514

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Alcohol use AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

{ 3 } 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

{ 1 } 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

{ 1 } 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

{ 1 } Negative AUDIT-C

{ 1 } Positive AUDIT-C * >>Provider Alerted<<

{ 1 } Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

{ 1 } Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

The following S/O Note Was Overwritten by MINOR, TIFFANY @ 12 Jun 2017 0905 EDT:**S/O Note Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0841 EDT****Chief complaint**

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male.

He reported: Good general overall feeling /health.

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 472

AR 0515

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Metamucil one capsule daily
 Peridex wash
 Motrin 800 mg po twice daily prn
 MVI one po daily
 RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
 OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY
 PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Alcohol use AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐

Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[3] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[] 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

The following S/O Note Was Overwritten by MINOR, TIFFANY @ 12 Jun 2017 0857 EDT:

S/O Note Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0841 EDT

Allergies

Allergies Verified and Updated

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 473

AR 0516

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
Tonsillectomy
PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
Alcohol - 3 drinks a week
single / no children / CTN at fort Mead.

Family history

Family medical history Mother A & W
Father DM/ CAD- MI / stent at 40 / melanoma
brother one half substance abuse
Sister three (one depression ; one substance abuse)
Denies a family hx of Crc. Breast CA

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28632267 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Jun 2017 1136 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 08 Jun 2017 1139 EDT**Subjective**

Patient called provider due to feeling that his anxiety has become overwhelming and is significantly negatively impacting his ability to be a sailor. Therapist and patient discussed next steps including initiating LimDu and Intensive Outpatient Program. Patient to follow up on scheduled appointment next week.

A/P Last Updated by PAUL, SHERIN @ 08 Jun 2017 1139 EDT**1. Generalized anxiety disorder**Disposition Last Updated by PAUL, SHERIN @ 08 Jun 2017 1139 EDT

Follow up: in the PSYCHIATRY BE clinic.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 08 Jun 2017 1139

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Jun 2017 at WRNMMC, Allergy Clinic Bethesda by PETERSEN, MAUREEN MICHELE

Encounter ID: BETH-28615590 Primary Dx: Allergic rhinitis due to animal (cat) (dog)
hair and dander

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: Outpatient

Date: 07 Jun 2017 1015 EDT
Clinic: ALLERGY CL BE

Appt Type: FTR
Provider: PETERSEN, MAUREEN
MICHELE

Reason for Appointment:

F/U skin testing

Appointment Comments:

yye

Vitals

Vitals Written by PROVENCIO, ELISHA S. @ 07 Jun 2017 1006 EDT

BP: 129/75, HR: 75, RR: 16, HT: 69 in, WT: 168 lbs, BMI: 24.81, BSA: 1.918 square meters, Tobacco Use: No,
Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: no anti-histamines in last 7 days or more

Note Written by ACKERMAN, JOI D @ 07 Jun 2017 1058 EDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

WRNMMC Aeroallergen
Skin Test Rep

20 [REDACTED]
 MERWIN DANIEL DENNIS
 SEX: M DOB: [REDACTED] AGE: 32
 USN N11 POT NRP
 STAFF PATIENT
 [REDACTED]

Name
SSN:Date:
DOB:

TREE POLLENS		Prick		MOLD SPORES		Prick	
	W	E		W	E		W
1 Ash, White (1.20 W/V)				32 Alternaria Tenax (1.20 W/V)			
2 Beech (1.20 W/V)				33 Aspergillus Fumigatus (1.20 W/V)			
3 Birch Mx (1.20 W/V)				34 Chaetomium Mx (1.20 W/V)			
4 Birch Elder (1.20 W/V)				35 Curvularia Speciosa (1.20 W/V)			
5 Cedar, MTM (1.20 W/V)				36 Epitocum Mignm (1.40 W/V)			
6 Cedarwood, Common (1.20 W/V)				37 Helminthosporium Bar (1.20 W/V)			
7 Elm, Amer (1.20 W/V)				38 Mucor Racemoseus (1.20 W/V)			
8 Maple, Red (1.20 W/V)				39 Penicillium Notatum (1.20 W/V)			
9 Mesquite (1.20 W/V)							
10 Mulberry, Red (1.20 W/V)							
11 Oak, Mx (BLR W)(1.20 W/V)							
12 Pecan (1.20 W/V)							
13 Pyracantha, East (1.20 W/V)							
14 Walnut, Black (1.20 W/V)							
GRASS POLLENS		Prick		PERENNIALS		Prick	
	W	E		W	E		W
15 Bahia (1.20 W/V)				40 Cat Hair (10,000BALU/ml)			
16 Bimunda (10,000BALU/ml)				41 AP Dog (1.100W/V)			
17 Bromegrass, KY (10,000BALU/ml)				42 Mite Mx (5,000 ALU/ml)			
18 Johnson (1.20 W/V)				43 Cockroach Mx (1.20 W/V)			
19 Rye Perennial (10,000BALU/ml)							
20 Timothy (10,000BALU/ml)							
WEED POLLENS		Prick		OTHER		Prick	
	W	E					W
21 Buckwheat Mx (1.20 W/V)							
22 Kochia (1.20 W/V)							
23 Lemna's Quarters (1.20 W/V)							
24 Marshmallow Mx (1.20 W/V)							
25 Pigweed-Cockweed Mx (1.20 W/V)							
26 Portulac, English (1.20 W/V)							
27 Ragweed Mx (1.20 W/V)							
28 Ragweed Weed (1.20 W/V)							
29 Russian Thistle (1.20 W/V)							
30 Sage, Mexican (1.20 W/V)							
31 Watercress (1.20 W/V)							

CONTROLS		W	E
• 50% Glycerin			
• [REDACTED]			

NP= Not Performed
 W = Wheal (mm)
 E = Erythema (mm)
 P = Pseudopod

Skin Test Protocol and Standards

Last use of antihistamine (or other medication affecting response to histamine) _____ days

Location of skin test: Arm ☒ Back ☐

Device used for prick test: Greer Prick (GP-1) ☐

All extracts are manufactured by Greer Laboratories, Lenoir North Carolina

Results are determined by measuring the largest diameter of induration (W) by the largest diameter of erythema (E)

Testing Technician:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Medical Record	WFOHMAC Request for Administration of Anesthetics and for Performance of Operations and Other Procedures	
1. OPERATION or PROCEDURE (Describe)		A. IDENTIFICATION
Allergen Skin Test		B. STATEMENT OF REQUEST
		2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made in my consenting to the results of the operation or procedure. I understand the nature of the operation or procedure to be performed and I consent to the procedure in my own free will.
The purpose of allergen skin test is to identify the substances causing allergic symptoms. It is performed by applying an extract of an allergen to your skin, scratching or pricking the skin to allow exposure, and then evaluating the skin's reaction. It may also be done by injecting the allergen under the skin, or by applying it to a patch that is worn on the skin for a specified period of time. Allergy may also be detected by a blood test. Risks are local discomfort, allergic reaction including hives, swelling, cough, wheezing, shortness of breath, nose symptoms, throat closure, blood pressure drop, and rarely shock.		
which is to be performed by or under the direction of [REDACTED]		
3. I request the performance of the above-stated operation or procedure as it is found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-stated operation or procedure.		
4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.		
5. I consent to surgery or anesthesia, if any, and if "Yes", as being [REDACTED]		
6. I request the deposit of my signature in the below-named medical facility of my [REDACTED] or [REDACTED] which I may be necessary to remove.		
7. I understand that photographs and x-rays may be taken of this operation, and that they may be viewed by various personnel undergoing training or education at this or other facilities. I consent to the taking of such pictures and the disclosure of the operation by authorized personnel, subject to the following conditions:		
a. The name of the patient and his/her family is not used in identifying the patient.		
b. All obtained for use only for the purposes of medical research or research.		
8. I understand that an individual's Health Care Industry Registration or other authorized personnel may be present (Cross out any parts above which are not applicable)		
C. SIGNATURES (Signatures must be in parts A & B area) (See instructions below regarding signatures.)		
9. COUNSELING PROVIDER: I have explained the nature of the proposed procedure, the risks involved, and expected results, as described above. I have also discussed possible problems related to anesthesia, sedation, and equipment alternatives through.		
Provider's Signature:	[Signature]	
Provider's Printed Name:	Maureen Petersen, MD	
10. PATIENT/Consent: I understand the nature of the proposed procedure, the risks involved, and expected results, as described above, and hereby request that the procedure be performed.		
Witness/Observer's Signature:	[Signature]	06/07/2017 1030
Witness' Signature:	[Signature]	
D. UNIVERSAL PROTOCOL / TIME OUT		
"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:		
1. CORRECT PATIENT (Full Name / Birth Date)..... <input type="checkbox"/> YES		
2. CORRECT PROCEDURE..... <input type="checkbox"/> YES		
3. CORRECT SITE..... <input type="checkbox"/> YES		
4. REQUIRED EQUIPMENT AVAILABLE..... <input type="checkbox"/> YES N/A <input type="checkbox"/>		
5. IMAGES / LABS AVAILABLE, PROPERLY LABELED..... <input type="checkbox"/> YES N/A <input type="checkbox"/>		
"The site must be marked and verified for procedure including correct direction, multiple sites (e.g., right), or multiple levels (e.g., right) as indicated on the procedure plan.		
Signatures below indicate the procedure may be started. If any element is not completed as required, procedure may NOT be started.		
Witness Verified by: [Signature] 06/07/2017 1030		
PATIENT'S IDENTIFICATION: Please print name, date of birth, and last, first, middle initial, or last, first, middle initial, or last, first, middle initial.		
2. [REDACTED] 32		
REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES		
LOCAL FORM 802 (Rev. 2014)		
Prescribed by: [REDACTED] (M) (F) (N) (S) (D) (O) (P) (A) (C) (E) (R) (T) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MM) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YY) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)		

Note Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1412 EDT
32 yo M who presents for skin testing.

Patient with significant PMH for anxiety and IBS was previously seen for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking zyrtec for these symptoms.

No history of food/medication/venom allergies, eczema, or history of anaphylaxis.
Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

NKDA.

Current medication

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.

Personal history

Social history reviewed Denies etoh and tobacco abuse

Pets: none.

Family history

Family medical history

non-contributory.

Review of systems**Systemic:** No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.**Head:** No headache, no facial pain, and no sinus pain.**Eyes:** No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort and no palpitations.**Pulmonary:** Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Skin:** No pruritus. No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 479

AR 0522

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Middle Ear: ° No fluid in middle ear.

Nose:**General/bilateral:**

Discharge: ° No nasal discharge seen.

External Deformities: ° No external nose deformities.

Cavity: ° Nasal septum normal. ° Nasal mucosa normal. ° Nasal turbinate not erythematous. ° Nasal turbinate not swollen.

Sinus Tenderness: ° No sinus tenderness.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Neurological:

° Oriented to time, place, and person.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Allergic rhinitis: 32 yo M with skin testing only positive to Cat. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass (picture of back shown to me by patient today is c/w large urticaria on back). Exam today WNL.

-Cont treatment with albuterol prn symptoms

-Discussed acute urticaria and rhinitis. Plan for daily Zyrtec to prevent urticaria and prevent symptoms in the presence of cats.

Discussed avoidance measures.

-Would avoid Singulair use in this patient due to behavioral health issues (Singulair has a black box warning regarding SI)

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

A/P Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT**1. Allergic rhinitis due to animal (cat) (dog) hair and dander:** See above.**Procedure(s):**

-Allergy Percutaneous tests - allergenic extracts x 45 ADDITIONAL PROVIDER(S): ACKERMAN, JOI D - Benefits and risks of skin testing discussed to include the risk of discomfort, bleeding/bruising, and allergic reactions. Patient agreed to proceed and consent signed. Positive and negative controls were placed along with a full aeroallergen panel. Test was read at 15 minutes and results were recorded.

Disposition Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT**Released w/o Limitations****Follow up:** as needed with PCM. - Comments: f/u prn; meds reconciled.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By PETERSEN, MAUREEN M (Staff Attending, WRNMMC Allergy, Immunology, & Immunizations) @ 10 Jun 2017 1418

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Jun 2017 at WRNMMC, Int Med CL C Medical Home BE by SMITH, MICKALYNN J

Encounter ID: BETH-28606622 Primary Dx: Encounter for other administrative examinations

Patient: MERWIN, DANIEL DENNIS Date: 06 Jun 2017 1409 EDT Appt Type: T-CON*
 Treatment Facility: WALTER REED Clinic: INT MED CL C MEDICAL HOME Provider: SMITH, MICKALYNN J
 NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: Outpatient Call Back Phone: close

Reason for Telephone Consult: Written by DUVALL, MICHAEL R @ 06 Jun 2017 1409 EDT
 PCM/DR. RODAK - RELAY HEALTH

Telephone Consult Comments: Written by DUVALL, MICHAEL R @ 06 Jun 2017 1409 EDT

From Daniel Merwin

To Ms. Colleen Rodak, NP

Provider Ms. Colleen Rodak NP

Patient Daniel Merwin

Sent Date Jun 06, 2017 10:23 AM

Subject Mental Health - Service

Message I think that being in the Navy is compounding my stress and anxiety levels so much that it is not helping me in my behavior health treatment and IBS. Additionally I have not been able to have in person relationship with my mom or two sisters ever. Also being makes away for so long makes it even more difficult. Being able to live near them and properly develop a relationship for the first time with my mom and sisters (I never lived with or saw my mom or even saw her much in life) would significantly improve my healing, learning and ability to cope. Unfortunately they live in South Carolina. I am not technically able to be "mobilized or deployed" with the IBS issues that I am having and my mental health is causing problems with my day to day living with the numerous extra responsibilities required of me as a Sailor on top of just showing up to do my technical job. I am unable to be productive and get past the fact I have no one locally and my family that I want to build a relationship with beyond a phone are distant and I have never had the opportunity to do so. For my mental health I feel that it is critical as well as I am unsure that I am mentally fit for service.

R,
 Daniel Merwin

Questionnaire AutoCites Refreshed by GRIFFIN, GERALDINE @ 06 Jun 2017 1520 EDT
Questionnaires

Note Written by SMITH, MICKALYNN J @ 06 Jun 2017 1603 EDT

RN note

Spoke with pt who denies SI/ HI and having a plan. Pt has hx of anxiety dx, and is being treated in BH. Pt would like to bve seen to assess his continued treatment and ways to develop relationships and support systems while int he armed forces. Pt scheudled with PCM. TCON closed.

A/P Written by SMITH, MICKALYNN J @ 07 Jun 2017 0837 EDT

1. Encounter for other administrative examinations

Procedure(s):
 -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1
 -Internet Med Svc Qual Nonphys Healthcare Prof Estab Patient x 1

Disposition Last Updated by SMITH, MICKALYNN J @ 07 Jun 2017 0837 EDT
Referred for Appointment

Note Written by GRIFFIN, GERALDINE @ 06 Jun 2017 1541 EDT

Patient scheduled an appointment with Provider pls. see below.

INT MED CL F MEDICAL/WRNMMC RODAK, COLLE 12Jun2017@0845 FTR/30 PENDING
 Arrive 15 min early

Signed By SMITH, MICKALYNN J (Registered Nurse) @ 07 Jun 2017 0837

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28555023 Primary Dx: Other specified counseling

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **01 Jun 2017 1159 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **T-CON***
Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by KAMARA, KADIDJA B @ 01 Jun 2017 1159 EDT

Correspondance with Gastroenterology

Telephone Consult Comments: Written by KAMARA, KADIDJA B @ 01 Jun 2017 1159 EDT

From Daniel Merwin

To Ms. Colleen Rodak, NP

Provider Ms. Colleen Rodak NP

Patient Daniel Merwin

Sent Date Jun 01, 2017 7:53 AM

Subject Correspondance Between Gastroenterology

Message Just provided a copy of the correspondence I have sent to Gastroenterology relating to the last appointment.

=== Start Email ===

I was just wanting to update you on how the last appointment changes went.

Taking a fiber supplement has stopped some of the diarrhea symptom and at least made my stool softened; as long as I take 2 x 0.52 grams "Psyllium Husk Fiber" capsules. The problem with this is I still have pain; the pain is now lasting a lot longer up to a few hours now at a time instead of 15-60 minutes. A few of the days this week the pain was all day. Additionally I feel a lot more bloated. I have had work interrupted on several occasions due to the pain or need to use the bathroom. I have actually almost felt like lost control of holding it in twice and nearly went in my pants.

The Simethicone has not reduced my gas.
The Hyoscyamine does not help the pain at all.

=== End Email ===

View/Print Never Updated Merwin, Daniel -- DOB Feb 16, 1985

Lab Result Cited by RODAK, COLLEEN M @ 01 Jun 2017 1610 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

A/P Last updated by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT**1. Other specified counseling****2. Irritable bowel syndrome with diarrhea:** Symptoms of diarrhea & pain ; chart reviewed & patient called-PLAN:

1. HLD --> (confirmed fasting) will start omega 3 FA 2 po daily, referred to nutrition & repeat lipids in 3 months

2. For IBS symptoms --> Rifaximin 550 mg po Q 8 h x 14 days & FU with GI after completion

patient verbalized understanding

Medication(s): -OMEGA-3/DHA/EPA/FISH OIL--PO 1,000MG CAP - TAKE 2 BY MOUTH EVERY DAY R3 #180 RF3
-RIFAXIMIN--PO 550MG TAB - TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
R0 #42 RF0

Disposition Written by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT**Follow up:** as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Note Written by KAMARA, KADIDJA B @ 01 Jun 2017 1221 EDT

Patient was last seen in the internal medicine on 05/17/2017. Patient is sending a correspondence he had with Gastroenterology. Please review and advise. Thank you.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 01 Jun 2017 1614

CHANGE HISTORY

The following A/P Note Was Overwritten by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT:

The A/P section was last updated by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT - see above. Previous Version of A/P section was entered/updated by KAMARA, KADIDJA B @ 01 Jun 2017 1202 EDT.

1. Other specified counseling

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 483

AR 0526

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

25 May 2017 at WRNMMC, Allergy Clinic Bethesda by BANKS, TAYLOR ALLEN

Encounter ID: BETH-28494443 Primary Dx: Dyspnea, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **25 May 2017 0930 EDT**
 Clinic: **ALLERGY CL BE**

Appt Type: **SPEC**
 Provider: **BANKS,TAYLOR ALLEN**

Reason for Appointment:

Encounter for other general examination

Appointment Comments:

MJ/IRMAC

Vitals**Vitals** Written by ACKERMAN,JOI D @ 25 May 2017 1001 EDT

BP: 124/83, HR: 74, RR: 16, HT: 69 in, WT: 165 lbs, SpO₂: 96%, BMI: 24.37, BSA: 1.903 square meters,
 Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

S/O Note Written by HERNANDEZ,CAMELLIA L @ 25 May 2017 1036 EDT**Chief complaint**

The Chief Complaint is: Concern for asthma.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

32 yo M without significant PMH presents for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking Zyrtec for these symptoms.

No history of food/medication/venom allergies, eczema, or history of anaphylaxis.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated

NKDA.

Current medication

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.

Personal history

Social history reviewed Denies etoh and tobacco abuse

Pets: none.

Family history

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 484

AR 0527

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Family medical history
non-contributory.

Review of systems

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.

Head: No headache, no facial pain, and no sinus pain.

Eyes: No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.

Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.

Gastrointestinal: No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.

Musculoskeletal: No back pain.

Neurological: No lightheadedness.

Skin: No pruritus. No skin lesions and no rash.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: • PERRL. • Size of the pupil was normal. • Pupil accommodation was not impaired.

External: • Eyelids showed no abnormalities. • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Right Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Left Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • No nasal discharge seen.

External Deformities: • No external nose deformities.

Cavity: • Nasal septum normal. • Nasal mucosa normal. • Nasal turbinate not erythematous. • Nasal turbinate not swollen.

Sinus Tenderness: • No sinus tenderness.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

Oropharynx: • Normal. • Tonsils showed no abnormalities.

Lymph Nodes:

• Cervical lymph nodes were not enlarged. • Submandibular lymph nodes were not enlarged. • Supraclavicular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard. • No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2. • No gallop was heard. • No click was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Neurological:

• Oriented to time, place, and person.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 485

AR 0528

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Test conclusions

[x] Written care plan and [] clinical summary of today's visit was provided to patient.

Practice Management

Preventive medicine services.

A/P Last Updated by HERNANDEZ, CAMELLIA L @ 25 May 2017 1055 EDT

1. Dyspnea, unspecified: 32 yo M without significant PMH presents with symptoms of chest tightness and difficulty getting air in on exposure to cats, dogs and grass. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass. Exam today WNL. Spirometry performed today also WNL. History and symptoms could be consistent with allergic asthma, however, could also be due to VCD.

-Could not perform SPT today due to recent antihistamine use, however, Pt will follow up on June 7th at 10:15 for SPT to the aeroallergens. Pt will discontinue Zyrtec 5 days prior to next apt.

-Cont treatment with albuterol prn symptoms

-If SPT negative, would consider referral to pulmonology for consideration of MCCT vs laryngoscopy to evaluate for asthma and VCD

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

Procedure(s): -Spirometry Pre-bronchodilator x 1 ADDITIONAL PROVIDER(S): BANKS, TAYLOR ALLEN - Interpretation: The patient has normal baseline spirometry.

Disposition Last updated by BANKS, TAYLOR ALLEN @ 25 May 2017 2031 EDT**Released w/o Limitations****Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by HERNANDEZ, CAMELLIA L @ 25 May 2017 0953 EDT**Consult Order****Referring Provider:** RODAK, COLLEEN M**Date of Request:** 17 May 2017**Priority:** Routine**Provisional Diagnosis:**

Encounter for other general examination

Reason for Request:

This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander → wheezing / bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you

Note Written by BANKS, TAYLOR ALLEN @ 25 May 2017 2031 EDT

I saw and evaluated the patient. Discussed with resident/fellow and reviewed the history/PE and assessment and plan as documented in the note and agree.

Signed By BANKS, TAYLOR ALLEN (WRNMMC Allergy-Immunology Staff Physician, Physician/Workstation) @ 25 May 2017 2031

CHANGE HISTORYThe following Disposition Note Was Overwritten by BANKS, TAYLOR ALLEN @ 25 May 2017 2031 EDT:

The Disposition section was last updated by BANKS, TAYLOR ALLEN @ 25 May 2017 2031 EDT - see above. Previous Version of Disposition section was entered/updated by HERNANDEZ, CAMELLIA L @ 25 May 2017 1056 EDT.

Released w/o Limitations**Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.The following Allergy was Deleted: OTHER by HERNANDEZ, CAMELLIA L @ 25 May 2017 1038 EDT:The following Allergy was Deleted: OTHER by HERNANDEZ, CAMELLIA L @ 25 May 2017 1037 EDT:The following Allergy was Deleted: OTHER by HERNANDEZ, CAMELLIA L @ 25 May 2017 1037 EDT:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 486

AR 0529

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

23 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28460959 Primary Dx: Other hyperlipidemia

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **23 May 2017 0843 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **T-CON***
Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

AutoCites Refreshed by RODAK, COLLEEN M @ 23 May 2017 0844 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by RODAK, COLLEEN M @ 23 May 2017 0843 EDT
Lipid panelQuestionnaire AutoCites Refreshed by RODAK, COLLEEN M @ 23 May 2017 0844 EDT
QuestionnairesLab Result Cited by RODAK, COLLEEN M @ 23 May 2017 0847 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Last Updated by RODAK, COLLEEN M @ 23 May 2017 0852 EDT

1. **Other hyperlipidemia:** Called patient and confirm that lab was fasting; reviewed lipid panel. DAL the potential long term risk of HLD and I have requested he see nutrition for a consultation. Additionally I have placed him on FA and will repeat lipids in 3 months. (Aug. 2017)

Medication(s): -OMEGA-3/DHA/EPA/FISH OIL-PO 1,000MG CAP - TAKE ONE CAPSULE BY MOUTH THREE TIMES A DAY R3 #270 RF3

Laboratory(ies): -LIPID PANEL (Routine) Start Date: 08/01/2017

Disposition Last Updated by RODAK, COLLEEN M @ 23 May 2017 0845 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 23 May 2017 0859

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28447547 Primary Dx: Other specified counseling

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **22 May 2017 1022 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **T-CON***
Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by RAYMOND, KEVIN D @ 22 May 2017 1022 EDT
message sent via relayhealth - rodak**Telephone Consult Comments:** Written by RAYMOND, KEVIN D @ 22 May 2017 1022 EDT

Prescription

Message I have not picked up the probiotic as they did not have it in stock. I will make a follow up with dermatology.

Respectfully,
Daniel Anderson**Questionnaire AutoCites** Refreshed by KAMARA, KADIDJA B @ 22 May 2017 1517 EDT
Questionnaires**A/P** Last updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT**1. Other specified counseling:** Noted**Disposition** Last Updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT**Note** Written by KAMARA, KADIDJA B @ 22 May 2017 1522 EDTPt wants to inform you that medication is not in stock for pick up but will follow up with dermatologist. Please review and advise.
Thank you.**Signed By** RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 23 May 2017 0914**CHANGE HISTORY****The following A/P Note Was Overwritten by** RODAK, COLLEEN M @ 23 May 2017 0913 EDT:

The A/P section was last updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT - see above. Previous Version of A/P section was entered/updated by KAMARA, KADIDJA B @ 22 May 2017 1521 EDT.

1. Other specified counseling

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

17 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28408872 Primary Dx: Encounter for other general examination

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **17 May 2017 1345 EDT**
Clinic: **INT MED CL F MEDICAL HOME**
BEAppt Type: **FTR**
Provider: **RODAK, COLLEEN M****Reason for Appointment:**

referral allergy testing

Appointment Comments:

mjs

Vitals**Vitals Written by KAMARA, KADIDJA B @ 17 May 2017 1415 EDT**BP: 116/78 Left Arm, Adult Cuff, HR: 85, RR: 18, T: 98.4 °F Oral, HT: 69 in Stated, With Shoes,
WT: 82.2 kg Upright Scale, Actual, With Shoes, SpO₂: 98%, BMI: 26.76, BSA: 1.981 square meters,
Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2 TO 3 PER WEEK, Pain Scale: 6/10 Moderate, Pain Scale
Comments: Tooth and facial pain**Questionnaire AutoCites Refreshed by KAMARA, KADIDJA B @ 17 May 2017 1428 EDT****Questionnaires**

Anxiety & Depression Screening Taken On: 17 May 2017

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: More than half the days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

Falls Risk Screening (Outpatient) Taken On: 17 May 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. Physical appearance: **No concerns;**
4. Balance: **No concerns with balance;**
5. Is the patient patient a falls risk?: No

S/O Note Written by RODAK, COLLEEN M @ 19 May 2017 1032 EDT**Chief complaint**

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is my first visit with this 32 yo male ADSM with a HX of IBS-d/ pain, GAD/depression, EtOH abuse and genital warts. He presents today with concerns about his allergies and possible asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patient reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
 Alcohol - 3 drinks a week
 single / no children / CTN at fort Mead.

Family history

Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.

Review of systems

Systemic: No fever, no chills, no night sweats, and no recent weight loss.

Head: No headache. Facial pain.

Eyes: No vision problems.

Cardiovascular: No chest pain or discomfort. Palpitations.

Pulmonary: No cough and no wheezing.

Gastrointestinal: Heartburn. No nausea and no vomiting. Abdominal pain and diarrhea. No constipation.

Genitourinary: No hematuria and no testicular symptoms were present. No abnormal urethral discharge.

Neurological: No motor disturbances and no sensory disturbances.

Psychological: Anxiety, depression, and thinking about suicide passive

once a month in CBT / discusses these thoughts ; one previous suicide attempt took large amounts of ASA -> no treatment. No homicidal thoughts.

Skin: No pruritus. Skin lesion: No rash. Nails are normal.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

External: • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Right Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Left Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • Nasal discharge seen clear.

Cavity: • Nasal turbinate erythematous. • Nasal turbinate swollen.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 491

AR 0534

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Oral Cavity:

Lips: ° Showed no abnormalities.
 Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Abnormal + braces speaking with reduced opening of mouth due to recent surgery / no erythema, (pain improving QD) no head / neck LAD / no clinical evidence of infectious process ; + PND.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.
 ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.
 Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.
 Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.
 Auscultation: ° Bowel sounds were not diminished or absent.
 Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.
 Liver: ° Normal to palpation.
 Spleen: ° Normal to palpation.
 Hernia: ° No hernia was discovered.

Test conclusions

Medication list was updated at the beginning of the visit.

Note Written by MINOR, TIFFANY @ 17 May 2017 1414 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. on May 17, 2017 at 14:14

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232
Gamma-Glutamyl Transferase	SERUM	49

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232
Albumin	SERUM	4.9
Alkaline Phosphatase	SERUM	58
Alanine Aminotransferase	SERUM	34
Aspartate Aminotransferase	SERUM	24
Bilirubin	SERUM	0.3
Bilirubin Direct	SERUM	<0.2
Protein	SERUM	7.6

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

CBC W/o Diff	Site/Specimen	12 Apr 2017 1147
WBC	BLOOD	6.0
RBC	BLOOD	4.58
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	42.3
MCV	BLOOD	92.4
MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	262
RDW CV	BLOOD	13.1
MPV	BLOOD	8.7

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Basic Metabolic Panel	Site/Specimen	12 Apr 2017 1147
Urea Nitrogen	SERUM	16.0
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.88
Glucose	SERUM	112 (H)
Potassium	SERUM	4.9
Sodium	SERUM	140
Calcium	SERUM	9.9
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	113.7
GFR Calculated Black	SERUM	131.4 <=>

A/P Written by RODAK, COLLEEN M @ 19 May 2017 1032 EDT

1. Encounter for other general examination: This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander -> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you

Medication(s): -CETIRIZINE--PO 10MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF0
-ALBUTEROL--PO 90MCG/PUFF MDI - INHALE 2 PUFFS BY MOUTH EVERY FOUR HOURS AS NEEDED FOR COUGH, WHEEZE, OR SHORTNESS OF BREATH #1 RF0

Laboratory(ies): -HEMOGLOBIN A1C (Routine); LIPID PANEL (Routine)
Consult(s): -Referred To: ALLERGY NCR (Routine) Specialty: ALLERGY Clinic: RM ALLERGY IR Provisional
Diagnosis: Encounter for other general examination

2. Irritable bowel syndrome with diarrhea: He has a long HX of IBS -D / pain and is followed closely by GI; he denies changes to his baseline.

Medication(s): -PROBIOTIC (VSL#3 DS)--PO PACK - TAKE ONE BY MOUTH EVERY DAY R1 #3 RF1
-SIMETHICONE--PO 80MG TBCH - CHEW 1 TABLET FOUR TIMES A DAY AS NEEDED FOR GAS #100 RF2

3. Anogenital (venereal) warts: Previously treated with topicals and cryosurgery by dermatology; on PE -> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology will refer to dermatology.

Referred to dermatology--> 32 to with penile lesions Previously treated for genital warts with topicals and cryosurgery by dermatology; on PE -> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology please evaluate additional question is if this patient should undergo an anal PAP thank you

Consult(s): -Referred To: DERMATOLOGY NCR (Routine) Specialty: DERMATOLOGY Clinic: RM
DERMATOLOGY IR Provisional Diagnosis: Anogenital (venereal) warts Order Date: 05/19/2017 10:31

Disposition Written by RODAK, COLLEEN M @ 19 May 2017 1042 EDT**Released w/o Limitations**

Follow up: as needed in 6 month(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 19 May 2017 1042

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 17 May 2017 1443 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 17 May 2017 1406 EDT

Chief complaint

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Patient is a 32 yo male ADPM that presents with concerns about his allergies and asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patient reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Past medical/surgical history**Reported:**

Surgical / Procedural: Surgical / procedural history

Jaw surgery April.

Family history

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 493

AR 0536

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Family medical history Dad diabetic sister diabetic

The following S/O Note Was Overwritten by KAMARA, KADIDJA B @ 17 May 2017 1422 EDT:S/O Note Written by MINOR, TIFFANY JOHNETTA @ 17 May 2017 1406 EDTChief complaint

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Patient is an 32 yo male AD/SM that's presents with concerns about his allergies and asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patients reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Past medical/surgical historyReported:

Surgical / Procedural: Surgical / procedural history

Jaw surgery April.

Family history

Family medical history Dad diabetic sister diabetic

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 494

AR 0537

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

16 May 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28427406 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS

Date: 16 May 2017 1400 EDT

Appt Type: FTR

Treatment Facility: WALTER REED

Clinic: PSYCHIATRY BE

Provider: PAUL, SHERIN

NATIONAL MILITARY MEDICAL CNTR

Patient Status: Outpatient

Appointment Comments:

djs

Note Written by PAUL, SHERIN @ 19 May 2017 0658 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE**

Patient Name: Daniel Merwin

Patient last 4: 0538

Appt #: Intake + 5

Therapy time: 60 minutes

E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN

Rank: PO1

MOS: CTN

TIS: 11-years

Deployments: N/A

Deployment Related: N/A

Trauma: N/A

WTU: N/A

MEB in progress: N/A

AdmSep in progress: N/A

Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

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Page 495

AR 0538

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: Psychoeducation & Behavior Mod

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that since his last visit, he received feedback that he had been observed in inappropriate conversation at work which was reported by a coworker. Patient expressed surprise that this happened as he tries to be a positive leader and role model. He noted that he teaches the ethics and sexual harassment seminars. However, he acknowledged that he may have felt too comfortable with someone and said something inappropriate for the workplace. Patient expressed guilt and embarrassment about this. He stated that he needed to work on how to filter his conversations better. Therapist and patient discussed how he felt about making a mistake of this level that was reported to authority figures. Patient described difficult process in not feeling ashamed to go into work. He stated that he tries to remind himself that this incident was a mistake and not representative of who he is as a whole person. Therapist encouraged continuing to follow up with therapy more regularly.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 496

AR 0539

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:****Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 497

AR 0540

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 30 Oct 2017

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 01 March 2017

Reviewed with patient on: 01 March 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 498

AR 0541

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 19 May 2017 0700 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 19 May 2017 0700 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 19 May 2017 0700

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 May 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-28385488 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **16 May 2017 0930 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 16 May 2017 0950 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by DAVIS, ANNETTE R @ 16 May 2017 0934 EDT

BP: 116/68, HR: 88, RR: 18, HT: 69 in, WT: 170 lbs, BMI: 25.1, BSA: 1.928 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: Social Drinker, Pain Scale: 5/10 Moderate, Pain Scale Comments: Acute Fluctuating Jaw pain
Comments: Denies fever and or chills in the past 72 hours.

Appointment Comments:

djs

VitalsVitals Written by DAVIS, ANNETTE R @ 16 May 2017 0934 EDT

BP: 116/68, HR: 88, RR: 18, HT: 69 in, WT: 170 lbs, BMI: 25.1, BSA: 1.928 square meters, Tobacco Use: No,
 Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: Social Drinker, Pain Scale: 5/10 Moderate, Pain Scale Comments: Acute Fluctuating Jaw pain
Comments: Denies fever and or chills in the past 72 hours.

Note Written by TOBAR, EDEN @ 16 May 2017 2051 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #8

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 500

AR 0543

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up. Since we last met two months ago he's had his dental surgery. He admits he stopped taking his Lexapro several weeks ago because he felt more flat on it. He does not want to take psychiatric medication. He would rather work on himself through therapy. He notes lately he's under increased stress at work because he has been told he's under investigation and he's not sure why. He was drinking 1 to 2 beers a night before his surgery. He tried drinking a beer after his surgery and didn't like how he felt so hasn't drank since. He is not taking a Lunesta as he does not like how he feels on it. He has an appointment with Dr. Paul later today. We discussed his symptoms may be best to respond to therapy alone. Reviewed his psychologic testing results, which he went over with the testing psychologist.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 501

AR 0544

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 502

AR 0545

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

Medications: Lexapro 20 mg po daily, naltrexone 50 mg po daily , lunesta 1-2 mg po qhs prn insomnia

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 503

AR 0546

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	Date	Time	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM	04 Jan 2017	1232	U/L	(10.0-71.0)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Hepatic Function Panel	SERUM	04 Jan 2017	1232		
Albumin	SERUM	4.9		g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	58		U/L	(40-129)
Alanine Aminotransferase	SERUM	34		U/L	(0-41)
Aspartate Aminotransferase	SERUM	24		U/L	(0-40)
Bilirubin	SERUM	0.3		mg/dL	(0.15-1.2)
Bilirubin Direct	SERUM	<0.2		mg/dL	(0.0-0.3)
Protein	SERUM	7.6		g/dL	(6.6-8.7)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Basic Metabolic Panel	SERUM	22 Jun 2016	1240		
Urea Nitrogen	SERUM	14.8		mg/dL	(6-20)
Carbon Dioxide	SERUM	28		mmol/L	(22-29)
Chloride	SERUM	98		mmol/L	(98-107)
Creatinine	SERUM	1.00		mg/dL	(0.7-1.2)
Glucose	SERUM	89		mg/dL	(74-106)
Potassium	SERUM	4.5		mmol/L	(3.5-5.1)
Sodium	SERUM	139		mmol/L	(136-145)
Calcium	SERUM	10.1		mg/dL	(8.6-10.2)
Anion Gap	SERUM	13		mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8		mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4		mL/min	(60->=60)

Test	Site/Specimen	Date	Time	Units	Ref Rng
CBC W/Diff	BLOOD	22 Jun 2016	1240		
WBC	BLOOD	5.6		x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86		x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1		g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4		%	(37.5-50.9)
MCV	BLOOD	91.4		fL	(79.5-96.8)
MCH	BLOOD	31.1		pg	(26.2-33.1)
MCHC	BLOOD	34.1		g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9		%	(12.0-16.2)
Platelets	BLOOD	272		x10(3)/mcL	(162-427)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

MPV BLOOD 9.0 fL (7.0-10.9)
 Neutrophils BLOOD 59.4 % (40.7-76.4)
 Lymphocytes BLOOD 29.8 % (15.9-47.8)
 Monocytes BLOOD 8.9 % (4.5-11.8)
 Eosinophils BLOOD 1.5 % (0.3-7.1)
 Basophils BLOOD 0.4 % (0.2-1.2)
 ABS Neutrophils BLOOD 3.3 x10(3)/mcL (1.8-7.5)
 ABS Lymphocytes BLOOD 1.7 x10(3)/mcL (1.0-3.1)
 ABS Monocytes BLOOD 0.5 x10(3)/mcL (0.2-0.8)
 ABS Eosinophils BLOOD 0.1 x10(3)/mcL (0.0-0.5)
 ABS Basophils BLOOD 0.0 x10(3)/mcL (0.0-0.4)
 Differential Review BLOOD MANUAL DIFF NOT PERFORMED

Lyme Disease Ab Total Screen Site/Specimen 11 Apr 2016 1043 Units Ref Rng
 Borrelia burgdorferi Ab SERUM Negative <i> (See-Below)

Treponema pallidum Ab Site/Specimen 11 Apr 2016 1043 Units Ref Rng
 Treponema pallidum Ab SERUM Negative <i> (Negative)

Methylmalonic Acid Site/Specimen 16 Feb 2016 1430 Units Ref Rng
 Methylmalonate SERUM 170 nmol/L 0-378

HIV-1/O/2 Ab Site/Specimen 16 Feb 2016 1430 Units Ref Rng
 HIV-1/O/2 Ab SERUM Negative <r>

Vitamin B12 (Cyanocobalamin) Site/Specimen 16 Feb 2016 1430 Units Ref Rng
 Vitamin B12 (Cobalamins) SERUM 293 <i> pg/mL (211-946)

Homocysteine Site/Specimen 16 Feb 2016 1430 Units Ref Rng
 Homocysteine SERUM 8.9 <i> mcmol/L (4.0-15.4)

Comprehensive Metabolic Panel Site/Specimen 16 Feb 2016 1430 Units Ref Rng

Albumin SERUM 4.7 g/dL (3.5-5.2)
 Alkaline Phosphatase SERUM 53 U/L (40-129)
 Alanine Aminotransferase SERUM 17 U/L (0-41)
 Bilirubin SERUM 0.4 mg/dL (0.15-1.2)
 Urea Nitrogen SERUM 13.8 mg/dL (6-20)
 Calcium SERUM 9.7 mg/dL (8.6-10.2)
 Carbon Dioxide SERUM 29 mmol/L (22-29)
 Chloride SERUM 98 mmol/L (98-107)
 Creatinine SERUM 0.96 mg/dL (0.7-1.2)
 Glucose SERUM 89 mg/dL (74-106)
 Potassium SERUM 4.4 mmol/L (3.5-5.1)
 Protein SERUM 7.6 g/dL (6.6-8.7)
 Sodium SERUM 141 mmol/L (136-145)
 Anion Gap SERUM 14 mmol/L (7-16)
 GFR Calculated Non-Black SERUM 105.6 mL/min (60->=60)
 GFR Calculated Black SERUM 122.1 <i> mL/min (60->=60)
 Aspartate Aminotransferase SERUM 20 U/L (0-40)

ETG/ETS, UA (250 Cut-Off) Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Ethyl Glucuronide URINE Negative <i> ng/mL Cutoff=250

Drug Abuse Screen Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Amphetamines URINE NEGATIVE <i> (Negative)
 Barbiturates URINE NEGATIVE <i> (Negative)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Benzodiazepines	URINE	NEGATIVE <i>	(Negative)
Cocaine	URINE	NEGATIVE <i>	(Negative)
Opiates	URINE	NEGATIVE <i>	(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in psychotherapy

Intervention: pt declines pharmacotherapy and it is not absolutely indicated. Have discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep
Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: prn

Referrals: pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR, EDEN @ 16 May 2017 2056 EDT

1. Generalized anxiety disorder

Disposition Written by TOBAR, EDEN @ 16 May 2017 2057 EDT

Released w/o Limitations

Follow up: as needed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR, EDEN @ 16 May 2017 1000 EDT

Additional A/P Information:

Discontinued ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY

Note Written by TOBAR, EDEN @ 16 May 2017 1000 EDT

Additional A/P Information:

Discontinued NALTREXONE--PO 50MG TAB - TAKE 1/2 TABLET BY MOUTH EVERY DAY X 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 16 May 2017 2058

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

19 Apr 2017 at WRNMMC, Int Med CL F Medical Home BE by SMITH, MICKALYNN J

Encounter ID: BETH-28097609 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **19 Apr 2017 1152 EDT**
Clinic: **INT MED CL F MEDICAL HOME
BE**Appt Type: **T-CON***
Provider: **SMITH, MICKALYNN J**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by RAYMOND, KEVIN D @ 19 Apr 2017 1152 EDT
referral request sent via relayhealth - rodak**Telephone Consult Comments:** Written by RAYMOND, KEVIN D @ 19 Apr 2017 1152 EDT

I have in the past been seen for breathing issues around cats. I have been getting burning sensations on my skin/eyes from grass and animals; sometimes dust will seem to cause breathing issues. I think I have allergies and or asthma related to allergies. Previously I have been seen and given an inhaler which worked for the breathing but I am not under and long term treatment or related to the skin/eyes. This effects me during Physical Training sessions and sometimes in the office (dust). I was not sure if it would be better to email about this over making an appointment just to get a referral.

Questionnaire AutoCites Refreshed by SMITH, MICKALYNN J @ 19 Apr 2017 1400 EDT
Questionnaires**A/P** Written by SMITH, MICKALYNN J @ 21 Apr 2017 1539 EDT**1. Encounter for other administrative examinations**

Procedure(s): -Non-Physician Phone Call To Pt/Provider Intermed (11-20 min) x 1

Disposition Last Updated by SMITH, MICKALYNN J @ 21 Apr 2017 1539 EDT
Referred for Appointment**Note** Written by SMITH, MICKALYNN J @ 20 Apr 2017 0924 EDT

Left general message for pt to call back to Team Fox River.

Note Written by SMITH, MICKALYNN J @ 21 Apr 2017 0832 EDT

Left general message for pt to call back to Team Fox River.

Note Written by SMITH, MICKALYNN J @ 21 Apr 2017 1536 EDT

Pt returned Team Fox River phone call, scheduled with NP RODAK, COLLE 17May2017@1345. Pt agreed with appt time. TCON Closed.

Signed By SMITH, MICKALYNN J (Registered Nurse) @ 21 Apr 2017 1539

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

13 Apr 2017 at WRNMMC, GI Clinic Bethesda by WONG, ROY KWOCK

Encounter ID: BETH-28042661 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: MERWIN, DANIEL DENNIS

Date: 13 Apr 2017 1500 EDT

Appt Type: FTR

Treatment Facility: WALTER REED

Clinic: GI CL BE

Provider: WONG, ROY KWOCK HUNG

NATIONAL MILITARY MEDICAL CNTR

Patient Status: Outpatient

****Limited System Patient Data at time of Encounter******Reason for Appointment:**

follow up

Appointment Comments:

Ima/irmac

Vitals**Vitals Written by KNIGHT, ASIA L @ 13 Apr 2017 1449 EDT**BP: 129/90, HR: 72, T: 98.1 °F, HT: 69 in, WT: 165.5 lbs, SpO₂: 95%, BMI: 24.44, BSA: 1.906 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free**S/O Note Written by HALL, NOAH MONTGOMERY @ 13 Apr 2017 1739 EDT****History of present illness**

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. He reports minimal improvement since starting a low-FODMAP diet and is not following this strictly currently. He denies any benefit from avoiding dairy, caffeine, and sugar-substitutes.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

Allergies

Allergies Verified and Updated

NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.

Lexapro (stopped recently)

Past medical/surgical history**Reported:**

Medical: Reported medical history

Anxiety/depression

IBS-D

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

PRK

Personal history

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 509

AR 0552

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Family history

Family medical history

No malignant neoplasm of the gastrointestinal tract.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Eyes:** No eye pain. No red eyes.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Appetite not decreased. No dysphagia, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no hematemesis. Abdominal pain. No jaundice and no bright red blood per rectum. Diarrhea. No constipation.**Musculoskeletal:** No back pain, no localized joint pain, and no localized joint swelling.**Neurological:** No lightheadedness.**Skin:** No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Eyes:

General/bilateral:

Pupils: • PERRL. • Size of the pupil was normal. • Pupil accommodation was not impaired.

External: • Eyelids showed no abnormalities. • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Nose:

General/bilateral:

External Deformities: • No external nose deformities.

Cavity: • Nasal septum normal.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

Oropharynx: • Normal. • Tonsils showed no abnormalities.

Lymph Nodes:

• Submandibular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard. • No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2. • No gallop was heard. • No click was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Auscultation: • Bowel sounds were not diminished or absent.

Palpation: • Abdomen was soft. • No abdominal guarding. • Abdominal non-tender. • No mass was palpated in the abdomen.

Liver: • Normal to palpation.

Spleen: • Normal to palpation.

Hernia: • No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: • Mobility was not limited.

Other:

General/bilateral: • No muscle tenderness.

Neurological:

• Oriented to time, place, and person. • Remote memory was not impaired. • Recent memory was not impaired.

Balance: • Normal.

Gait And Stance: • Normal.

Psychiatric:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 510

AR 0553

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Mood: ° Euthymic.
 Affect: ° Normal.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

A/P Last Updated by HALL, NOAH M. @ 13 Apr 2017 1746 EDT

1. Irritable bowel syndrome with diarrhea:

32 y/o male with IBS-D reports minimal benefit with dietary modification. Predominant symptom is abdominal pain and episodes are closely associated with anxiety.

- Will start trial of Metamucil for stool bulking
- If bloating/flatulence becomes an issue, consider transition to a non-fermentable fiber (citrucel OTC)
- Will also provide Levsin SL for symptomatic relief
- Recommended continued f/u with Behavioral Health provider, and could discuss a trial of a low-dose TCA at bedtime as a centrally-acting pain modulator
- F/u in GI clinic in 3-4 months
- Could consider a trial of Rifaximin in the future if no benefit

Medication(s): -PSYLLIUM/SUCROSE-PO 3.4GM/SCOOP POWD - TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #2 RF3 Ordered By: HALL, NOAH M. Ordering Provider: HALL, NOAH MONTGOMERY
 -HYOSCYAMINE IR-PO 0.125MG TBSL - DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #30 RF3 Ordered By: HALL, NOAH M. Ordering Provider: HALL, NOAH MONTGOMERY

Disposition Last Updated by HALL, NOAH M. @ 13 Apr 2017 1747 EDT

Released w/o Limitations

Follow up: as needed in 3 to 4 month(s) in the GI CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By WONG, ROY KWOCK (Physician/Workstation, WRAMC) @ 14 Apr 2017 0925

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

05 Apr 2017 at WRNMMC, Medical Readiness Clinic Bethesda by RENTA, DANA K

Encounter ID: BETH-27946761 Primary Dx: EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE MEMBER
PERIODIC HEALTH ASSESSMENT
(PHA)

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: Outpatient

Date: 05 Apr 2017 1100 EDT
Clinic: MEDICAL READINESS CL BE

Appt Type: WELL
Provider: RENTA,DANA KAY

AutoCites Refreshed by RENTA,DANA K @ 05 Apr 2017 1159 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1106 EDT

BP: 123/77 Right Arm, Adult Cuff, HR: 72 Regular, Radial Artery, RR: 20, T: 98.4 °F Oral, HT: 69 in Actual, With Shoes,
WT: 165 lbs Upright Scale, Actual, With Shoes, SpO₂: 96%, Uncorr OD: 20/40, Uncorr OS: 20/40,

Uncorr OU: 20/40, BMI: 24.37, BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes,

Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 4 Drink per week., Pain Scale: 0 Pain Free

Comments: SM:Presents to Medical Readiness for PHA. Arrives in civilian attire . States feeling good at this time but in several days he feeling down . Reports no H/O of Positive PPD. Referred to speak with Ms. Herbert (Health Educator for Anxiety & Depression screening and Epworth sleepiness scale.)

Reason for Appointment:

pha/navy

Appointment Comments:

ash4105625345

Screening Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1057 EDT**Reason For Appointment:** pha/navy

Allergen information verified by VASQUEZ, BLANCA T @ 05 Apr 2017 1057 EDT

VitalsVitals Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1106 EDT

BP: 123/77 Right Arm, Adult Cuff, HR: 72 Regular, Radial Artery, RR: 20, T: 98.4 °F Oral, HT: 69 in Actual, With Shoes,

WT: 165 lbs Upright Scale, Actual, With Shoes, SpO₂: 96%, Uncorr OD: 20/40, Uncorr OS: 20/40,

Uncorr OU: 20/40, BMI: 24.37, BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes,

Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 4 Drink per week., Pain Scale: 0 Pain Free

Comments: SM:Presents to Medical Readiness for PHA. Arrives in civilian attire . States feeling good at this time but in several days he feeling down . Reports no H/O of Positive PPD. Referred to speak with Ms. Herbert (Health Educator for Anxiety & Depression screening and Epworth sleepiness scale.)

Questionnaire AutoCites Refreshed by RENTA,DANA K @ 05 Apr 2017 1159 EDT**Questionnaires**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 512

AR 0555

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

EPWORTH Sleepiness Scale Version: 1 Completed On: 05 Apr 2017

Questionnaire Notes: EPWORTH : 19

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3
2. How likely are you to doze off or fall asleep while WATCHING TV?: 1
3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 2
4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3
5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 3
6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 2
7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 3
8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 2

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 05 Apr 2017

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis(i.e. with persistent cough, weight loss, night sweats, and/or fever)? No
2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations?: No
3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: NONE
4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No
5. Have you had a prior history of TB or prior treatment for Latent TB?: No
6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No
7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade?: No
8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use?: No

Anxiety & Depression Screening Taken On: 05 Apr 2017

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Several days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by RENTA,DANA KAY @ 07 Apr 2017 1930 EDTChief complaint

The Chief Complaint is: Face to Face PHA. Active Duty Navy.

Reason for Visit

Visit for: Face to Face PHA.

History of present illness

The Patient is a 32 year old male.

He reported: Military service [] Y [X] N Deployed since previous PHA
 [] Y [X] N Post-Deployment Health Assessment completed
 [] Y [X] N Post-Deployment Health Reassessment completed
 [] Y [X] N Post-Deployment labs/tests completed
 [] Y [X] N Deployment/Shipboard limiting conditions identified

Allergies

No allergies NKDA.

Past medical/surgical historyReported:

Past medical history Myopia (resolved initially with PRK however degraded now); Irritable Bowel Syndrome (predominance: diarrhea)- chronic; Alcohol Abuse (s/p self-referred treatment) stable; Anxiety/Depression (dx GAD since childhood)- stable (continues BH treatment); Left ankle sprain (resolved), anogenital warts (Feb16) s/p podofil; Allergic rhinitis, folliculitis, exercise induced asthma, fx right 5th MC casted (2008); Lifetime hx of concussions: no incidents.

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No.

Surgical / Procedural: Surgical / procedural history Wisdom Teeth Extraction (4); PRK (2011); Dental surgery pending - jaw alignment with orthodontic braces replaced (27Apr17); tonsillectomy (2003); s/p skin biopsies benign (x2);

Medications: Medication history: Lexapro, Naltrexone (prn alcohol); +multivitamins; no protein supplements;

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No
 2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 513

AR 0556

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

- 3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No
 4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No
 5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [X] No.

Personal history

Behavioral: Caffeine use. No tobacco use none. (remote one year in Hookah sometimes in Japan – none since 2007);
 Alcohol: Alcohol two to three drinks a couple of times per week. not bingeing. very different now and knows the difference and behaving differently. doesn't like getting drunk or feeling poorly the following day.

Family history

Family medical history paternal addiction— sister drug; dad-alcohol problem; maternal aunt- alcohol;
 Father is alive not in contact
 Mother is alive No DM, No CAD. healthy
 Cancer Dad- melanoma;
 Heart disease dad/PGF- CAD; dad- stent 2v (alcohol); Dad/PGM/PGF/sister- DM,
 Dad- AMI (s/p heart surgery); no CVA.

Review of systems**Head:** No head symptoms.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Otolaryngeal:** No otolaryngeal symptoms.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms.**Pulmonary:** No pulmonary symptoms.**Gastrointestinal:** No gastrointestinal symptoms.**Genitourinary:** No genitourinary symptoms.**Endocrine:** No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Musculoskeletal:** No musculoskeletal symptoms Exercises Aerobic three hours minimum weekly. Enjoys running however his IBS causes problems during exercise. PRT passes easily. Doing about one hour weekly strengthening exercises weekly. Meets recommendations of 150 minutes aerobic exercise and 30-60 minutes strengthening exercises weekly.**Neurological:** No neurological symptoms.**Psychological:** Psychological symptoms refer to BH screening questionnaire above. No suicidal/homicidal ideation; sleeps 6-7 hours nightly; unrested; tired often; has good routine; discussed sleep hygiene. problems staying asleep and can go back easily asleep; already did a the process for the sleep study; doesn't want to see someone. Wants to sleep all the time. Not narcoleptic.**Skin:** No skin symptoms.**Allergic and Immunologic:** No allergic/immunologic symptoms.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing.

Head:

Appearance: ° Head normocephalic.

Neurological:

° Level of consciousness was normal. ° Cognitive functioning was normal.

Speech: ° Normal.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Appearance: ° Normal.

Mood: ° Pleasant.

Affect: ° Normal.

Thought Processes: ° Not impaired.

Skin:

° Skin: very fair skin with many freckles of same tone, nothing.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

° Military service status

IMR Category:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Fully Medically Ready ()
 Partially Medically Ready ()
 Not Medically Ready (xxx)
 Medical Readiness Indeterminant ()
 Comments: undergoing evaluation by GI for IBS predominantly diarrhea

Therapy

- The likelihood of a heart attack was not recorded CVSP: FRAMINGHAM RISK SCORE:presumed to be less than 1%.

Lab Result Cited by RENTA,DANA K @ 05 Apr 2017 1126 EDT

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1101 EDT

Varicella Zoster Virus DFA	Site/Specimen	29 Sep 2015 1730
Varicella Zoster Virus Ag	SKIN	NO VZ ANTIGEN DETECTED <i>

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1100 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1100 EDT

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240
Urea Nitrogen	SERUM	14.8
Carbon Dioxide	SERUM	28
Chloride	SERUM	98
Creatinine	SERUM	1.00
Glucose	SERUM	89
Potassium	SERUM	4.5
Sodium	SERUM	139
Calcium	SERUM	10.1
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	99.8
GFR Calculated Black	SERUM	115.4 <i>

A/P Last updated by RENTA,DANA K @ 07 Apr 2017 1942 EDT

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225: SM is NOT MEDICALLY READY as is undergoing evaluation for IBS (diarrhea predominance). however is capable, of conducting PRT with understanding he may leave to go to restroom. has further GI assessment pending.

Face to Face PHA today. Updated in MRRS today.

All significant PMH and ROS noted above. Medications reviewed. SM to f/u with PCM for active concerns.

No suicidal or homicidal ideation noted.

TB Exposure Risk Assessment questionnaire completed.

SM currently meets/exceeds weekly aerobic Exercises at least 150 minutes and 30-60 minutes strengthening exercises

Patient has is current with:

Influenza vax completed.

Audiology assessment

Sleep --continue as recommended for 6-8 hours daily.

HIV current (22Feb16)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 515

AR 0558

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lifetime concussions: no incident

Procedure(s):
-(G8420) BMI IS DOC W/IN NORMAL PARAMETERS & NO FOLLOW-UP PLAN IS REQD x 1
ADDITIONAL PROVIDER(S): VASQUEZ, BLANCA T
-(99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S):
VASQUEZ, BLANCA T
-(94760) Pulse Oximetry x 1 ADDITIONAL PROVIDER(S): VASQUEZ, BLANCA T
-(G0444) ANNUAL DEPRESSION SCREENING, 15 MINUTES x 1 ADDITIONAL PROVIDER(S):
VASQUEZ, BLANCA T

2. Other specified counseling Z71.89: SM does not use tobacco products.

Discussed use of condoms to protect self and partner from potential STIs. Educated SM on PreP Program at Infectious Disease for HIV prophylaxis.

Continue to balance professional goals with personal goals.

Disposition Written by RENTA, DANA K @ 07 Apr 2017 1942 EDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by VASQUEZ, BLANCA T @ 05 Apr 2017 1118 EDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Health Risk Assessment

Page 1 of 4

NMCPHC HRA Website HRA Tool Home HRA Helpdesk Email: (757) 953-0737

NMCPHC Workplace HRA - Participant Report

UK/Command: 00168 - NATNAV MEDCEN BETHESDA

You rated your health as Good. Personal perception about how healthy you are is usually quite accurate. Your Personal Health Risk Appraisal Report identified 3 risk categories from the answers you provided on key topics that relate to overall health, which places you in a LOW risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the low risk category by reducing the number of behavioral risks, and for those already in low risk to avoid increasing the number of risk factors over time.

**Tobacco Use - Current Tobacco Usage - No**

<http://www.nmcpchc.org>
<http://www.nmcpchc.org/hra/hra.htm>

Being tobacco free is a great choice. You are healthier, more mission ready and are saving money.

**Alcohol Use - Binge Drinking - One or twice per year**

<http://www.nmcpchc.org/hra/hra.htm>

Many Sailors and Marines occasionally drink more heavily than usual during celebrations or special events. Plan ahead to avoid alcohol-related incidents that will put your career in danger.

**Alcohol Use - Alcohol Use Driving - Never (i.e., not during the past year)**

<http://www.nmcpchc.org/hra/hra.htm>

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol-related incidents by looking out for those who try to drink and drive, and help them get home safely.

**Injury Prevention - Seatbelts - Always**

<http://www.nmcpchc.org/hra/hra.htm>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

**Injury Prevention - Vehicle Helmet - Always**

<http://www.nmcpchc.org/hra/hra.htm>

Your use of a protective helmet provides significant protection against head injury or death. Wearing other protective gear, maintaining control of your vehicle and driving defensively can also reduce your risk.

**Injury Prevention - Safety Equipment - Always**

<http://www.nmcpchc.org/hra/hra.htm>

<https://nmcpchc-hprwebsvr.med.navy.mil/HRA/Pages/Results.aspx>

4/5/2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 517

AR 0560

Page 2 of 4

You are protecting yourself against injuries and disease at your worksite by using appropriate safety equipment.

<http://www.elsevier.com/locate/jep>
<http://dx.doi.org/10.1016/j.jep.2006.05.004>

You are mostly satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationships, and social activities can all contribute to life satisfaction.

<http://www.madbury-madison.com/members/list.asp> <http://www.madbury-madison.com/members/list.asp>

Occasional stress in your work or at home is common. Problem solving or discussing possible solutions with someone who may help reduce or eliminate some of your stress.

<http://www.mcs.vuw.ac.nz/~mcs04/courses/intermediateV2/stressManagement/17689main.html>

Expressing your feelings can help you see that you are not alone in how you feel. Talking with others can also provide you with advice on successfully managing your concerns.

<http://www.mindgarden.com/healthcare/healthcare.asp> or the published version: <http://www.mindgarden.com/healthcare/healthcare.asp>

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection.

<http://www.cdc.gov/ebook/ncid/ncidhome.htm#adults>

The national goal for Americans is to get at least 1 hour and 30 minutes (90 minutes) of moderate intensity aerobic activity every week. Aerobic (cardio) exercise has many benefits, including giving you more energy and higher endurance, preventing many chronic diseases, like diabetes, high blood pressure, and high cholesterol, and maintaining a healthy body weight. Continue to include cardio exercise into your lifestyle.

<http://www.cdc.gov/od/oc/media/press/2007/s070625a.htm>

You routinely engage in strength training, which improves your strength, maintains lean body mass, builds strong bones, and decreases many of the risk factors associated with coronary heart disease.

<http://www.elsevier.com/locate/jnlp>

4/5/2017

Page 3 of 4

! Nutrition - Fruits - One

Supplements - Supplement Use - Seldom

☒ Dental - Flossing - Daily

! Nutrition - Vegetables - One

☒ **Sleep - Sleep Deprivation** - Most of the time

☒ **Sexual Health - Pregnancy** - My partner or I are correctly and consistently using birth control ALL the time

<https://nmcpeh-hpwebsvt.med.navy.mil/HRA/Pages/Results.aspx>

4-5 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Health Risk Assessment

Page 1 of 4

[REDACTED]

https://unacph-hpweb-vn.med.navy.mil/HRA/Pages/Results.aspx

4/5/2017

Signed By RENTA, DANA K (COL, MC, WRNMMC) @ 07 Apr 2017 1942**CHANGE HISTORY****The following A/P Note Was Overwritten by RENTA, DANA K @ 05 Apr 2017 1308 EDT:**

The A/P section was last updated by RENTA, DANA K @ 05 Apr 2017 1308 EDT - see above. Previous Version of A/P section was entered/updated by VASQUEZ, BLANCA T @ 05 Apr 2017 1058 EDT.

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225

Procedure(s):

-(99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): VASQUEZ, BLANCA T
 -(94760) Pulse Oximetry x 1 ADDITIONAL PROVIDER(S): VASQUEZ, BLANCA T
 -(G0444) ANNUAL DEPRESSION SCREENING, 15 MINUTES x 1 ADDITIONAL PROVIDER(S): VASQUEZ, BLANCA T

The following S/O Note Was Overwritten by RENTA, DANA K @ 05 Apr 2017 1127 EDT:**S/O Note Written by VASQUEZ, BLANCA T @ 05 Apr 2017 1106 EDT****History of present illness**

The Patient is a 32 year old male.

He reported: Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 520

AR 0563

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

[] Y [X] N Deployment/Shipboard limiting conditions identified

Allergies

No allergies.

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready ()

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 521

AR 0564

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 Mar 2017 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-27723764 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 16 Mar 2017 1156 EDT
Clinic: GI CL BEAppt Type: T-CON*
Provider: COPSEY, HELEN C.

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 16 Mar 2017 1156 EDT
Patient emailS/O Note Written by COPSEY, HELEN C. @ 16 Mar 2017 1157 EDT**Subjective**

Hi Daniel, Given the severity of your symptoms I'm surprised that you have not been back for a follow-up or contacted me since last November. I am glad you made an appointment. There are many options for treatment of IBS, but it will require several follow-up visits to discuss and implement. I agree if we are unable to manage your symptoms better, you'll need to undergo an MEB, but again, there are many options available that you have not yet tried. V/R, Helen

-----Original Message-----
From: Merwin, Daniel D [mailto:ddmerwi@radium.ncsc.mil]
Sent: Thursday, March 16, 2017 10:44 AM
To: Copsey, Helen C CTR (US)
Cc: Lafranchise, David M; Fisher, Christopher M
Subject: RE: Follow-Up - Pain

Helen, I CCed my chain of command so they know that I have been seen on and off for this issue over the years and are aware of anything on-going. I scheduled an appointment for 13 April with Dr. Hall which was the next available in the clinic. Even with management of my diet, I still have 4-6 severe episodes a week or more (spasms, pain, expedient evacuation and diarrhea). Every episode is extremely draining of me. A lot of times after an episode I just want to lay down and sleep because of the extreme intensities. A few of the most recent issues almost had me call 911 due to the extreme pain. I scheduled the appointment for a few reasons. 1. Currently I have the note you provided which makes me technically non-deployable and this needs to be discussed. 2. I really need to try anything available within the military system to help manage the episodes if there is nothing else then I would like to start medical separation in order to seek alternative treatments. Respectfully, CTN1

(IW/SW/AW) Merwin, Daniel D
NIOC Maryland
Work: 667-812-2006
Cell: [REDACTED]

A/P Last Updated by COPSEY, HELEN C @ 16 Mar 2017 1157 EDT

1. Irritable bowel syndrome with diarrhea

Disposition Last Updated by COPSEY, HELEN C @ 16 Mar 2017 1157 EDT

Follow up: in the GI CL BE clinic.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 16 Mar 2017 1158

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Mar 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-27574008 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **01 Mar 2017 1100 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

FOLLOW UP

Appointment Comments:

aap

Note Written by PAUL, SHERIN @ 02 Mar 2017 1049 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 4
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Psychoeducation & Behavior Mod****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he was doing well. He stated that he received the results of the psychological testing but was unsure of the content. Therapist and patient reviewed diagnostic results which confirmed diagnosis of GAD and identified Schizoid traits. Therapist provided psychoeducation regarding diagnoses. Further conversation focused on patient's positive progress towards his goals. He stated that he has been interacting more with people. Therapist and patient discussed differences between rigidity and appropriate boundaries. Final conversation focused on identifying goals for next weeks.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked**Mental Status Exam:**

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 01 March 2017

Reviewed with patient on: 01 March 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 02 Mar 2017 1050 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 02 Mar 2017 1051 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 02 Mar 2017 1051

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Mar 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-27554297 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 01 Mar 2017 0800 EST
Clinic: PSYCHIATRY BEAppt Type: FTR
Provider: TOBAR, EDEN TAutoCites Refreshed by TOBAR, EDEN @ 01 Mar 2017 0818 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by DAVIS, ANNETTE R @ 01 Mar 2017 0803 ESTBP: 120/80, HR: 64, RR: 18, T: 98.4 °F, HT: 69 in, WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes,
Have you ever felt you should Cut down on your drinking? No,
Have people Annoyed you by criticizing or complaining about your drinking? No,
Have you ever felt bad or Guilty about your drinking? No,
Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
Pain Scale: 0 Pain Free**Appointment Comments:**

et/phq9/gad7

VitalsVitals Written by DAVIS, ANNETTE R @ 01 Mar 2017 0803 ESTBP: 120/80, HR: 64, RR: 18, T: 98.4 °F, HT: 69 in, WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes,
Have you ever felt you should Cut down on your drinking? No,
Have people Annoyed you by criticizing or complaining about your drinking? No,
Have you ever felt bad or Guilty about your drinking? No,
Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
Pain Scale: 0 Pain FreeNote Written by TOBAR, EDEN @ 02 Mar 2017 1243 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #7

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for follow up with this provider. At our last meeting pt was advised to resume naltrexone 50 mg po qam to reduce alcohol use. Today he says he drinks less when he drinks (1-2 drinks at a time now) and thinks the medication is helpful. He has dental surgery at the end of April so we discussed stopping naltrexone 3-7 days before the surgery and resuming it a week after the surgery as he believes he will be prescribed opiate pain medication. He takes lunesta rarely. He continues to experience variable sleep. He already had CBT-I and had a sleep study that was negative for sleep apnea. He is stressed about work as he juggles many responsibilities and wishes he didn't reenlist. He is trying to pursue a med board for his GI symptoms. He has psychologic testing but hasn't had his feedback session about it yet. He denies having suicidal thoughts since we last met.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 529

AR 0572

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

Risk Assessment:**C-SSRS Baseline (9/6/2016):** 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, naltrexone 50 mg po daily, lunesta 1-2 mg po qhs prn insomnia

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Page 530

AR 0573

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: easy to establish

Speech: normal tone and kinetics

Mood: mildly anxious

Affect: full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight: wnl

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin SERUM 4.9	g/dL	(3.5-5.2)		
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin SERUM 0.3	mg/dL	(0.15-1.2)		
Bilirubin Direct SERUM	<0.2	mg/dL	(0.0-0.3)	
Protein SERUM 7.6	g/dL	(6.6-8.7)		

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen SERUM 14.8	mg/dL	(6-20)		
Carbon Dioxide SERUM 28	mmol/L	(22-29)		
Chloride SERUM 98	mmol/L	(98-107)		
Creatinine SERUM 1.00	mg/dL	(0.7-1.2)		
Glucose SERUM 89	mg/dL	(74-106)		
Potassium SERUM 4.5	mmol/L	(3.5-5.1)		
Sodium SERUM 139	mmol/L	(136-145)		
Calcium SERUM 10.1	mg/dL	(8.6-10.2)		
Anion Gap SERUM 13	mmol/L	(7-16)		
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4 <i>	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC BLOOD 5.6	x10(3)/mcL	(3.6-10.6)		
RBC BLOOD 4.86	x10(6)/mcL	(4.21-5.92)		
Hemoglobin BLOOD 15.1	g/dL	(12.8-17.7)		
Hematocrit BLOOD 44.4	%	(37.5-50.9)		
MCV BLOOD 91.4	fL	(79.5-96.8)		
MCH BLOOD 31.1	pg	(26.2-33.1)		
MCHC BLOOD 34.1	g/dL	(32.6-35.0)		
RDW CV BLOOD 12.9	%	(12.0-16.2)		
Platelets BLOOD 272	x10(3)/mcL	(162-427)		
MPV BLOOD 9.0	fL	(7.0-10.9)		
Neutrophils BLOOD 59.4	%	(40.7-76.4)		
Lymphocytes BLOOD 29.8	%	(15.9-47.8)		

Medical Record

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Created: 30 Oct 2017

Monocytes	BLOOD	8.9	%	(4.5-11.8)		
Eosinophils	BLOOD	1.5	%	(0.3-7.1)		
Basophils	BLOOD	0.4	%	(0.2-1.2)		
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)		
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)		
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)		
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)		
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)		
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED				
Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng		
Borrelia burgdorferi Ab	SERUM Negative <i>	(See-Below)				
Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng		
Treponema pallidum Ab	SERUM Negative <i>	(Negative)				
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng		
Methylmalonate	SERUM 170	nmol/L	0-378			
HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng		
HIV-1/O/2 Ab	SERUM Negative <i>					
Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng		
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL	(211-946)			
Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng		
Homocysteine	SERUM 8.9 <i>	mcmol/L	(4.0-15.4)			
Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng		
Albumin	SERUM 4.7	g/dL	(3.5-5.2)			
Alkaline Phosphatase	SERUM 53	U/L	(40-129)			
Alanine Aminotransferase	SERUM 17	U/L	(0-41)			
Bilirubin	SERUM 0.4	mg/dL	(0.15-1.2)			
Urea Nitrogen	SERUM 13.8	mg/dL	(6-20)			
Calcium	SERUM 9.7	mg/dL	(8.6-10.2)			
Carbon Dioxide	SERUM 29	mmol/L	(22-29)			
Chloride	SERUM 98	mmol/L	(98-107)			
Creatinine	SERUM 0.96	mg/dL	(0.7-1.2)			
Glucose	SERUM 89	mg/dL	(74-106)			
Potassium	SERUM 4.4	mmol/L	(3.5-5.1)			
Protein	SERUM 7.6	g/dL	(6.6-8.7)			
Sodium	SERUM 141	mmol/L	(136-145)			
Anion Gap	SERUM 14	mmol/L	(7-16)			
GFR Calculated Non-Black	SERUM 105.6	mL/min	(60->=60)			
GFR Calculated Black	SERUM 122.1 <i>	mL/min	(60->=60)			
Aspartate Aminotransferase	SERUM 20	U/L	(0-40)			
ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng		
Ethyl Glucuronide	URINE Negative <i>	ng/mL	Cutoff=250			
Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng		
Amphetamines	URINE NEGATIVE <i>	(Negative)				
Barbiturates	URINE NEGATIVE <i>	(Negative)				
Benzodiazepines	URINE NEGATIVE <i>	(Negative)				
Cocaine	URINE NEGATIVE <i>	(Negative)				
Opiates	URINE NEGATIVE <i>	(Negative)				

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Phencyclidine, UA URINE NEGATIVE <i> (Negative)
 Cannabinoids URINE NEGATIVE <i> (Negative)
 Methadone URINE NEGATIVE <i> (Not-Detected)
 Oxycodone URINE NEGATIVE <i> ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: Continue Lexapro 20 mg po daily. Advised pt not to take lunesta 1-2 mg po qhs prn insomnia if he is sleeping well without it. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Continue naltrexone 50 mg po daily. Have discussed at referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor

Measure: self-report, lab results

Therapy Type:

Not Set

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 534

AR 0577

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one month

Referrals: pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**Can Service Member perform MOS duties? **Yes**A/P Written by TOBAR, EDEN @ 02 Mar 2017 1244 EDT1. **Generalized anxiety disorder:** Med management 30 minutes; psychotherapy 20 minutes

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #70 RF3 Ordered

By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 02 Mar 2017 1244 EDT**Released w/o Limitations****Follow up:** 6 to 8 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR, EDEN @ 01 Mar 2017 0900 EST**Additional A/P Information:**

Discontinued ESZOPICLONE--PO 1MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP

Signed By TOBAR, EDEN (Physician/Workstation) @ 02 Mar 2017 1244

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

08 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-27327225 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 08 Feb 2017 0700 EST
 Clinic: PSYCHOLOGY ASSESSMENT
 BE

Appt Type: SPEC
 Provider: BENTON, JIKESHA R

AutoCites Refreshed by BENTON, JIKESHA R @ 10 Feb 2017 1306 EST

Problems

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED #0 RF3	2 of 3	01 Feb 2017
ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3	0 of 3	01 Feb 2017
ESZOPICLONE, 1 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1	1 of 1	04 Jan 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml	Active		NR	14 Oct 2016

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

SYRINGE PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015- 16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment:

Dx Interview

Appointment Comments:

CAC

Note Written by BENTON, JIKESHA R @ 10 Feb 2017 1406 EST

SM Merwin is as 31 year old, single, Caucasian, male, AD USN E-6 Cryptologist. SM was seen for a 1 hour clinical interview by LT Martinez on 02FEB17 under Dr. Benton's supervision. This writer engaged in 2 hours of chart review and 5 hours of psychological report preparation and writing. A 1 hour feedback session was scheduled after the conclusion of the clinical interview. LT Martinez administered the MCMI-III, MMPI-2, and RISB on 02FEB17.

Initial Impressions

Psychological testing results were consistent with the established diagnoses of Generalized Anxiety Disorder. SM Merwin does not meet criteria for Borderline Personality Disorder. SM Merwin endorsed anxious ruminative thoughts and stress caused by feelings of guilt. SM Merwin's pattern of unstable relationships appears to be more in line with Schizoid personality traits that may have been adaptive at a young age in the context of his childhood physical and emotional abuse. SM Merwin exhibits a lack of interest in social relationships, a tendency towards a solitary lifestyle, emotional coldness, and apathy. Individuals with Schizoid traits may also demonstrate a rich, elaborate and exclusively internal fantasy world. SM Merwin indicated he enjoys the fantasy world of movies and frequently finds himself daydreaming.

Mental Status Exam

Mental status examination revealed an alert, fully oriented, appropriately dressed and groomed male who appeared his stated age. SM Merwin presented with a pleasant mood and congruent affect. Throughout the session, SM Merwin's mood and affect appeared unchanged, even when discussing difficult or emotional topics. SM Merwin maintained appropriate eye contact throughout the session. SM Merwin was engaged in the interview and testing. His speech was normal in tone and rate. Cognition was grossly intact and abstraction was adequate. Recent and remote memory was intact. Thought process was clear and goal oriented. SM Merwin did not exhibit ideas of reference, paranoia, or delusions. There was no evidence of mania. Judgment and impulse control were good. No indication of psychomotor retardation or agitation. SM Merwin denied current suicidal or homicidal ideation, plans, or intent.

Risk Assessment

SM Merwin has a history of suicidal ideation occurring approximately once a month since adulthood. His protective factors include his job, his hobby of creating video games, and wanting to find purpose in his life. SM Merwin has low social support, but this does not seem to be a significant stressor. SM Merwin does not have a history of attempts and denies access to lethal means. He denied current ideation, plan, or intent. SM Merwin is currently assessed at a mild risk for suicide, and should continue to be monitored by his healthcare providers.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

1. Generalized anxiety disorder

Procedure(s):
-Psychiatric Diagnostic Evaluation Comprehensive Examination x 1
-Psychologic Testing And Report Administered By Physician x 8

Disposition Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 10 Feb 2017 1407

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

02 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-27275465 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **02 Feb 2017 0800 EST**
 Clinic: **PSYCHOLOGY ASSESSMENT**
BE

Appt Type: **PROC**
 Provider: **BENTON, JIKESHA R**

AutoCites Refreshed by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

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- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
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- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED #0 RF3	2 of 3	01 Feb 2017
ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3	0 of 3	01 Feb 2017
ESZOPICLONE, 1 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1	1 of 1	04 Jan 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml	Active		NR	14 Oct 2016

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

SYRINGE PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015- 16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment:

Generalized anxiety disorder

Appointment Comments:

mta

Note Written by BENTON, JIKESHA R @ 07 Feb 2017 1531 EST**Reason for Visit**

Visit for: Psychological Testing. Assessment time 5.5 hrs. PT denied any physical pain. He c/o'ed of issues w/ interpersonal relationships. PT discussed his history of physical and emotional abuse by his father. He was cooperative and no management problem. The raw data can be found in room 7131. The report will be uploaded once complete.

History of present illness

The Patient is a 31 year old male.

He reported: Feeling numb; he appeared apathetic w/ a flat affect. Not thinking about suicide. No homicidal thoughts, no hallucinations, and not hearing voices when no one is talking.

Compliant with testing: Y /

Oriented X4 Y /

Risks reported to patient treatment team NA/ none at this time

Provider follow-up scheduled Y /

If yes date is: ___, scheduled for the Dx interview w/ 2 LT Hannah Martinez; the feedback session is pending.

Subjective

The patient was seen to discuss participation in a psychological evaluation requested by his provider. The purpose, nature and limits of confidentiality were explained to the patient and all questions were answered.

Tests

He completed the RISB and the LNA.

Laboratory Studies:

Psychometric:

Minnesota Multiphasic Personality Inventory (MMPI), Millon clinical multi-axial inventory, and projective administration of psychologic test.

A/P Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST**1. Generalized anxiety disorder**

Procedure(s): -Psychologic Testing and Report Administered By Physician x 6 ADDITIONAL PROVIDER(S):
MARTINEZ, HANNAH R

Disposition Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST**Consult Order****Referring Provider:** PAUL, SHERIN**Date of Request:** 08 Dec 2016**Priority:** Routine**Provisional Diagnosis:**

Generalized anxiety disorder

Reason for Request:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 540

AR 0583

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 07 Feb 2017 1541

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

01 Feb 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-27297932 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **01 Feb 2017 1500 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

F/U

Appointment Comments:

AAP

Note Written by PAUL, SHERIN @ 06 Feb 2017 0945 EST**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 3
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 31-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Behavior Mod****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he has been reading through his mother's journals from his childhood. He stated that he feels reassured that his perceived experiences are in line with what actually happened. Patient and therapist discussed abusive home and abusive interactions that he had with his father. He expressed concern that he has become like his father in rigidity, emotional detachment, and isolation. However, patient agreed that he has a level of insight that his father does not. He expressed interest in working on these trends. He identified a goal for the week.

Response to treatment: ☐ None ☒ Some ☐ Significant ☐ Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT**Diagnosis:**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Axis I: Generalized Anxiety Disorder
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support
 Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☐ Low ☒ Intermediate ☐ High

Harm to Others: ☒ Not Elevated ☐ Low ☐ Intermediate ☐ High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Safety Plan:

☐ Pt released without limitations, verbally commits to plan below and current safety to self/others.

☐ Pt released to Chain of Command with the following limitations: _____

☒ Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016

Reviewed with patient on: 15 November 2016

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would NOT like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 545

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 06 Feb 2017 0946 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 06 Feb 2017 0946 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Feb 2017 0946

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Feb 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-27255467 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Feb 2017 1130 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR, EDEN @ 01 Feb 2017 1154 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by NATHAN, YOGESWARI S @ 01 Feb 2017 1120 EST

BP: 131/82, HR: 66, RR: 16, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 0 Pain Free

Comments: Drinks 1-2 a week 3-4 drinks at a time.
 No SX of fever or chills.

Appointment Comments:

ett/phq9/gad7

VitalsVitals Written by NATHAN, YOGESWARI S @ 01 Feb 2017 1120 EST

BP: 131/82, HR: 66, RR: 16, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No,
 Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: Drinks 1-2 a week 3-4 drinks at a time.
 No SX of fever or chills.

Note Written by TOBAR, EDEN @ 01 Feb 2017 1225 EST**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and
 signature was obtained.

Appointment #6

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and
 undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Anger Problems: Yes Spouse/Sig Other Problems: No
 Legal Problems: No Financial Problems: Yes
 Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good
 Pain Level (0-10): 0 Currently treated: not answered
 Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes
 # past attempts: 3 (as of 09/06/2016)
 Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A
 Patient with access to weapons: No

Notes from current session:

Pt presents for his fifth appt with this provider. At our last meeting we added naltrexone 50 mg po qam to reduce alcohol use. We also added lunesta 1-2 mg prn for sleep. Today pt states he took the naltrexone for a week and found it helped him desire to drink less, but he was taking it at night and waking up frequently so he stopped taking it. He doesn't think the lunesta is helpful so hasn't been taking it. He has stopped drinking during the week and over the weekend drank four beers on Saturday night and two beers on Sunday. He stopped drinking caffeine two days ago. He has felt more awake and slept well last night. He asked his mother for a copy of her journal from the 1990s when he was a child, which he brought to today's appt. He states it is 357 pages. He pointed out a few pages that indicate his father, who had custody of pt and his sisters, was physically abusive to pt and his sisters. Pt plans to show journal to Dr Paul later today. He has psychologic testing scheduled for tomorrow. He denies having nightmares about the journal. He denies having suicidal thoughts since we last met.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:
General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Depression - PHQ2: 2 - Depressive Syndrome Unlikely
 PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.
 Thoughts that you would be better off dead, or of hurting yourself in some way
 Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7
 GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated
 PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen

Rating scales:

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)

☒ Male

☐ History of family/friend suicide

☐ Chronic medical conditions

☒ Impulsivity

☒ History of abuse

☐ Chronic pain

PROTECTIVE FACTORS (Strengths):

☐ Married, children

☒ Active treatment engagement

☐ Good coping/problem solving skills

☒ Hopefulness present

☐ Faith/religion commitment

☐ Positive future orientation

Allergies: nkda

Medications: Lexapro 20 mg po daily, wellbutrin xl 300 mg po qam, unisom OTC

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin

Anderson, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 549

AR 0592

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: easy to establish

Speech: normal tone and kinetics

Mood: mildly dysphoric

Affect: full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight: wnl

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel		Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM	28	mmol/L	(22-29)	
Chloride	SERUM	98	mmol/L	(98-107)	
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM	89	mg/dL	(74-106)	
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM	139	mmol/L	(136-145)	
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM	13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM	115.4	mL/min	(60->=60)	

CBC W/Diff		Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD	44.4	%	(37.5-50.9)	
MCV	BLOOD	91.4	fL	(79.5-96.8)	
MCH	BLOOD	31.1	pg	(26.2-33.1)	
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD	12.9	%	(12.0-16.2)	
Platelets	BLOOD	272	x10(3)/mcL	(162-427)	
MPV	BLOOD	9.0	fL	(7.0-10.9)	
Neutrophils	BLOOD	59.4	%	(40.7-76.4)	
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)	
Monocytes	BLOOD	8.9	%	(4.5-11.8)	
Eosinophils	BLOOD	1.5	%	(0.3-7.1)	
Basophils	BLOOD	0.4	%	(0.2-1.2)	
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED			

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L 0-378		
HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <i>			
Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL (211-946)		
Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L (4.0-15.4)		
Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM 4.7	g/dL (3.5-5.2)		
Alkaline Phosphatase	SERUM 53	U/L (40-129)		
Alanine Aminotransferase	SERUM 17	U/L (0-41)		
Bilirubin	SERUM 0.4	mg/dL (0.15-1.2)		
Urea Nitrogen	SERUM 13.8	mg/dL (6-20)		
Calcium	SERUM 9.7	mg/dL (8.6-10.2)		
Carbon Dioxide	SERUM 29	mmol/L (22-29)		
Chloride	SERUM 98	mmol/L (98-107)		
Creatinine	SERUM 0.96	mg/dL (0.7-1.2)		
Glucose	SERUM 89	mg/dL (74-106)		
Potassium	SERUM 4.4	mmol/L (3.5-5.1)		
Protein	SERUM 7.6	g/dL (6.6-8.7)		
Sodium	SERUM 141	mmol/L (136-145)		
Anion Gap	SERUM 14	mmol/L (7-16)		
GFR Calculated Non-Black	SERUM 105.6	mL/min (60->=60)		
GFR Calculated Black	SERUM 122.1 <i>	mL/min (60->=60)		
Aspartate Aminotransferase	SERUM 20	U/L (0-40)		
ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE Negative <i>	ng/mL Cutoff=250		
Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE NEGATIVE <i>			(Negative)
Barbiturates	URINE NEGATIVE <i>			(Negative)
Benzodiazepines	URINE NEGATIVE <i>			(Negative)
Cocaine	URINE NEGATIVE <i>			(Negative)
Opiates	URINE NEGATIVE <i>			(Negative)
Phencyclidine, UA	URINE NEGATIVE <i>			(Negative)
Cannabinoids	URINE NEGATIVE <i>			(Negative)
Methadone	URINE NEGATIVE <i>			(Not-Detected)
Oxycodone	URINE NEGATIVE <i>	ng/mL		(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: [] Not Elevated [x] Low [x] Intermediate [] High

Harm to Others: [] Not Elevated [x] Low [] Intermediate [] High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: Continue Lexapro 20 mg po daily. Advised pt not to take lunesta 1-2 mg po qhs prn insomnia if he is sleeping well without it. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Encouraged pt to restart naltrexone 25 mg po daily for reduction in alcohol use x 1 week, then increase to 50 mg po daily, and take it in the morning. Discussed at referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: one month

Referrals: pt had therapy intake with Dr Paul on 18NOV

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: SM has no duty restrictions necessitating a profile. Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
 Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR, EDEN @ 01 Feb 2017 1227 EST

1. **Anxiety disorder, unspecified:** Med management 15 minutes; psychotherapy 15 minutes.
 Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1
2. **Major depressive disorder, recurrent, unspecified**

Disposition Written by TOBAR, EDEN @ 01 Feb 2017 1228 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 01 Feb 2017 1228

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

04 Jan 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26995185 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **04 Jan 2017 1400 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN**Reason for Appointment:
f/uNote Written by PAUL, SHERIN @ 06 Jan 2017 1442 EST**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 2
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 31-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: Behavior Mod

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he was contacted by psych testing regarding diagnosis clarification and he will follow through on scheduling appointment. Patient reported that he spent time with his mother's side of the family which was a positive experience. He stated that he learned a lot about his parent's early relationship. Therapist and patient processed his feelings about this. Patient recognized that throughout childhood, his experiences with his father shaped his behavior. He acknowledged keeping people away from him as he cannot contend with guilt or disappointing others. He stated that when he does engage with others it feels overwhelming because he goes above and beyond standards to make others happy. However, this has led to isolation as he does not want to risk disappointing others. Patient also identified rigidity of behavior, especially in regards to cleanliness, which is also an outdated defense mechanism from childhood. Therapist and patient discussed engaging in uncomfortable target behaviors to help ease rigidity and to encourage social development.

Response to treatment: [] None [☒] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 556

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016

Reviewed with patient on: 15 November 2016

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 558

AR 0601

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL SHERIN @ 06 Jan 2017 1443 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL SHERIN @ 06 Jan 2017 1443 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Jan 2017 1444

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

04 Jan 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26957487 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Jan 2017 0930 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR, EDEN @ 04 Jan 2017 1026 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

Vitals Written by TEKELENBURG, JAAP @ 04 Jan 2017 0947 EST
 BP: 138/99, HR: 89, RR: 14, T: 97.2 °F, Pain Scale: 0 Pain Free

Appointment Comments:
 ett/phq9/gad7

Vitals

Vitals Written by TEKELENBURG, JAAP @ 04 Jan 2017 0947 EST
 BP: 138/99, HR: 89, RR: 14, T: 97.2 °F, Pain Scale: 0 Pain Free

Note Written by TOBAR, EDEN @ 04 Jan 2017 1243 EST**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #5

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male
Military Data:

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes Work Colleague Problems: No
 Anger Problems: Yes Spouse/Sig Other Problems: No
 Legal Problems: No Financial Problems: Yes
 Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 560

AR 0603

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his fourth follow-up with this provider. At our last meeting we added Wellbutrin xl 150 mg po qam to target mood at his request as his mother and sister take it and find it helpful. Today pt states he continued to feel tired on it so started taking it at night about a week. He has had disrupted sleep. He has also continued to drink 3-4 drinks 3-4 nights per week. He didn't drink any alcohol over Christmas as he was visiting his relatives who don't drink, but drank 18 Corona beers over the four-day New Year's holiday (he did not have to work). Discussed with pt he shouldn't be drinking while taking his medications as they won't work while on alcohol, and his fatigue and sleep disturbance could be caused by his drinking. He acknowledges this though also states he drinks to help him sleep because he can't turn his mind off at night. Discussed he should not take Wellbutrin at night as this will also impair his sleeping. Noted increased phq9 and gad7 scores. He thinks he feels more anxious since starting Wellbutrin so we agreed to stop it. His work is going well. Dr Paul referred him for psychologic testing but he missed the phone call to make the appt. He plans to call back to schedule it. His abdominal pain has improved.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, wellbutrin xl 300 mg po qam, unisom OTC**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page 562

AR 0605

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4
 Tobacco/e-cigs: none PPD Equivalent:
 Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.
 Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.
 Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.
 Highest level of education achieved is: High School graduate.
 Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.
 Patient reports religion, faith or spirituality DO NOT play an important role in life.
 Social support reported as satisfactory.
 Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure
 Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)
 Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None
 Patient denies treatment team needs to be aware of specific ethnic/cultural issues.
 Learns best by: Pictures. Learning is adversely affected by: None.
 Patient would not like family members involved in care.
 Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.
 Behavior/Orientation: Polite, and cooperative.
 Abnormal Movements: normal gait. No abnormal movements apparent.
 Rapport: easy to establish
 Speech: normal tone and kinetics
 Mood: mildly dysphoric
 Affect: full
 Thought Process: circumstantial
 Thought Content: no current SI/HI/AVH
 Judgment: fair

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Basic Metabolic Panel				
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)
Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	mL/min	(60->=60)

Test	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
CBC W/Diff				
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Lyme Disease Ab Total Screen				
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab				
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid				
Methylmalonate	SERUM	170	nmol/L	0-378

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab				
HIV-1/O/2 Ab	SERUM	Negative <r>		

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cyanocobalamin)				
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L (4.0-15.4)		

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin SERUM 4.7	g/dL (3.5-5.2)			
Alkaline Phosphatase SERUM 53	U/L (40-129)			
Alanine Aminotransferase SERUM 17	U/L (0-41)			
Bilirubin SERUM 0.4	mg/dL (0.15-1.2)			
Urea Nitrogen SERUM 13.8	mg/dL (6-20)			
Calcium SERUM 9.7	mg/dL (8.6-10.2)			
Carbon Dioxide SERUM 29	mmol/L (22-29)			
Chloride SERUM 98	mmol/L (98-107)			
Creatinine SERUM 0.96	mg/dL (0.7-1.2)			
Glucose SERUM 89	mg/dL (74-106)			
Potassium SERUM 4.4	mmol/L (3.5-5.1)			
Protein SERUM 7.6	g/dL (6.6-8.7)			
Sodium SERUM 141	mmol/L (136-145)			
Anion Gap SERUM 14	mmol/L (7-16)			
GFR Calculated Non-Black SERUM 105.6	mL/min (60->=60)			
GFR Calculated Black SERUM 122.1 <i>	mL/min (60->=60)			
Aspartate Aminotransferase SERUM 20	U/L (0-40)			

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines URINE	NEGATIVE <i>		(Negative)	
Barbiturates URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines URINE	NEGATIVE <i>		(Negative)	
Cocaine URINE	NEGATIVE <i>		(Negative)	
Opiates URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA URINE	NEGATIVE <i>		(Negative)	
Cannabinoids URINE	NEGATIVE <i>		(Negative)	
Methadone URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o GAD; r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

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Page 565

AR 0608

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

Safety Plan:

- ☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: discontinue Wellbutrin xl by tapering back down from 300 mg to 150 mg po qam x 3 days, then stopping. Continue Lexapro 20 mg po daily. May start lunesta 1-2 mg po qhs pm insomnia to address racing thoughts at night, with plan for short term use. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Start naltrexone 25 mg po daily for reduction in alcohol use x 1 week, then increase to 50 mg po daily if tolerated. Discussed ats referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

- ☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: one month

Referrals: pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: SM has no duty restrictions necessitating a profile. Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page 566

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
 Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR, EDEN @ 04 Jan 2017 1245 EST

1. Generalized anxiety disorder: Medication management 30 minutes; psychotherapy 15 minutes
 Procedure(s): -Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management x 1
 Medication(s): -ESZOPICLONE--PO 1MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED
 FOR SLEEP #30 RF1 Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T
 -NALTREXONE--PO 50MG TAB - T1/2 TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN
 INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERAT #30 RF3 Ordered By:
 TOBAR, EDEN Ordering Provider: TOBAR, EDEN T
 Laboratory(ies): -G- GLUTAMYL TRANSFERASE (Routine) Ordered By: TOBAR, EDEN Ordering Provider: TOBAR,
 EDEN T; HEPATIC FUNCTION PANEL (Routine) Ordered By: TOBAR, EDEN Ordering Provider:
 TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 04 Jan 2017 1246 EST**Released w/o Limitations****Follow up:** 1 month(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR, EDEN @ 04 Jan 2017 1055 EST**Additional A/P Information:**

Discontinued buPROpion XL--PO 150MG TBER 24H - TAKE ONE TABLET BY MOUTH EVERY MORNING FOR 1 WEEK, THEN
 INCREASE TO TWO TABLETS BY MOUTH EVERY MORNING IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 04 Jan 2017 1246

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

06 Dec 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26743398 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Dec 2016 0900 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

f/u

Appointment Comments:

jc

Note Written by PAUL, SHERIN @ 08 Dec 2016 1424 EST

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 1
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 31-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 568

AR 0611

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Supportive****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He stated that he visited his family recently and confirmed that both his grandmother and mother were diagnosed with Bipolar Disorder. He stated that his mother at least has been treated with Wellbutrin in the past. Patient's two other sisters also have been diagnosed with Depression and Bipolar disorder. Therapist and patient discussed patient's diagnosis and find that a referral to psychological testing is warranted to clarify diagnosis. Further conversation focused on patient's perfectionism and difficulty with emotional/relational/physical intimacy.

Response to treatment: [] None [X] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT**Diagnosis:**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 570

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016

Reviewed with patient on: 15 November 2016

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 08 Dec 2016 1427 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Consult(s): -Referred To: PSY DIAGNOSTIC TESTING MTF BE (Routine) Specialty: PSYCHOLOGY Clinic:
PSYCHOLOGY ASSESSMENT BE Provisional Diagnosis: Generalized anxiety disorder Order Date:
12/08/2016 14:26

Disposition Written by PAUL, SHERIN @ 08 Dec 2016 1427 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Administrative Options: Consultation requested

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 08 Dec 2016 1427

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 572

AR 0615

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 Dec 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26690229 Primary Dx: Major depressive disorder, recurrent, unspecified

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 05 Dec 2016 1000 EST
Clinic: PSYCHIATRY BEAppt Type: FTR
Provider: TOBAR, EDEN TAutoCites Refreshed by TOBAR, EDEN @ 05 Dec 2016 1040 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Appointment Comments:

ett/phq9/gad7

Note Written by TOBAR, EDEN @ 05 Dec 2016 1557 EST**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #4

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes Work Colleague Problems: No
Anger Problems: Yes Spouse/Sig Other Problems: No
Legal Problems: No Financial Problems: Yes
Overall level of difficulty in work, home, social functioning: Very difficult**Behavioral Health Vitals (patient reported):**

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A
 Patient with access to weapons: No

Notes from current session:

Pt presents for his third follow-up with this provider. At our last meeting we increased his Lexapro to 20 mg po daily to target anxiety/irritability. Today he states he has not had suicidal thoughts since our last meeting. He has felt more tired since increasing the Lexapro. Two days ago he switched it to night time dosing. He started taking unisom last night for sleep as he was waking up frequently, and slept well on it. He just returned from visiting his family (grandmother, mother and sister) in California. He found out GM and mother have bipolar disorder and sister has depression> they all take Wellbutrin and find it helpful. He started seeing Dr Paul and has a follow up with her tomorrow. He is drinking 3 drinks (beers) around 3-4 nights per week. He plans to stop drinking during the week now. He continues to have ongoing abdominal pain and is seeing GI about this.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page 574

AR 0617

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

Risk Assessment:**C-SSRS Baseline (9/6/2016):** 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, unisom OTC**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Page 575

AR 0618

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4
 Tobacco/e-cigs: none PPD Equivalent:
 Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.
 Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.
 Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.
 Highest level of education achieved is: High School graduate.
 Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.
 Patient reports religion, faith or spirituality DO NOT play an important role in life.
 Social support reported as satisfactory.
 Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure
 Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)
 Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None
 Patient denies treatment team needs to be aware of specific ethnic/cultural issues.
 Learns best by: Pictures. Learning is adversely affected by: None.
 Patient would not like family members involved in care.
 Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.
 Behavior/Orientation: Polite, and cooperative.
 Abnormal Movements: normal gait. No abnormal movements apparent.
 Rapport: easy to establish
 Speech: normal tone and kinetics
 Mood: mildly dysphoric
 Affect: full
 Thought Process: circumstantial
 Thought Content: no current SI/HI/AVH
 Judgment: wnl
 Insight: wnl
 Impulsivity: none at time of interview
 Cognition: grossly intact
 Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 576

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	

Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 577

AR 0620

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)	
Barbiturates	URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)	
Cocaine	URINE	NEGATIVE <i>		(Negative)	
Opiates	URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)	
Cannabinoids	URINE	NEGATIVE <i>		(Negative)	
Methadone	URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o GAD; r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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Page 578

AR 0621

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Goal:pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: will add Wellbutrin xl 150 mg po qam x 1 week, then increase to 300 mg po qam if tolerated/efficacious. Continue Lexapro 20 mg po daily. Consider taper down on dose due to side effects if Wellbutrin tolerated/effective. Discussed possible interaction with unisom and Lexapro. Counseled pt on risks/benefits and he consented to treatment.

Measure:gad7, pcl, phq9

Problem #2: safety

Goal:pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal:pt will minimize alcohol use

Objective: pt will minimize alcohol use

Intervention: discussed adverse effects of alcohol on mood and sleep. Pt insists he is cutting back.

Continue to monitor. Consider ats referral.

Measure:self-report

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one month

Referrals:pt has therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**Can Service Member perform MOS duties? **Yes**Lab Result Cited by TOBAR,EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone

Site/Specimen

06 Sep 2016 0923

Units

Ref Rng

Thyrotropin

SERUM

2.500 <i>

mIU/mL

(0.27-4.2)

Thyroxine Free

Site/Specimen

06 Sep 2016 0923

Units

Ref Rng

Thyroxine Free

SERUM

1.28 <i>

ng/dL

(0.93-1.7)

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Page 579

AR 0622

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by TOBAR, EDEN @ 05 Dec 2016 1558 EST

1. Major depressive disorder, recurrent, unspecified

Procedure(s): -Psych Ther Indiv Approx 60 Min W/ Medical Evaluation & Management x 1
Medication(s): -buPROpion XL-PO 150MG TBER 24H - TAKE ONE TABLET BY MOUTH EVERY MORNING FOR 1
WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY MORN #60 RF1 Ordered By:
TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 05 Dec 2016 1558 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 05 Dec 2016 1559

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Page 580

AR 0623

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

28 Nov 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26612374 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **28 Nov 2016 1243 EST**
Clinic: **GI CL BE**Appt Type: **T-CON***
Provider: **COPSEY, HELEN C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 28 Nov 2016 1243 EST
Pt email**S/O Note** Written by COPSEY, HELEN C. @ 28 Nov 2016 1243 EST**Subjective**

Hi Daniel, Great insight- there is certainly a relationship between IBS and mental health. That's why we call your gut your "second brain". It sounds like you've started to make some progress and I'm more than happy to meet with you again to talk about next steps in your care. Please let me know if you need any assistance setting up another appointment. In the meantime, if you've already stopped dairy and Splenda and are looking for more ways to modify your diet, you may consider choosing low fodmap foods (see attached sheet). It may give you a bit more flexibility than just meat/potatoes. -Helen-----Original Message-----From: daniel.d.merwin [mailto:daniel.d.merwin@gmail.com] Sent: Friday, November 25, 2016 2:09 PM To: Copsey, Helen C CTR (US) Subject: [Non-DoD Source] RE: Follow-Up - Pain I probably will schedule a follow up soon. I have more food log completed. I also wanted to bring up important information I learned more extensively about recently. I am being treated for mental disorders. My family mom, grandma, great grandma, sister have mental health issues and IBS-D/C. Which made me look for association between mental health and IBS and see some papers have been written on it. Anyways I have been eating mostly meat and potatoes for now because it's really the only safe food so far and really needed a break from the pain and diarrhea. I still have diarrhea half the week but no pain on meat and potato diet. - Daniel Merwin

A/P Last Updated by COPSEY, HELEN C @ 28 Nov 2016 1243 EST**1. Irritable bowel syndrome with diarrhea****Disposition Last Updated by** COPSEY, HELEN C @ 28 Nov 2016 1243 EST**Follow up:** in the GI CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 28 Nov 2016 1243

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 581

AR 0624

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

15 Nov 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26519450 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **15 Nov 2016 1300 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **SPEC**
Provider: **PAUL, SHERIN****Reason for Appointment:**
specNote Written by PAUL, SHERIN @ 16 Nov 2016 1451 EST**WR ADULT BEHAVIORAL HEALTH CLINIC INTAKE NOTE**

Patient Name: Daniel Merwin

Patient last 4: 0538

Appt type: ☒ **Initial Eval** ☐ **Command-Directed** ☐ **Special Duty Screen** ☐ **Admin**
Eval

Referred by: Dr. Tobar

Limits of Confidentiality and clinic no-show policy reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.**IDENTIFYING DATA:** 31-year-old, Single, Caucasian, Male**MILITARY DATA:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**CHIEF COMPLAINT:** The patient reports the following problems/difficulties:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 582

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

Pt reports the following additional issues:

Work Performance Issues: Yes	Spouse/Sig Other Problems: No
Work Colleague Problems: No	Legal Problems: No
Anger Problems: Yes	Financial Problems: Yes
Overall level of difficulty in work, home, social functioning: Very difficult	

Behavioral Health Vitals (patient reported):

Overall health reported as: Good
Pain Level (0-10): 0
Is pain currently treated: not answered
Difficulty in work, home, social functioning: Very difficult

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

HISTORY OF PRESENT ILLNESS:

Patient identified that depressive and anxiety symptoms originated in childhood. Patient stated that because of an abusive home environment, patient was always anxious about getting in trouble with his father. Patient revealed that he attempted suicide 2 x during his adolescence by attempting to over dose on Aspirin once and drinking a significant quantity of alcohol on another occasion. He did not suffer any significant consequences from these attempts and never reported it to others.

PSYCHIATRIC ROS:

SM reports the following self-reported items on screening before appt:

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ2	DEPRESSION SCREENER	2	Depressive Syndrome Unlikely
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD2	ANXIETY SCREENER	5	Anxiety Syndrome Possible, see GAD7
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.

Anderson, Daniel Dennis

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Page 583

AR 0626

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported
9/6/2016	AUDIT-C	ALCOHOL SCREENER	6	Hazardous drinking possible, see full AUDIT when available
9/6/2016	AUDIT	ALCOHOL	13	Harmful or Hazardous Alcohol Consumption likely
9/6/2016	CSI	RELATIONSHIP ISSUES	N/A	Pt reports no significant other - no score

TBI/CONCUSSION SCREEN (Negative Screen): 9/6/2016**SLEEP ISSUES:** ISI ()

Hours of sleep per night: 6-7	Snores: No
Sleep latency: 0-15min	Daytime Somnolence: Yes

C-SSRS BASELINE (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?	Yes
Over lifetime, Suicidal Thoughts?	Yes
Over lifetime, Suicidal Thoughts with Method?	Yes
Over lifetime, Suicidal Intent?	Yes
Over lifetime, Suicide Intent with Specific Plan?	Yes
Over lifetime, Suicide Behavior?	Yes
Number of events?	3
Most recent Suicidal Thoughts/Behaviors?	1-3 months ago
Suicidal Thoughts Duration?	Less than 1 hour
Suicidal Thought Frequency?	Less than once a week

RISK ASSESSMENT:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No

Anderson, Daniel Dennis

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Page 584

AR 0627

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Age (risk factor if <25 or >60): No

Modifiable:

Suicidal Ideation/Plans/Intent:		Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No	
Access to Lethal Means:	No	
Poor Treatment Compliance:		No
Hopelessness:	Yes	
Psychic Pain/Anxiety:	Yes	
Acute Event:	No	
Insomnia:	No	
Low Self-Worth:	No	
Impulsivity:	Yes	
Substance Abuse:		Yes, previously
Financial Stress:		Yes
Legal Stress:	No	

Protective:

Strong Therapeutic Alliance:		TBD
Positive Coping Skills:	Yes	
Responsible to/for Family:	No	
Responsible to/for Pet:		
Frustration Tolerance	Limited	
Resilience:	Yes	
Good Reality Testing:	Yes	
Amenable to Treatment:	Yes	
Social Support:	No	
Religious Beliefs Contrary to Suicide:		

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low (X) Intermediate () High

Harm to Others: (X) Not Elevated () Low () Intermediate () High

DEVELOPMENTAL/SOCIAL HISTORY:

Patient was born in California. He is the oldest of 3 children born to his parents. He has 2 younger sisters. Patient stated that his parents separated when he was 3 years-of-age. His father was awarded primary custody of the children, which patient feels was done through his father's manipulations. Notably, patient reports both parents were physical in managing his younger sister's behavioral outburst and often left bruises on her. His father re-married when he was 8-years old and then remarried again when patient was 18. Patient had visitation with his mother as a child but noted that these visitations were often disrupted by his younger sister's behavioral outbursts. Patient stated that he was frequently scared as a child. He stated that his dad was always angry and yelling at someone. Patient stated that he tried hard to do everything correctly to avoid his dad's attention. He recalled trying to stay in his room as much as possible to avoid the overall family environment. Patient also reported that his father kept pets in the house despite significant exacerbation of his asthma that required medical intervention frequently. The patient and his family participated in intermittent family counseling but patient did not find it to be beneficial as they frequently changed therapists when his dad was displeased. Patient has had limited contact with his mother since leaving the home at 18. He recalls 6/7 visits in the past 15-years. However, he is working on rebuilding the relationship. Patient is currently estranged from his father and has not

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Page 585

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

interacted with him in the past 2-years. Prior to that, they saw each other 4 times in the past 15-years. Patient feels closest with his youngest sister because they have more shared experiences. However, he does not describe a strong relationship with her either. Notably, patient stated that he recently started recalling memories of sexual molestation by a paternal cousin in his early childhood (ages 6-12). He stated that the abuse stopped after the family moved from California to New Jersey.

The patient reported that he was teased by his peers for being underweight and because his clothes smelled like mildew as his parent's didn't properly do laundry. However, he was an excellent runner and gained positive experiences by participating in track and cross country. He stated that he struggled academically because he had difficulty learning and keeping focus. He acknowledged that he day dreamed a lot through school and didn't do his homework. However, patient graduated with a 2.2 GPA on time. After graduation, patient moved to Pennsylvania to get away from his home environment. He attempted 1 and ½ semesters at Allentown Business School (now closed) prior to dropping out. Patient worked at McDonald's and T-Mobile for 2 years prior to enlisting. Patient stated that he liked the Navy initially but finds the structure constricting at this point. Patient acknowledged that he likes what he does and is hoping to eventually build his own company developing video games.

Patient stated that he is currently in a romantic relationship but is dissatisfied. He stated that he does not ever feel close or connected to other people stating "I don't care about anyone except maybe my little sister". He described having significant difficulty experiencing empathy for others and described himself as selfish. He acknowledged that even the kind things he does for others is motivated by self-interest. He stated that he has tried to end the relationship with his current partner but she continues to dissuade him.

PAST PSYCHIATRIC HISTORY:

- August – October 2014: Individual Therapy w. Linda Nielsen
- March-April 2015: Inpatient Substance Abuse treatment at Ft. Belvoir
- April 2015- February 2016: Medication Management w. Dr. Zembruska
- September 2016- Present: Medication Management w. Dr. Tobar

FAMILY PSYCHIATRIC HISTORY:

- Maternal Grandmother: Bipolar
- Sister: Bipolar, Substance Abuse

SUBSTANCE USE:

Caffeine Use: Yes	Cups/Date Equivalent: 4
Tobacco/e-cigs: none	Packs/Date Equivalent: N/A
Alcohol: 2-3 glasses 2-3 x weekly	
Illicit drug use: denied	

Previous substance abuse tx: 30-days Inpatient program at Ft. Belvoir in 2014

MEDICAL/SURGICAL HISTORY:

Taken from Dr. Tobar's AHLTA Note Dated 24 October 2016

- Penile warts (HPV)
- Neurotic excoriation (scalp picking when anxious)
- Asthma during childhood
- Allergic response to pets
- Recurrent intestinal pain (possibly lactose intolerance)
- PRK (2011)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 586

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

CURRENT MEDICATIONS:

- Lexapro 20mg po daily

MENTAL STATUS EXAM:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

DIAGNOSTIC IMPRESSION DISCUSSION:

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

TREATMENT PLAN:**Setting:** (X) Outpatient () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 587

AR 0630

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Measure: GAD-7

Patient Strengths: Motivated for treatment, insight, positive coping skills**Intervention Types planned:**

Interpersonal Therapy ()

Cognitive Behavioral Therapy (X)

Acceptance & Commitment Therapy ()

Behavioral Therapy ()

Problem-Solving Therapy ()

Cognitive Processing Therapy ()

Prolonged Exposure ()

Group Psychotherapy ()

Family/Couples Therapy ()

Medication Management ()

Follow-up's scheduled: 1-week**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 16 Nov 2016 1452 EST**1. Generalized anxiety disorder**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

2. Alcohol dependence, uncomplicatedDisposition Written by PAUL, SHERIN @ 16 Nov 2016 1453 EST**Released w/o Limitations****Follow up:** 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

90 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 16 Nov 2016 1453

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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Page 588

AR 0631

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

24 Oct 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26237328 Primary Dx: Anxiety disorder, unspecified

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 24 Oct 2016 1100 EDT
Clinic: PSYCHIATRY BEAppt Type: FTR
Provider: TOBAR, EDEN TAutoCites Refreshed by TOBAR, EDEN @ 24 Oct 2016 1122 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by HAWKINS, DEREKSHEA J @ 24 Oct 2016 0956 EDT
BP: 133/85, HR: 78, RR: 16, T: 97.3 °F, Pain Scale: 0 Pain Free**Appointment Comments:**

swk

VitalsVitals Written by HAWKINS, DEREKSHEA J @ 24 Oct 2016 0956 EDT
BP: 133/85, HR: 78, RR: 16, T: 97.3 °F, Pain Scale: 0 Pain FreeNote Written by TOBAR, EDEN @ 24 Oct 2016 1254 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #3

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes Work Colleague Problems: No
Anger Problems: Yes Spouse/Sig Other Problems: No
Legal Problems: No Financial Problems: Yes
Overall level of difficulty in work, home, social functioning: Very difficult**Behavioral Health Vitals (patient reported):**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his second follow-up with this provider. At our last meeting started Lexapro 5 mg po daily tapered up to 10 mg po daily after a week to target anxiety/irritability. . Today he states he has not had suicidal thoughts since our last meeting. He does feel less urge to drink alcohol. He is drinking 3 drinks (beers) around 304 nights per week. He continues to feel mood lability in the mornings. We reviewed his phq9 and gad7 scores, noting they both decreased from last visit. He is picking at his scalp less. When he took Lexapro at night he found it hard to sleep so he takes it in the morning now. We discussed how conversely he had felt fatigued on Zoloft. Pt says he was on leave last week and spent the week building a computer and playing video games, which he enjoyed. He still wonders sometimes 'what's the point' and continues to date a young woman even though he is not so interested in her, because he wants to company and she is pursuing him. He is taking 15 days of leave next month to visit his grandparents in California as they are elderly and he has not seen them in almost twenty years. He continues to have ongoing abdominal pain and is seeing GI about this. He was diagnosed with irritable bowel syndrome.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people , and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anderson, Daniel Dennis

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Page 590

AR 0633

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7
 GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.
PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated
 PCL-5: 37 - Some PTSD symptoms reported
ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT
 AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely
RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score
SLEEP ISSUES:
 Average hours of sleep per night: 6-7 Snore: No
 Average sleep latency: 0-15min Daytime Somnolence: Yes
OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16
 24OCT16 phq9= 8 (#9=0); gad7= 12

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?	Yes
Over lifetime, Suicidal Thoughts?	Yes
Over lifetime, Suicidal Thoughts with Method?	Yes
Over lifetime, Suicidal Intent?	Yes
Over lifetime, Suicide Intent with Specific Plan?	Yes
Over lifetime, Suicide Behavior?	Yes
Most recent Suicidal Thoughts/Behaviors?	1-3 months ago
Suicidal Thoughts Duration?	Less than 1 hour
Suicidal Thought Frequency?	Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)

<input checked="" type="checkbox"/> Male	<input type="checkbox"/> History of family/friend suicide
<input type="checkbox"/> Chronic medical conditions	<input checked="" type="checkbox"/> Impulsivity
<input checked="" type="checkbox"/> History of abuse	<input type="checkbox"/> Chronic pain

PROTECTIVE FACTORS (Strengths):

<input type="checkbox"/> Married, children	<input checked="" type="checkbox"/> Active treatment engagement
<input type="checkbox"/> Good coping/problem solving skills	<input checked="" type="checkbox"/> Hopefulness present
<input type="checkbox"/> Faith/religion commitment	<input type="checkbox"/> Positive future orientation

Allergies: nkda**Medications:** Lexapro 10 mg po daily.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.
 Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.
 Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
 Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost

Anderson, Daniel Dennis

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Page 591

AR 0634

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, friendly, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: easy to establish

Speech: normal tone and kinetics

Mood: mildly anxious

Affect: full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight: wnl

Impulsivity: none at time of interview

Anderson, Daniel Dennis

DOB: [REDACTED]

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Page 592

AR 0635

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Cognition: grossly intact
Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Basic Metabolic Panel				
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)
Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	mL/min	(60->=60)

Test	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
CBC W/Diff				
WBC	BLOOD	5.6	x10(3)/mcl	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcl	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcl	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcl	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcl	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcl	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcl	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcl	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Lyme Disease Ab Total Screen				
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Test	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab				
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab				
HIV-1/O/2 Ab	SERUM	Negative <r>		

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cyanocobalamin)				
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Test	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine				

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Homocysteine SERUM 8.9 <i> mcmol/L (4.0-15.4)

		Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Comprehensive Metabolic Panel					
Albumin	SERUM 4.7	g/dL (3.5-5.2)			
Alkaline Phosphatase	SERUM 53	U/L (40-129)			
Alanine Aminotransferase	SERUM 17	U/L (0-41)			
Bilirubin	SERUM 0.4	mg/dL (0.15-1.2)			
Urea Nitrogen	SERUM 13.8	mg/dL (6-20)			
Calcium	SERUM 9.7	mg/dL (8.6-10.2)			
Carbon Dioxide	SERUM 29	mmol/L (22-29)			
Chloride	SERUM 98	mmol/L (98-107)			
Creatinine	SERUM 0.96	mg/dL (0.7-1.2)			
Glucose	SERUM 89	mg/dL (74-106)			
Potassium	SERUM 4.4	mmol/L (3.5-5.1)			
Protein	SERUM 7.6	g/dL (6.6-8.7)			
Sodium	SERUM 141	mmol/L (136-145)			
Anion Gap	SERUM 14	mmol/L (7-16)			
GFR Calculated Non-Black	SERUM 105.6	mL/min (60->=60)			
GFR Calculated Black	SERUM 122.1 <i>	mL/min (60->=60)			
Aspartate Aminotransferase	SERUM 20	U/L (0-40)			

		Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
ETG/ETS, UA (250 Cut-Off)					
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250	

		Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Drug Abuse Screen					
Amphetamines	URINE	NEGATIVE <i>		(Negative)	
Barbiturates	URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)	
Cocaine	URINE	NEGATIVE <i>		(Negative)	
Opiates	URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)	
Cannabinoids	URINE	NEGATIVE <i>		(Negative)	
Methadone	URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder; Alcohol Use Disorder; Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will consider pharmacotherapy, psychotherapy

Intervention: increase Lexapro to 20 mg po daily. Counseled pt on risks/benefits and he consented to treatment. Monitor alcohol use.

Measure: gad7, pcl

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: one month

Referrals: pt has therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? Yes
Can Service Member perform MOS duties? Yes

Lab Result Cited by TOBAR.EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyrotropin	SERUM	2.500 <i>	mIU/mL	(0.27-4.2)
Thyroxine Free	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyroxine Free	SERUM	1.28 <i>	ng/dL	(0.93-1.7)

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by TOBAR, EDEN @ 24 Oct 2016 1255 EDT

1. Anxiety disorder, unspecified

Procedure(s): -Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management x 1
Medication(s): -ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF3 Ordered
By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 24 Oct 2016 1256 EDT

Released w/o Limitations

Follow up: month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR, EDEN @ 24 Oct 2016 1136 EDT

Additional A/P Information:

Discontinued ESCITALOPRAM--PO 5MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY DAY IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 24 Oct 2016 1256

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 596

AR 0639

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26078538 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**

Date: **11 Oct 2016 1145 EDT**
Clinic: **GI CL BE**

Appt Type: **T-CON***
Provider: **COPSEY, HELEN C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 11 Oct 2016 1145 EDT
Pt email

Note Written by COPSEY, HELEN C @ 11 Oct 2016 1146 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

October 11th, 2016

To Whom It May Concern,

PO1 Daniel Merwin [REDACTED]/1985) is followed in our clinic for a chronic medical condition that can impact his day to day functioning. Please take this under consideration if/when PO1 Merwin requests reasonable accommodations to his work schedule.

Please feel free to contact me directly with any questions or concerns.

Sincerely,

**COPSEY.HELE
N.CHRISTINA.
1393890351**

Digitally signed by
COPSEY.HELEN.CHRISTINA.13938903
51
DN: c=US, o=U.S. Government,
ou=DoD, ou=PKI, ou=CONTRACTOR,
cn=COPSEY.HELEN.CHRISTINA.13938
90351
Date: 2016.10.11 11:43:25 -0400

Helen Copsey, PA-C
301-400-0552
Helen.C.Copsey.ctr@mail.mil

A/P Last Updated by COPSEY.HELEN C @ 11 Oct 2016 1146 EDT
1. Irritable bowel syndrome with diarrhea

Disposition Last Updated by COPSEY.HELEN C @ 11 Oct 2016 1146 EDT

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 11 Oct 2016 1146

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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AR 0641

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26016255 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2016 1500 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **COPSEY, HELEN C.**

Reason for Appointment:

F/U FOR Helicobacter pylori [H. pylori] as the cause of diseases cla

Appointment Comments:

ame.cc

Vitals**Vitals Written by THOMPSON, DEREK J @ 04 Oct 2016 1454 EDT**

BP: 145/86, HR: 65, RR: 18, T: 98.1 °F, HT: 69 in, WT: 158 lbs, BMI: 23.33, BSA: 1.869 square meters,
 Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 4/10 Moderate, Pain Scale Comments: abd

S/O Note Written by COPSEY, HELEN C. @ 04 Oct 2016 1617 EDT**Reason for Visit**

Visit for: Abdominal pain.

History of present illness

The Patient is a 31 year old male.

31 yo M here for abdominal pain. Reports a long history of GI symptoms, dating back to childhood. Symptoms have been more disruptive over the past few years. Notes generalized sharp abdominal pain about every other day, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft-liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. Reports he has never been formally diagnosed and has not been on treatment for these symptoms. Does consume cheese several times per week, and splenda on a daily basis.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal colitis at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He saw GI earlier this year after he was noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in June.

Allergies

NKDA.

Past medical/surgical history**Reported:**

Past medical history
 Anxiety/depression

Surgical / Procedural: Prior surgery
 Tonsillectomy
 PRK

Medications: Medication history
 Lexapro

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

• Pre-op ASA class 1

Previous therapy

• History of possible limitations and risks do not include complications from anesthesia

Personal history

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Family history

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 599

AR 0642

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

No malignant neoplasm of large intestine
No malignant neoplasm of the gastrointestinal tract.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Otolaryngeal:** No mouth sores.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea.**Gastrointestinal:** No heartburn and no regurgitation. No early satiety, no nausea, no vomiting, no abdominal swelling, no tenesmus, no melena, no hematochezia, and no nocturnal diarrhea.**Musculoskeletal:** No arthralgias, new. No nonspecific pain, swelling, and stiffness.**Skin:** No rash, new.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

Standard Measurements:

° Patient was not observed to be obese.

General Appearance:

° Awake. ° Alert. ° Well developed. ° Well nourished. ° In no acute distress. ° Patient did not appear uncomfortable. ° Not acutely ill. ° Not chronically ill.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Sclera: ° Showed no icterus.

Oral Cavity:

° Normal OP clear, Mallampati score = 1.

Chest:

° Visual inspection revealed no abnormalities.

Lungs:

° Normal CTA B.

Cardiovascular:

° System: normal RRR, no M or G.

Abdomen:

° Normal soft, NT/ND, +BS.

Neurological:

° Level of consciousness was normal. ° Oriented to time, place, and person.

Speech: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Thought Processes: ° Not impaired.

Skin:

° General appearance was normal. ° No jaundice. ° No skin lesions.

Therapy

° Medical regimen review – medication reconciliation performed.

Lab Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1454 EDT**Comprehensive Metabolic Panel** Site/Specimen 16 Feb 2016 1430

Aspartate Aminotransferase SERUM 20

Helicobacter pylori Ag EIA

Order # 160511-04658 (NNMC Bethesda)
 Filler # 160606 NBL 374 (NNMC Bethesda)
 Status: Final
 Ordering Provider: SHAH, NISHA AMISH
 Priority: ROUTINE
 Date Ordered: 11 May 2016 0843
 Date Resulted: 10 Jun 2016 0857
 COLLECT_SAMPLE: STOOL
 Order Comment: to be done two weeks after stopping protonix

BACTERIOLOGY RESULT: OBSERVATION: Negative

Specimen: Feces
 Collected: 06 Jun 2016 1312

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 600

AR 0643

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Results:

Final report

Tissue Exam

Date Collected: 12 Oct 2012 0001
 POC Enc: E4520771
 Enc Fac: WRNMMC
 Clinician: COX, TIFFANY CANDACE
 Status: Certify
 Procedure: TISSUE EXAM
 Order #: 121028-01374
 Provider: COX, TIFFANY CANDACE
 Ordered Date: 28 Oct 2012 1038
 Priority: ROUTINE
 Specimen: TISSUE
 Resulted Date: 28 Oct 2012 1038.1-0500
 121018 NSP 23631 Col: 12Oct12 TISSUE(TISSUE)
 Hcp: COX, TIFFANY CANDACE Req Loc: 5 EAST
 TISSUE E C: RB28Oct12@1038
 CoPath Report
 Patient: MERWIN, DANIEL DENNIS Specimen #: NS12-23631
 Accessioned: 10/18/12
 Pathologist: Ross Barner, COL MC USA
 SPECIMEN:
 A: ascending colon B: sigmoid colon

FINAL DIAGNOSIS:

A. ASCENDING COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATE.

B. SIGMOID COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATES.

Comment: There is no evidence of acute cryptitis, architectural distortion, or dysplasia.
 rxb/10/19/12 ** Report Electronically Signed Out **
 Ross Barner, COL MC USA

CLINICAL DIAGNOSIS AND HISTORY:

with

thickening of ascending colon on ct with no stranding, presented

PRE-OPERATIVE DIAGNOSIS:

obstructive symptoms, rule out mass vs. inflamm.

POST-OPERATIVE DIAGNOSIS:

ascending colon thickening

Operative Findings: sigmoid thickening

Post-operative Diagnosis: sigmoid thickening

GROSS DESCRIPTION:

name

A: The specimen is received in formalin, labeled with the patient's

white

Merwin, Daniel designated, "Ascending Colon" consists of two tan-

irregular soft tissue fragments measuring 0.4 and 0.6 cm in greatest dimension. Submitted entirely. 2/1/ng

name

B: The specimen is received in formalin, labeled with the patient's

irregular

Merwin, Daniel designated, "Sigmoid" consists of four tan-white

soft tissue fragments measuring 0.2 to 0.5 cm in greatest dimension. Submitted entirely. 4/1/ng NW/JAP/DVC
 HLS/meh

Lab Result Cited by COPSEY, HELEN C. @ 04 Oct 2016 1454 EDT

Thyroid Stimulating Hormone

Site/Specimen

06 Sep 2016 0923

Thyrotropin

SERUM

2.500 <i>

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CBC W/Diff	Site/Specimen	22 Jun 2016 1240
WBC	BLOOD	5.6
RBC	BLOOD	4.86
Hemoglobin	BLOOD	15.1
Hematocrit	BLOOD	44.4
MCV	BLOOD	91.4
MCH	BLOOD	31.1
MCHC	BLOOD	34.1
RDW CV	BLOOD	12.9
Platelets	BLOOD	272
MPV	BLOOD	9.0
Neutrophils	BLOOD	59.4
Lymphocytes	BLOOD	29.8
Monocytes	BLOOD	8.9
Eosinophils	BLOOD	1.5
Basophils	BLOOD	0.4
ABS Neutrophils	BLOOD	3.3
ABS Lymphocytes	BLOOD	1.7
ABS Monocytes	BLOOD	0.5
ABS Eosinophils	BLOOD	0.1
ABS Basophils	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED

Comprehensive Metabolic Panel	Site/Specimen	[REDACTED] 2016 1430
Albumin	SERUM	4.7
Alkaline Phosphatase	SERUM	53
Alanine Aminotransferase	SERUM	17
Bilirubin	SERUM	0.4
Urea Nitrogen	SERUM	13.8
Calcium	SERUM	9.7
Carbon Dioxide	SERUM	29
Chloride	SERUM	98
Creatinine	SERUM	0.96
Glucose	SERUM	89
Potassium	SERUM	4.4
Protein	SERUM	7.6
Sodium	SERUM	141
Anion Gap	SERUM	14
GFR Calculated Non-Black	SERUM	105.6
GFR Calculated Black	SERUM	122.1 <i>
Aspartate Aminotransferase	SERUM	20

Rad Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1453 EDT

MERWIN, DANIEL DENNIS 20/[REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M
 ***** MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)
 Event Date: 23-Oct-2012 15:54:00
 Exam #: 12359730
 Exam Date/Time: 02-Nov-2012 07:18:00
 Transcription Date/Time: 05-Nov-2012 09:56:00
 Provider: COPSEY, HELEN C
 Requesting Location:
 GSURG GI APU BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G
Supervised By: MARCIA JAVITT, MD
Approved By: JAVITT, MARCIA C
Approved Date: 05-Nov-2012 09:48:00
Supervised By: 115455 MARCIA JAVITT, MD
Supervised By Date: 05-Nov-2012 09:48:00

Amended Report Text:

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)
 Event Date: 11-Oct-2012 01:30:00
 Exam #: 12343907
 Exam Date/Time: 11-Oct-2012 00:30:00
 Transcription Date/Time: 12-Oct-2012 07:00:00
 Provider: HARDWARE, LESLIE
 Requesting Location:
 EMERGENCY RM BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G
 Supervised By: BERNARD, JACQUELINE, MD, CDR, USN
 Approved By: BERNARD, JACQUELINE M
 Approved Date: 11-Oct-2012 08:16:00
 Supervised By: BERNARD, JACQUELINE, MD, CDR, USN
 Supervised By Date: 11-Oct-2012 08:16:00
 Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12 Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12 Time:08:16

A/P Written by COPSEY, HELEN C @ 04 Oct 2016 1623 EDT

1. Irritable bowel syndrome with diarrhea: Clinical history is consistent with IBS-D. This diagnosis was discussed with the patient in detail and all questions were answered. Goals of management were reviewed including options such as natural interventions/ dietary change/ stress management, all the way to low dose TCA therapy. He v/u and opts to proceed as detailed below.

PLAN:

1. Celiac panel.
2. Strict dairy free trial x 2 weeks.
3. Stop Splenda.
4. Pending progress, consider 2 week course of Xifaxan.
5. F/u with me directly via phone/email/relay health with updates.

Disposition Written by COPSEY, HELEN C @ 04 Oct 2016 1623 EDT

Released w/o Limitations

Follow up: as needed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 04 Oct 2016 1623

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

28 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25944739 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **28 Sep 2016 0930 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 28 Sep 2016 1003 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by HAWKINS, DEREKSHEA J @ 28 Sep 2016 0923 EDT

BP: 139/91, HR: 74, RR: 16, T: 97.6 °F, Pain Scale: 3/10 Mild, Pain Scale Comments: intestinal pain

Appointment Comments:

djs

VitalsVitals Written by HAWKINS, DEREKSHEA J @ 28 Sep 2016 0923 EDT

BP: 139/91, HR: 74, RR: 16, T: 97.6 °F, Pain Scale: 3/10 Mild, Pain Scale Comments: intestinal pain

Note Written by TOBAR, EDEN @ 28 Sep 2016 2152 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #2

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs

UIC: Commander: NIOC Maryland Unit Phone: 3016770217

Deployment Related? No # Deployments: 1 Months Deployed: 36

WTU: No MEB: No AdmSep: No

Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 606

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A

Patient with access to weapons: No

History of Present Illness:

Pt presents for his first follow-up with this provider. At our last meeting we discussed another trial of SSRI for mood and anxiety as he didn't tolerate Zoloft previously; he wanted to think about it. Today he states he continues to feel guilt about how he functions in interpersonal relationships which leads him to feel suicidal. He continues to feel mood lability in the mornings. He is drinking around two glasses of wine per night. He last felt suicidal about two days ago without intent or plan. He continues to have ongoing abdominal pain and is seeing GI about this.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes Yes

Over lifetime, Suicidal Intent? Yes Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Patient denies taking medications/OTC meds/supplements.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4
 Tobacco/e-cigs: none PPD Equivalent:
 Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.
 Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.
 Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.
 Highest level of education achieved is: High School graduate.
 Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.
 Patient reports religion, faith or spirituality DO NOT play an important role in life.
 Social support reported as satisfactory.
 Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure
 Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)
 Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None
 Patient denies treatment team needs to be aware of specific ethnic/cultural issues.
 Learns best by: Pictures. Learning is adversely affected by: None.
 Patient would not like family members involved in care.
 Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.
 Behavior/Orientation: Polite, friendly, and cooperative.
 Abnormal Movements: normal gait. No abnormal movements apparent.
 Rapport: easy to establish
 Speech: normal tone and kinetics
 Mood: mildly anxious
 Affect: full
 Thought Process: circumstantial
 Thought Content: no current SI/HI/AVH
 Judgment: wnl
 Insight: wnl
 Impulsivity: none at time of interview
 Cognition: grossly intact
 Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)
Carbon Dioxide	SERUM	28	mmol/L	(22-29)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i> mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <i>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Alcohol Use Disorder, r/o Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will consider pharmacotherapy, psychotherapy

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Intervention: Start Lexapro 5 mg po daily x 1 week, then increase to 10 mg po daily. Counseled pt on risks/benefits and he consented to treatment. Monitor alcohol use.

Measure: gad7, pcl

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: two weeks with this provider

Referrals: referred to therapist

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

Lab Result Cited by TOBAR, EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyrotropin	SERUM	2.500 <i>	mIU/mL	(0.27-4.2)
Thyroxine Free	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyroxine Free	SERUM	1.28 <i>	ng/dL	(0.93-1.7)

A/P Written by TOBAR, EDEN @ 28 Sep 2016 2153 EDT**1. Anxiety disorder, unspecified**

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1
Medication(s): -ESCITALOPRAM-PO 5MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY DAY IF TO #60 RF1 Ordered By: TOBAR, EDEN
Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 28 Sep 2016 2154 EDT**Released w/o Limitations**

Follow up: 1 month(s) or sooner if there are problems.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 28 Sep 2016 2154

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED. **Page 613**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25742054 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Sep 2016 1517 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T**AutoCites Refreshed by TOBAR, EDEN @ 09 Sep 2016 0839 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Reason for Appointment: Written by TOBAR, EDEN @ 08 Sep 2016 1517 EDT
prolonged non face-to-face servicesS/O Note Written by TOBAR, EDEN T @ 09 Sep 2016 0842 EDT**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: Reviewed pt's previous medical records in AHLTA and HAIMS to assist with diagnostic clarification and for treatment planning.

A/P Written by TOBAR, EDEN @ 09 Sep 2016 0843 EDT**1. Anxiety disorder, unspecified**Disposition Written by TOBAR, EDEN @ 09 Sep 2016 0844 EDT**Released w/o Limitations**Signed By TOBAR, EDEN (Physician/Workstation) @ 09 Sep 2016 0844

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25701481 Primary Dx: Anxiety disorder, unspecified

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 06 Sep 2016 0800 EDT
Clinic: PSYCHIATRY BEAppt Type: SPEC
Provider: TOBAR, EDEN TAutoCites Refreshed by TOBAR, EDEN @ 06 Sep 2016 0905 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Reason for Appointment:

Spec

Appointment Comments:

ssb

Note Written by TOBAR, EDEN @ 08 Sep 2016 1443 EDT**Intake Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment type: [x] Initial evaluation [] Command-Directed [] Special Duty Screen []

Administrative evaluation

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A

Patient with access to weapons: No

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen

Clinician notes for ROS:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Risk Assessment:**C-SSRS Baseline (9/6/2016):** 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?	Yes
Over lifetime, Suicidal Thoughts?	Yes
Over lifetime, Suicidal Thoughts with Method?	Yes
Over lifetime, Suicidal Intent?	Yes
Over lifetime, Suicide Intent with Specific Plan?	Yes
Over lifetime, Suicide Behavior?	Yes
Most recent Suicidal Thoughts/Behaviors?	1-3 months ago
Suicidal Thoughts Duration?	Less than 1 hour
Suicidal Thought Frequency?	Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)

<input checked="" type="checkbox"/> Male	<input type="checkbox"/> History of family/friend suicide
<input type="checkbox"/> Chronic medical conditions	<input checked="" type="checkbox"/> Impulsivity
<input checked="" type="checkbox"/> History of abuse	<input type="checkbox"/> Chronic pain

PROTECTIVE FACTORS (Strengths):

<input type="checkbox"/> Married, children	<input checked="" type="checkbox"/> Active treatment engagement
<input type="checkbox"/> Good coping/problem solving skills	<input checked="" type="checkbox"/> Hopefulness present
<input type="checkbox"/> Faith/religion commitment	<input type="checkbox"/> Positive future orientation

Allergies: nkda**Medications:** Patient denies taking medications/OTC meds/supplements.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, friendly, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:mildly pressured

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen SERUM	14.8	mg/dL	(6-20)	
Carbon Dioxide SERUM	28	mmol/L	(22-29)	
Chloride SERUM	98	mmol/L	(98-107)	
CreatinineSERUM	1.00	mg/dL	(0.7-1.2)	
Glucose SERUM	89	mg/dL	(74-106)	
Potassium SERUM	4.5	mmol/L	(3.5-5.1)	
Sodium SERUM	139	mmol/L	(136-145)	
Calcium SERUM	10.1	mg/dL	(8.6-10.2)	
Anion Gap SERUM	13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4 <i>	mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Test	Site/Specimen	Date	Units	Ref Rng
Lyme Disease Ab Total Screen	SERUM	11 Apr 2016 1043		
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Test	Site/Specimen	Date	Units	Ref Rng
Treponema pallidum Ab	SERUM	11 Apr 2016 1043		
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	SERUM	16 Feb 2016 1430		
Methylmalonate	SERUM	170 nmol/L	0-378	

Test	Site/Specimen	Date	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	16 Feb 2016 1430		
HIV-1/O/2 Ab	SERUM	Negative <r>		

Test	Site/Specimen	Date	Units	Ref Rng
Vitamin B12 (Cyanocobalamin)	SERUM	16 Feb 2016 1430		
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL (211-946)	

Test	Site/Specimen	Date	Units	Ref Rng
Homocysteine	SERUM	16 Feb 2016 1430		
Homocysteine	SERUM	8.9 <i>	mcmol/L (4.0-15.4)	

Test	Site/Specimen	Date	Units	Ref Rng
Comprehensive Metabolic Panel	SERUM	16 Feb 2016 1430		
Albumin	SERUM	4.7 g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM	53 U/L	(40-129)	
Alanine Aminotransferase	SERUM	17 U/L	(0-41)	
Bilirubin	SERUM	0.4 mg/dL	(0.15-1.2)	
Urea Nitrogen	SERUM	13.8 mg/dL	(6-20)	
Calcium	SERUM	9.7 mg/dL	(8.6-10.2)	
Carbon Dioxide	SERUM	29 mmol/L	(22-29)	
Chloride	SERUM	98 mmol/L	(98-107)	
Creatinine	SERUM	0.96 mg/dL	(0.7-1.2)	
Glucose	SERUM	89 mg/dL	(74-106)	
Potassium	SERUM	4.4 mmol/L	(3.5-5.1)	
Protein	SERUM	7.6 g/dL	(6.6-8.7)	
Sodium	SERUM	141 mmol/L	(136-145)	
Anion Gap	SERUM	14 mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	105.6 mL/min	(60->=60)	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

GFR Calculated Black SERUM 122.1 <i> mL/min (60->=60)
 Aspartate Aminotransferase SERUM 20 U/L (0-40)

ETG/ETS, UA (250 Cut-Off) Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Ethyl Glucuronide URINE Negative <i> ng/mL Cutoff=250

Drug Abuse Screen Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Amphetamines URINE NEGATIVE <i> (Negative)
 Barbiturates URINE NEGATIVE <i> (Negative)
 Benzodiazepines URINE NEGATIVE <i> (Negative)
 Cocaine URINE NEGATIVE <i> (Negative)
 Opiates URINE NEGATIVE <i> (Negative)
 Phencyclidine, UA URINE NEGATIVE <i> (Negative)
 Cannabinoids URINE NEGATIVE <i> (Negative)
 Methadone URINE NEGATIVE <i> (Not-Detected)
 Oxycodone URINE NEGATIVE <i> ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Alcohol Use Disorder; r/o Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: diagnostic clarification

Goal: clarify diagnosis

Objective: pt will return for follow-up

Intervention: serial evaluations, chart review, lab evaluation

Measure: pt self-report, rating scales

Problem #2: anxiety

Goal: pt will experience decrease in anxiety

Objective: pt will consider pharmacotherapy, psychotherapy

Intervention: discussed considering alternative SSRI to Zoloft which he didn't tolerate. Will further discuss pharmacotherapy at next visit after eliciting further history. Monitor alcohol use.

Measure: gad7, pci

Problem #3: safety

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: two weeks with this provider

Referrals: refer to therapist at next visit.

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? YesCan Service Member perform MOS duties? YesA/P Last Updated by TOBAR, EDEN @ 08 Sep 2016 1428 EDT**1. Anxiety disorder, unspecified**

Procedure(s): -Psych Ther Indiv Approx 60 Min W/ Medical Evaluation & Management x 1

Laboratory(ies): -T4 FREE (Routine) Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T; THYROTROPIN (Routine) Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR, EDEN @ 08 Sep 2016 1431 EDT**Released w/o Limitations****Follow up:** 2 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By TOBAR, EDEN (Physician/Workstation) @ 08 Sep 2016 1444**CHANGE HISTORY**The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by TOBAR, EDEN @ 08 Sep 2016 1442 EDT:Signed TOBAR, EDEN T (Physician/Workstation) @ 08 Sep 2016 1432

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

25 Aug 2016 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-25603142 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **25 Aug 2016 1000 EDT** Appt Type: **SPEC**
 Clinic: **INTEGRATIVE HLTH & WELL BE** Provider: **JARRETT, ERICA M.**

Reason for Appointment:

counseling

Appointment Comments:

SKJ

S/O Note Written by HICKEY, LINDSEY S @ 25 Aug 2016 1715 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

History of present illness

The Patient is a 31 year old male.

This is the initial visit to the IBHC clinic.

Source of information was self.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Patient was seen by a trainee under the supervision of a licensed mental health professional. Patient indicated an understanding of this.

....

Feeling tired (fatigue).

Decreased appetite.

Decreased concentrating ability.

Sleep disturbances, loss of pleasure, and frequent thoughts of death /morbid ideation.

Previous history of visit is not deployment-related.

Pain Severity 0 / 10.

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Description of Symptoms: Extreme mood swings with depression and anxiety, irritability, concentration problems, poor sleep, fatigue, racing heart and thoughts, trouble relaxing, and worrying. PT reported dry heaving episodes for the past 2 years and pulling the hair off a spot on his scalp since 2008. Several times a week he has a "tingling sensation" with a mood change where he will suddenly smile or frown. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16.

PT reported having passive SI since he was a child. He reported 2 prior suicide attempts when he was in high school: one by overdosing on OTC medicine and one by overdosing on alcohol. His last plan was to overdose on helium before self-referring to substance abuse treatment last year. He last had passive SI ("why even bother") 3 weeks ago, with no plans or intent. PT denied any current SI, plans, or intent.

Duration of Problem: PT has experienced symptoms since his first ship tour in 2006. Symptoms have worsened since he re-enlisted last October.

Factors correlated with onset: Anxiety started after PT joined the Navy in 2006. He regrets re-enlisting last October, and because he waited so long to re-enlist he had last pick for orders. Subsequently he was stationed in the same same environment with the same work stress.

Frequency of symptoms: Symptoms occur every day.

Severity of symptoms: Depression symptoms from PHQ-9 are in the mild range. Anxiety symptoms from GAD-7 are in the moderate range.

Psychosocial factors: Occupational stress and minimal social support.

Aggravating/alleviating factors: Aggravating factors include occupational stress and feeling disconnected from others. Alleviating factors include cooking and programming.

Current tx: None

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Past tx: PT began behavioral health treatment in 2012.

Functional impact: Symptoms negatively impact PT's functioning at home and work.

Anxiety Intervention:

[x] Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).

[x] Developed Crisis Response plan.

[x] Trained in strategies for increasing balanced thinking.

[x] Provided IBHC handout on unhelpful thinking styles.

Current medication

None.

Past medical/surgical history**Reported:**Medical: Reported medical history Irritable bowel syndrome
Parageusia

.....BHM-20 Life Functioning - Severe distress.....

Personal history

Behavioral: Caffeine use 4 cups of coffee per day. No tobacco use history.

Alcohol: Alcohol use 3 days a week, 2 glasses of wine each day.

Review of systems

Neurological: No disorientation.

Psychological: A desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No impulsive behavior.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results: Value

.....PHQ-9 Score This Appointment:..... 8

Test Results: Value

.....BHM-20 Global Mental Health Scale - 1.95

Score:.....

Test Results: Value

.....GAD-7 Score This Appointment:..... 14

Test Results: Value

.....BHM-20 Well-being - 1.33

Score:.....

Test Results: Value

.....BHM-20 Psychological Symptoms - 2.23

Score:.....

Test Results: Value

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 623

AR 0667

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

.....BHM-20 Psychological Symptoms Anxiety - 1.25
 Score:.....

Test Results: Value
BHM-20 Psychological Symptoms Suicide - 3.00
 score:.....

Test Results: Value
BHM-20 Psychological Symptoms - 2.50
 ETOH/Drug Score:.....

Test Results: Value
BHM-20 Psychological Symptoms - 2.17
 Depression Score:.....

Tests: Value
BHM-20 Psychological Symptoms Harm to - 4.00
 Others score:.....

.....BHM-20 Psychological Symptoms Suicide - Low risk

.....BHM-20 Life Functioning Score:.....

.....BHM-20 Global Mental Health Scale - Severe distress.....

.....BHM-20 Well-being - Moderate distress.....

• **DEPRESSION SCREENING / MONITORING (PHQ-9)**

- [1] Little interest or pleasure in doing things
- [1] Feeling down depressed or hopeless
- [0] Trouble sleeping or sleeping too much
- [1] Feeling tired or little energy
- [0] Poor appetite or overeating
- [0] Feeling bad about self
- [3] Trouble concentrating on things
- [2] Moving or speaking slowly or being restless
- [0] Thoughts that you would be better off dead

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [] Somewhat [x] Very [] Extremely

• **Generalized Anxiety Disorder Screening:**

- [3] 1. Feeling nervous, anxious, or on edge
- [2] 2. Not being able to stop or control worrying
- [3] 3. Worrying too much about different things
- [2] 4. Trouble relaxing
- [1] 5. Being so restless that its hard to sit still
- [3] 6. Becoming easily annoyed or irritable
- [0] 7. Feeling afraid as if something awful might happen

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [] Somewhat [x] Very [] Extremely

• **Counseling/Education**

Anxiety Recommendations for patient:

1. Identify and challenge at least one maladaptive thought per day.
2. Engage in at least one enjoyable activity per week.
3. Follow up with outpatient behavioral health.
4. Use crisis response plan if having SI or crisis.
5. RTC if symptoms persist or worsen.

Anxiety Recommendations for PCM Team:

1. Monitor for safety.
2. Monitor symptoms for improvement.

....

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 624

AR 0668

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by HICKEY,LINDSEY S @ 25 Aug 2016 1714 EDT

1. Generalized anxiety disorder: 31yo PT with history of anxiety, depression, and alcohol abuse seen f2f for 30min initial appt. PT presents with sys secondary to occupational stress and limited social support. Sys are consistent with Generalized Anxiety Disorder. PT also has SI history with two previous attempts and one previous plan. PT reported last having passive SI 3 weeks ago with no plan or intent; he denied any current SI, plans, or intent. Developed crisis response plan with PT with triggers, coping skills, and resources for SI or crisis. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16. PT was encouraged to RTC if symptoms persist or worsen. PT appears to be in the preparation stage of change and agreed to implement the recommendations made during today's appt. RTC as needed.

Anxiety Recommendations for patient:

1. Identify and challenge at least one maladaptive thought per day.
2. Engage in at least one enjoyable activity per week.
3. Follow up with outpatient behavioral health.
4. Use crisis response plan if having SI or crisis.
5. RTC in symptoms persist or worsen.

Anxiety Recommendations for PCM Team:

1. Monitor for safety.
2. Monitor symptoms for improvement.

Discussed with LT Hickey and plan reviewed with PT.

Disposition Last updated by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT**Released w/o Limitations****Follow up:** as needed .Signed By JARRETT, ERICA M (Clinical Health Psychologist, NNMC Bethesda, MD) @ 25 Aug 2016 1756**CHANGE HISTORY**The following Disposition Note Was Overwritten by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT:

The Disposition section was last updated by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT - see above. Previous Version of Disposition section was entered/updated by HICKEY,LINDSEY S @ 25 Aug 2016 1715 EDT.

Released w/o Limitations**Follow up:** as needed .

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

23 Jun 2016 at WRNMMC, Int Med CL C Medical Home BE by ATCHERSON, KATHY A

Encounter ID: BETH-24977587 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **23 Jun 2016 1140 EDT**
Clinic: **INT MED MEDICAL HOME CL C**
BEAppt Type: **T-CON***
Provider: **ATCHERSON, KATHY A**
Call Back Phone: [REDACTED]**Reason for Telephone Consult:** Written by ATCHERSON, KATHY A @ 23 Jun 2016 1140 EDT

Emergency room follow up call.

Telephone Consult Comments: Written by ATCHERSON, KATHY A @ 23 Jun 2016 1140 EDT

No answer. Left message for patient to call 301-319-2349 or 301-295-0196 and make an appointment with PCM if further care is needed.

Questionnaire AutoCites Refreshed by ATCHERSON, KATHY A @ 23 Jun 2016 1144 EDT**Questionnaires****A/P** Last Updated by ATCHERSON, KATHY A @ 23 Jun 2016 1145 EDT**1. Encounter for other administrative examinations****Disposition** Last Updated by ATCHERSON, KATHY A @ 23 Jun 2016 1337 EDT**Referred for Appointment****Follow up:** as needed .

Signed By ATCHERSON, KATHY A (Physician/Workstation) @ 23 Jun 2016 1338

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Jun 2016 at WRNMMC, GI Clinic Bethesda by KWOK, RYAN M

Encounter ID: BETH-24961678 Primary Dx: Other chest pain

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **22 Jun 2016 1040 EDT**
Clinic: **GI CL BE**Appt Type: **FTR**
Provider: **KWOK, RYAN MITCHELL**AutoCites Refreshed by SHAH,NISHA A @ 22 Jun 2016 1111 EDT**Allergies**

-OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

f/u

Appointment Comments:

BAR

VitalsVitals Written by THOMPSON,DEREK J @ 22 Jun 2016 1039 EDTBP: 146/87, HR: 74, RR: 14, T: 98.2 °F, HT: 69 in, WT: 165 lbs, SpO₂: 99%, BMI: 24.37,
BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 4/10 Moderate,
Pain Scale Comments: Sharp Pain in Chest when taking deep breaths on inhale.S/O Note Written by SHAH,NISHA AMISH @ 22 Jun 2016 1349 EDT**Chief complaint**

The Chief Complaint is: F/u.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male to f/u for lab results (confirmed h pylori eradication) but states he is having intense chest pain worsened with coughing and breathing right now. Denies n/v/diaphoresis. Denies pain radiating to back/jaw/arm. He is very anxious and concerned and would like to go to ED. Appointment ended at this time.

A/P Last Updated by SHAH,NISHA A @ 22 Jun 2016 1335 EDT**1. Other chest pain R07.89:** Due to lightheadedness/dizziness although stable vital signs and continued chest pain, will send to ED for evaluation. Can f/u in 4 weeks after trial of fodmap as discussed in past. H pylori eradication confirmed.Disposition Written by KWOK,RYAN M @ 23 Jun 2016 1507 EDT**Immediate Referral** - Referred to: ED**Follow up:** 4 week(s) in the GI CL BE clinic or sooner if there are problems. - Comments: Case discussed with GI staff, Dr. Kwok, who agrees with above plan.

Patient was wheelchaired to ED. ED staff was called and case discussed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by KWOK,RYAN M @ 23 Jun 2016 1508 EDT

Pt not seen as triaged to ER prior to my encounter, agree with plan for urgent triage via ER prior to GI evaluation.

Signed By KWOK, RYAN M (Physician, Gastroenterology / Transplant Hepatology Staff, Walter Reed National Military Medical Center) @ 23 Jun 2016 1508

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

15 Jun 2016 at WRNMMC, GI Clinic Bethesda by SHAH, NISHA AMISH

Encounter ID: BETH-24897721 Primary Dx: Encounter for issue of other medical certificate

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 15 Jun 2016 1621 EDT
Clinic: GI CL BEAppt Type: T-CON*
Provider: SHAH,NISHA AMISH

Call Back Phone: [REDACTED]

AutoCites Refreshed by SHAH,NISHA A @ 15 Jun 2016 1621 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by SHAH,NISHA A @ 15 Jun 2016 1621 EDT

Lab results

Questionnaire AutoCites Refreshed by SHAH,NISHA A @ 15 Jun 2016 1621 EDT

Questionnaires

S/O Note Written by SHAH,NISHA AMISH @ 15 Jun 2016 1624 EDT**Subjective**

Called and spoke with patient about results and confirmation of eradication; off PPI for two weeks prior to testing.

A/P Last Updated by SHAH,NISHA A @ 15 Jun 2016 1624 EDT

1. Encounter for issue of other medical certificate Z02.79

Disposition Last Updated by SHAH,NISHA A @ 15 Jun 2016 1624 EDT

Follow up: as needed with PCM.

Signed By SHAH, NISHA A (LCDR MC USN, Physician, Gastroenterology Fellow) @ 15 Jun 2016 1624

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Jun 2016 at WRNMMC, Otolaryngology Clinic Bethesda by XYDAKIS, MICHAEL S

Encounter ID: BETH-24803403 Primary Dx: Unspecified disturbances of smell and taste

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 07 Jun 2016 1300 EDT
Clinic: OTOLARYNG CL BEAppt Type: SPEC
Provider: XYDAKIS, MICHAEL S**Reason for Appointment:**

Unspecified disturbances of smell and taste

Appointment Comments:

emh

S/O Note Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1341 EDT**Chief complaint**

The Chief Complaint is: 31 active duty navy from Ft Meade referred by colleague (dr David Thompson) for dysgusia of approximately 8 months duration. Specifically, patient indicates that on 16 Oct 2015, he was making pizza and noticed the alteration in taste. He presented to his nurse practitioner on 9 Nov 2015 and was referred to ENT. Smell is fine. NO tobacco (social smoker about 9 years ago). Patient does have a h/o alcohol dependence requiring counseling (notes in AHLTA indicate that therapy began in Aug 2014). MRI Brain (15 April 2016) = Normal olfactory eloquent structures.

History of present illness

The Patient is a 31 year old male.

He reported: Past medical history reviewed, problem list reviewed, medication list reviewed, family history reviewed, and surgical history reviewed.

Past medical/surgical history**Reported:**

Recent Events: An active illness Longstanding history of irritable bowel syndrome. History of H. Pylori and GERD (followed by GI).

Physical findings**Neck:**

• Neck: No palpable adenopathy.

Nose:

Right Side Of Nose:

• Examined.

Left Side Of Nose:

• Examined Moderate nasal septal deflection to the left with fracture / dislocation at the bony cartilagenous junction. No infectious, inflammatory nor obstructive pathology noted.

Oral Cavity:

• General condition was good S/p tonsillectomy. + discoloration and brownish/green film noted on posterior 1/3 of the tongue.

Mucosa otherwise pale pink and moist. + discoloration of the teeth.

Tongue: • Mucositis scale.

A/P Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1356 EDT**1. Unspecified disturbances of smell and taste****2. Glossitis**

3. Gastro-esophageal reflux disease without esophagitis: Sniffen extended battery 16 panel odorant test performed. Patient scored 16/16 with rapid, crisp reliable responses. Olfactory threshold testing performed. Patient scored 8/16 which is normal for age. Olfactory discrimination was normal. Burghart taste strips and sprays administered. Patient was able to discern tastes (sweet, salty, sour, bitter) at even the lowest concentrations. Hence, completely normal taste. A/P: Dysgusia due to mild glossitis which is due to GERD up to the level of the hypopharynx and base of tongue. Patient is scheduled to see GI in the next week or so. Likely his symptomatology will resolve once his acid reflux is under control and the tongue is no longer inflamed. Would consider Nystatin or mycelex oral troches. However, it would be preferable to address the underlying cause of the problem (i.e. Acid reflux) and see if the tongue inflammation resolves. Patient understands and agrees with this approach. He will send me an e-mail to assess interval change.

Disposition Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1357 EDT**Released w/o Limitations****Follow up:** as needed .**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Note Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1255 EDT

Consult Order

Referring Provider: THOMPSON, DAVID HERRON

Date of Request: 11 Apr 2016

Priority: Routine

Provisional Diagnosis:

Unspecified disturbances of smell and taste

Reason for Request:

Consult from Dr Thompson to Dr Xydakis: SM with chronic bitter tastes with surgery like foods. Normal ENT exam, Ordered MRI Brain, Please evaluate and treat

Signed By XYDAKIS, MICHAEL S (Physician) @ 07 Jun 2016 1357

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 May 2016 at WRNMMC, GI Clinic Bethesda by LACZEK, JEFFREY T

Encounter ID: BETH-24528671 Primary Dx: Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 11 May 2016 0800 EDT
Clinic: GI CL BEAppt Type: SPEC
Provider: LACZEK, JEFFREY TAutoCites Refreshed by SHAH,NISHA A @ 11 May 2016 0808 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Appointment Comments:

ek/irmac

VitalsVitals Written by THOMPSON,DEREK J @ 11 May 2016 0752 EDTBP: 118/72, HR: 68, RR: 10, T: 98.4 °F, HT: 69 in, WT: 167 lbs, SpO₂: 98%, BMI: 24.66,
BSA: 1.913 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 6/10 Moderate,
Pain Scale Comments: Cramping intermittent pain in the IntestinesS/O Note Written by SHAH,NISHA AMISH @ 11 May 2016 1523 EDT**Chief complaint**

The Chief Complaint is: + h pylori test.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male referred from ENT when during w/u of dysgeusia was found to + serum H pylori Ab and presents for further management. Patient states he has never been treated for h pylori.

He also states that he has had 'ibs pain' since age 15. The pain is in the upper abdomen described as sharp and does not radiate. The pain can last minutes to longer and resolves once he goes to the bathroom having a soft stool; bristol type 5-6. Episodes occur weekly and are triggered by certain foods (spicy foods/fiber filled foods).

Of note, he went to the ED a few years ago for similar abdominal pain, he was then seen in the GI clinic and found to have a normal MRE after initial colonoscopy was concerning for thickened folds. He was lost to follow up.

Heartburn burning sensation - 2x per month, abdominal pain, and diarrhea.

AllergiesAllergies Verified and Updated
NKDA.**Current medication**Including OTCs, vitamins, herbals, supplements, etc.
Albuterol prn

Denies otc/herbals/supplements.

Past medical/surgical history**Reported:**

Medical: Reported medical history

SAR

He denies any other medical issues.

Surgical / Procedural: Surgical / procedural history None.

Personal history

Social history reviewed Denies tob/etoh.

Family historyFamily medical history
No hx of celiac/IBD

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 631

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

No hx of GI malignancies

Mom and grandmother with also 'stomach problems'.

Review of systems**Systemic:** Not feeling tired (fatigue). No fever, no chills, and no night sweats.**Eyes:** No eye pain. No red eyes.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Appetite not decreased. No dysphagia and no pain on swallowing. No nausea, no vomiting, no hematemesis, no jaundice, no bright red blood per rectum, and no constipation.**Musculoskeletal:** No localized joint pain.**Skin:** No rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Neck:

Appearance: • Of the neck was normal.

Eyes:

General/bilateral:

External: • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

• Pharynx: MC3.

Oropharynx: • Normal. • Tonsils showed no abnormalities.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard. • No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2. • No gallop was heard. • No click was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Auscultation: • Bowel sounds were not diminished or absent.

Palpation: • Abdomen was soft. • No abdominal guarding. • Abdominal non-tender Mild ttp in RLQ. • No mass was palpated in the abdomen.

Liver: • Normal to palpation.

Spleen: • Normal to palpation.

Hernia: • No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: • Mobility was not limited.

Neurological:

• Oriented to time, place, and person.

Gait And Stance: • Normal.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Skin:

• Showed no ecchymosis. • Temperature was normal. • No skin lesions.

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

CBC W/o Diff	Site/Specimen	11 Apr 2016 1043
WBC	BLOOD	4.7
RBC	BLOOD	4.88
Hemoglobin	BLOOD	15.4
Hematocrit	BLOOD	45.0
MCV	BLOOD	92.3
MCH	BLOOD	31.5

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 632

AR 0676

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

MCHC	BLOOD	34.1
Platelets	BLOOD	293
RDW CV	BLOOD	13.3
MPV	BLOOD	8.6

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Basic Metabolic Panel	Site/Specimen	11 Apr 2016 1043
Urea Nitrogen	SERUM	9.7
Carbon Dioxide	SERUM	28
Chloride	SERUM	97 (L)
Creatinine	SERUM	0.87
Glucose	SERUM	92
Potassium	SERUM	4.4
Sodium	SERUM	139
Calcium	SERUM	10.2
Anion Gap	SERUM	15
GFR Calculated Non-Black	SERUM	115.0
GFR Calculated Black	SERUM	132.9 <i>

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Helicobacter pylori Ab IgG	Site/Specimen	11 Apr 2016 1043
Helicobacter pylori Ab IgG	SERUM	7.1 (H) <i>

A/P Last Updated by SHAH,NISHA A @ 11 May 2016 1553 EDT

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere B96.81: 31 year old male with incidental finding of h pylori, unlikely related to dysphagia but would be interested at follow up to see if treatment affects symptoms. As it is a carcinogen, would recommend therapy. No exposure to antibiotics in last 6-8 months, will do triple therapy. Patient counseled on importance of compliance as well as confirmation of eradication two weeks after stopping PPI therapy.

Medication(s): -PANTOPRAZOLE--PO 40MG TBDR - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR TWO WEEKS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 -AMOXICILLIN--PO 500MG CAP - TAKE TWO CAPSULE BY MOUTH TWICE A DAY FOR TWO WEEKS #56 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 -CLARITHROMYCIN--PO 500MG TAB - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR FOURTEEN DAYS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 Laboratory(ies): -H PYLORI AG, EIA (Routine): to be done two weeks after stopping protonix Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

2. Irritable bowel syndrome with diarrhea K58.0: No red flags and triggers seem to be primarily food/stress. Will first focus on understanding triggers with food diary and assess if high fodmap (sheet given). After two week of observation, asked that he eliminate one food a week from his triggers. Plan to see back in 6-8 weeks and decide next step in management.

Disposition Last Updated by SHAH,NISHA A @ 11 May 2016 1612 EDT**Released w/o Limitations**

Follow up: 6 to 8 week(s) in the GI CL BE clinic or sooner if there are problems. - Comments: Case discussed with GI staff, Dr. Laczek, who agrees with above plan.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by MCPHERSON,CARL E @ 11 May 2016 0721 EDT**Consult Order**

Referring Provider: THOMPSON, DAVID HERRON

Date of Request: 13 Apr 2016

Priority: Routine

Provisional Diagnosis:

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Reason for Request:

SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.

Note Written by LACZEK,JEFFREY T @ 17 May 2016 1432 EDT**GI Staff**

I saw PO1 Merwin with Dr. Shah. I agree with Dr. Shah's assesment that his dysphagia is unlikely related to his H. pylori infection. I also agree with the plan to treat his H. pylori infection.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By LACZEK, JEFFREY T (Staff Gastroenterologist, WRNMMC Bethesda, MD) @ 17 May 2016 1434

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

22 Apr 2016 at WRNMMC, Medical Readiness Clinic Bethesda by TACKIE, DIANE A

Encounter ID: BETH-24331899 Primary Dx: EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE MEMBER
PERIODIC HEALTH ASSESSMENT
(PHA)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**

Date: **22 Apr 2016 0830 EDT**
Clinic: **MEDICAL READINESS CL BE**

Appt Type: **WELL**
Provider: **TACKIE, DIANE A**

AutoCites Refreshed by TACKIE, DIANE A @ 22 Apr 2016 0942 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

pha/navy

Appointment Comments:

ass4105625345

VitalsVitals Written by WOOTEN, LORI A @ 22 Apr 2016 0911 EDT

BP: 114/73, HR: 72, RR: 14, T: 98.1 °F, HT: 69 in, WT: 170.4 lbs, Uncorr OD: 20/40, Uncorr OS: 20/40, Uncorr OU: 20/40, BMI: 25.16,

BSA: 1.93 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 2 or 3 drinks 2 or 3 times a week, Pain Scale: 0 Pain Free

Comments: PRK 2011

Epworth Study 15 Pt went to Sleep Clinic and was told he didn't meet the threshold to have a sleep study.

Questionnaire AutoCites Refreshed by TACKIE, DIANE A @ 22 Apr 2016 0942 EDT**Questionnaires**

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 22 Apr 2016

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis(i.e. with persistent cough, weight loss, night sweats, and/or fever)? No

2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations? No

3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: N/A

4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No

5. Have you had a prior history of TB or prior treatment for Latent TB?: No

6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No

7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade?: No

8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use?: No

EPWORTH Sleepiness Scale Version: 1 Completed On: 22 Apr 2016

Questionnaire Notes: 15

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Epworth 15: SM has already been seen by PCM and appropriate specialty care for sleep disturbances.

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3
2. How likely are you to doze off or fall asleep while WATCHING TV?: 2
3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 0
4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3
5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 3
6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 0
7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 2
8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 2

S/O Note Written by TACKIE, DIANE A @ 22 Apr 2016 0952 EDT**Chief complaint**

The Chief Complaint is: PHA.

Reason for Visit

Visit for: FACE TO FACE PHA, U.S. NAVY AND HRA REVIEW.

History of present illness

The Patient is a 31 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Past medical history reviewed and problem list reviewed. Medication reconciliation performed. Medication list reviewed, family history reviewed, and surgical history reviewed.

- Military service [] Y [X] N Deployed since previous PHA
 [] Y [X] N Post-Deployment Health Assessment completed
 [] Y [X] N Post-Deployment Health Reassessment completed
 [] Y [X] N Post-Deployment labs/tests completed
 [] Y [X] N Deployment/Shipboard limiting conditions identified.

Patient identified by first and last name as well as DOB. 31yo Male U.S. Navy Active Duty Service Member presents for Face to Face PHA. SM states he is not on Limited Duty or Light Duty Status at the current time. Refer to the A/P section of this SF 600 for HRA documentation.

Past medical/surgical history**PMH DISCUSSED WITH SM**

- Unspecified disturbances of smell and taste, Parosmia: under the care of Otolaryngeal Clinic, last seen 19 April 2016, MRI wnl.
- Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere: referred to GI per ENT Clinic.
- Pain in left ankle and joints of left foot: under the care of Physical Therapy Clinic, last seen 05 April 2016.
- Alcohol dependence, uncomplicated: SM states he has completed treatment. Last seen by BH Clinic last in Feb 2016.

Reported:

- Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No [X] N/A. No allergies – NKDA.
 Surgical / Procedural: Surgical / procedural history – PRK OD/OS 2011.
 Medications: Medication history – SM states he is not taking any medications at the current time.
 Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No
 2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No
 3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No
 4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No
 5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No [X] N/A.

Personal history

Behavioral: No tobacco use.

Alcohol: Alcohol SM reports consuming alcohol 3 times per week with 2-3 drinks per occasion.

Work: Occupation Computer Network Intelligence Analyst, Fort Meade.

Marital: Marital history Single, no children.

Review of systems

Otolaryngeal symptoms– parosmia, taste and smell disturbances

Gastroenterology symptoms– H. pylori positive, heart burn, stomach discomfort

Musculoskeletal symptoms– left foot and ankle pain

Skin symptoms– Anogenital (venereal) warts, being managed by Derm Clinic, last seen 24 Feb 2016

Behavioral Health symptoms– alcohol dependence previous history, resolved.

Systemic: No systemic symptoms.**Head:** No head symptoms.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms.**Pulmonary:** No pulmonary symptoms.**Genitourinary:** No genitourinary symptoms.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 636

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Endocrine: No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Neurological:** No neurological symptoms.**Allergic and Immunologic:** No allergic/immunologic symptoms.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing ? Not tired. ? Clothing was appropriate. ? Grooming was within normal limits.

Head:

Appearance: ° Head normocephalic.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.

Neurological:

° Level of consciousness was normal.

Speech: ° Normal.

Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Affect: ° Normal o Full-ranging. ? Not inappropriate. ? Not labile. ? Congruent with the mood.

Thought Processes: ° Not impaired ? No thought disorder was noted. ? Evaluation of connectedness showed no deficiency. ?

Rate of thought was normal. ? Attention demonstrated no abnormalities.

Thought Content: ° Revealed no impairment ? Insight was intact. ? No suicidal tendency. ? No preoccupation with violent thoughts was observed. ? No homicidal tendencies.

Objective

REVIEWED AHLTA SF 600 PREVIOUS ENCOUNTERS. PAPER/ HARD COPY MEDICAL RECORDS NOT AVAILABLE.

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunizations and Labs [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminate ()

Comments:

Lab Result Cited by TACKIE, DIANE A @ 22 Apr 2016 0946 EDT

HIV-1/O/2 Ab

Site/Specimen

16 Feb 2016 1430

Units

Ref Rng

HIV-1/O/2 Ab

SERUM

Negative <I>

Lab Result Cited by WOOTEN, LORI A @ 22 Apr 2016 0918 EDT

Varicella Virus Ab

Site/Specimen

03 Nov 2005 1849

Varicella Zoster Virus Ab

SERUM

IMMUNE

Lab Result Cited by WOOTEN, LORI A @ 22 Apr 2016 0918 EDT**Chlamydia+Gonococcus DNA Panel NAAT Site/Specimen**

Neisseria gonorrhoeae DNA

URINE

28 Jan 2013 1110

Chlamydia trachomatis DNA

URINE

NEGATIVE FOR N.GONORRHOEAE <I>

NEGATIVE FOR C.TRACHOMATIS <I>

Lab Result Cited by WOOTEN, LORI A @ 22 Apr 2016 0917 EDT**Lipid Panel**

Site/Specimen

10 Apr 2014 0951

Cholesterol

SERUM

208 (H) <I>

Triglyceride

SERUM

158 (H) <I>

HDL Cholesterol

SERUM

64.0 (H)

LDL Cholesterol

SERUM

112 <I>

VLDL Cholesterol

SERUM

32

Cholesterol/HDL Cholesterol

SERUM

3.25

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 637

AR 0681

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lab Result Cited by WOOTEN, LORI A @ 22 Apr 2016 0917 EDT

Varicella Zoster Virus DFA	Site/Specimen	29 Sep 2015 1730
Varicella Zoster Virus Ag	SKIN	NO VZ ANTIGEN DETECTED <i>

Lab Result Cited by WOOTEN, LORI A @ 22 Apr 2016 0917 EDT

Basic Metabolic Panel	Site/Specimen	11 Apr 2016 1043
Urea Nitrogen	SERUM	9.7
Carbon Dioxide	SERUM	28
Chloride	SERUM	97 (L)
Creatinine	SERUM	0.87
Glucose	SERUM	92
Potassium	SERUM	4.4
Sodium	SERUM	139
Calcium	SERUM	10.2
Anion Gap	SERUM	15
GFR Calculated Non-Black	SERUM	115.0
GFR Calculated Black	SERUM	132.9 <i>

Lab Result Cited by TACKIE, DIANE A @ 22 Apr 2016 0859 EDT

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

A/P Last updated by TACKIE, DIANE A @ 22 Apr 2016 1153 EDT**1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225:**

Face to Face PHA completed and updated in MRRS.
 TB Exposure Risk Assessment Questionnaire complete. Medications reconciled.
 Copy of IMR given to SM. Next PHA one year.

MEDICAL READINESS STATUS: Fully Medically Ready.

Reviewed Immunization Records in AHLTA and on IMR, Tdap and Influenza vaccines up to date.

Procedure(s): -(99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): WOOTEN, LORI A

2. Counseling, unspecified Z71.9: SM educated to the PHA visit. Reviewed HRA survey results, discussed, education provided. Epworth Sleepiness Scale review and discussed.

SM educated to Skin Cancer Prevention. To lower your skin cancer risk, protect your skin from the sun and avoid indoor tanning. CDC recommends these easy options:

- Stay in the shade, especially during midday hours.
- Wear clothing that covers your arms and legs.
- Wear sunglasses that block both UVA and UVB rays.
- Use sunscreen with SPF 15 or higher and both UVA and UVB protection.
- Avoid indoor tanning.
- Consider your Skin cancer risk factors: Personal history of skin cancer or precancerous skin lesions, tendency to freckle or burn easily, lots of sun exposure throughout your life, family history of skin cancer
- Perform a thorough skin check regularly, preferably once a month. Do this in a brightly lit room in front of a full-length mirror.

Procedure(s): -(G8420) BMI IS DOC W/IN NORMAL PARAMETERS &NO FOLLOW-UP PLAN IS REQD x 1 ADDITIONAL PROVIDER(S): WOOTEN, LORI A

Patient Instruction(s): -Guidance: Concerns About Stress Management
 -Inquiry And Counseling: Contraceptive Practices
 -Inquiry And Counseling: Family Planning
 -Patient Education - Nutrition
 -Anticipatory Guidance: Food Groups
 -Anticipatory Guidance: Maintaining Healthy Weight
 -Maintain Healthy Diet
 -Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure
 -Parent Education: Avoiding Direct Sun Exposure
 -Avoid Exposure Bright Sunlight

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Written by TACKIE, DIANE A @ 22 Apr 2016 1153 EDT**Released w/o Limitations****Follow up:** as needed with PCM. - Comments: SM to continue to fu with the appropriate specialists for continuity of care.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** TACKIE, DIANE A (Physician Assitant) @ 22 Apr 2016 1154**CHANGE HISTORY***The following A/P Note Was Overwritten by TACKIE, DIANE A @ 22 Apr 2016 0948 EDT:*

The A/P section was last updated by TACKIE, DIANE A @ 22 Apr 2016 0948 EDT - see above. Previous Version of A/P section was entered/updated by WOOTEN, LORI A @ 22 Apr 2016 0920 EDT.

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA)

Procedure(s):

- Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): WOOTEN, LORI A

The following Lab Note Was Deleted by TACKIE, DIANE A @ 22 Apr 2016 0946 EDT:

Note Written by WOOTEN, LORI A @ 22 Apr 2016 0917 EDT

Lab Result

HIV-1/O2 Ab

Site/Specimen

16 Feb 2016 1430

HIV-1/O2 Ab

SERUM

*The following S/O Note Was Overwritten by TACKIE, DIANE A @ 22 Apr 2016 0945 EDT:**S/O Note Written by WOOTEN, LORI A @ 22 Apr 2016 0918 EDT***History of present illness**

The Patient is a 31 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANNED.

Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

[] Y [X] N Deployment/Shipboard limiting conditions identified

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No. An allergy Feathers, Cats.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [] Yes [X] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No.

Physical findings**Vital Signs:**

* Current vital signs reviewed.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

* Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness indeterminate ()

Comments:

Therapy

* Electronic medical alert pendant in possession as indicated.

The following Text Note Was Deleted by WOOTEN, LORI A @ 22 Apr 2016 0923 EDT:

Note Written by WOOTEN, LORI A @ 22 Apr 2016 0923 EDT

You rated your health as **Good**. Personal perception about how healthy you are is usually quite accurate. ; Your Personal Health Risk Appraisal Report identified **3 risk categories** from the answers you provided that relate to overall health, which places you in a **MEDIUM** risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the "low risk" category by reducing the number of behavioral risks, and for those already at low risk, to avoid increasing the number of risk factors over time.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

High Risk	= 5 or more risk categories	You reported 3 categories, which places you at MEDIUM risk. The categories you scored "unhealthy" on included: <ul style="list-style-type: none"> • Stress Management • Sexual Health • Nutrition
Medium Risk	= 3-4 risk categories	
Low Risk	= 0-2 risk categories	

Body Mass Index (Note the limitations of BMI below) ; *Normal Weight* ;;;;
http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

YOUR BODY MASS INDEX = 24.4.

Both being overweight or being underweight are related to increased risk of disease and death. Among most Americans, BMI is a reliable indicator of total body fat. It is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. Limitations of BMI are that it may overestimate body fat in athletes and others who have a muscular build or underestimate body fat in individuals who lack lean muscles mass.

TOBACCO USE; *Never used tobacco* ;;;; <http://www.ucanquit2.org> ; ;

<http://betobaccofree.hhs.gov/>

You are doing the single most important thing to stay healthy! Not smoking saves you money (over \$2000/year for one pack per day), helps you avoid many tobacco related diseases, and adds to your fitness level and overall health.

TOBACCO USE; *Never used tobacco* ;;;; <http://www.ucanquit2.org> ; ;

<http://betobaccofree.hhs.gov/>

Not using smokeless tobacco is a great choice. You can avoid oral cancer, tooth and gum disease, and maintain a fresh and clean mouth.

ALCOHOL USE; *No* ;;;; <http://www.nlm.nih.gov/medlineplus/alcoholconsumption.html>
ALCOHOL USE; *Once or twice per year* ;;;;
<http://www.rethinkingdrinking.niaaa.nih.gov/>

Many Sailors and Marines occasionally drink more heavily than usual during celebrations or special events. Plan ahead to avoid alcohol-related incidents. DUIs will put your career in danger.

ALCOHOL USE; *Never (i.e. not during the past year)* ;;;;
<http://www.rethinkingdrinking.niaaa.nih.gov/>

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol related incidents by looking out for those who try to drink and drive - and help them get home safely.

INJURY PREVENTION; *Always* ;;;; <http://www.nhtsa.gov/Driving+Safety>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

INJURY PREVENTION; *Does not apply to me / None recommended* ;;;; <http://www.nhtsa.gov/Driving+Safety>

If you ride these vehicles in the future, a helmet will provide significant protection against head injury and death. A large portion of medical, disability, and rehabilitation costs from these head injuries are paid for by the general public.

INJURY PREVENTION; *Does not apply to me / None recommended* ;;;; <http://www.cdc.gov/niosh/topics/safety.html>

If you visit work sites, encounter an environmental hazard, or work at home, use appropriate safety equipment

STRESS MANAGEMENT; *Somewhat satisfied* ;;;; <http://www.nlm.nih.gov/medlineplus/stress.html> ;;;; <http://afterdeployment.dcoe.mil>

You are only somewhat satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationships and social activities can all contribute to life satisfaction. Look to these sources for improving your level of satisfaction.

STRESS MANAGEMENT; *Most of the time* ;;;; <http://www.med.navy.mil/sites/nmcscd/nccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx> ;;;; <http://startmovingforward.dcoe.mil>

Long-term and short-term stress in your work or at home may increase your risk of cardiovascular disease and impact on your personal and professional relationships. Problem-solving or discussing possible solutions with someone else may help reduce or eliminate some of your stress.

STRESS MANAGEMENT; *Most of the time* ;;;; <http://www.helpguide.org/topics/relationships.htm> ;;;; <http://afterdeployment.dcoe.mil>

Expressing your feelings can help you see that you are not alone in how you feel. Talking with others can also provide you with strategies to successfully manage your concerns.

SEXUAL HEALTH; *Most of the time* ;;;; http://nationalcoalitionforsexualhealth.org/tools/communicating-to-the-public/document/SexualHealthGuide_national.pdf

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

PHYSICAL ACTIVITY; 3 weeks per month ;;;;<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

To promote and maintain health, all healthy adults aged 18-64 years need moderate-intensity aerobic activity for a minimum of 150 minutes each week or vigorous-intensity aerobic activity for 75 minutes each week. Combinations of moderate- and vigorous-intensity activity can be performed to meet this recommendation. Exercise sessions can be broken up into as little as 10 minutes at a time.

PHYSICAL ACTIVITY; 2 days per week ;;;;<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

Muscle-strengthening activities should work all the major muscle groups of your body (legs, hips, back, chest, abdomen, shoulders, and arms). To gain health benefits, muscle-strengthening activities need to be done to the point where it is hard for you to do another repetition without help. Adding muscle allows you to do more activities, improves appearance, and reduces the risk of several chronic diseases.

NUTRITION; At least 3-5 times per week or more ;;;;<http://www.cdc.gov/nutrition/everyone/basics/fat/index.html>

Some dietary fat is needed for good health, but high levels of fat in your diet may lead to excessive weight gain and increase your risk of certain cancers. Eating foods high in saturated and trans-fats also increases your risk of heart disease. Select foods low in saturated fats, trans fats, and cholesterol; eat plenty of whole grains, fruits and vegetables; and choose low fat milk products and lean meats.

NUTRITION; Less than one ;;;;<http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is to consume at least two servings of fruits per day. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individual's age, gender, and level of physical activity.

SUPPLEMENTS; Seldom ;;;; <http://humanperformancecenter.org/dietary-supplements>

People choosing to supplement their diets with herbals, vitamins, minerals, or other substances need to know about the products they choose so that they can make informed decisions about them. The choice to use a dietary supplement can be a wise decision that provides health benefits. However, under certain circumstances, these products may be unnecessary for good health or they may even create unexpected risks or interact with medications. It is wise to ask your physician or pharmacist before taking supplements.

DENTAL; Daily ;;;; <http://www.ada.org/public.aspx>

You are to be commended for flossing your teeth daily. Daily flossing is recommended

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

to remove plaque and food particles from between the teeth and under the gum line, which prevents gum disease, tooth loss, decay, and bad breath. In addition to flossing, the American Dental Association recommends brushing your teeth twice a day with fluoride toothpaste to achieve good dental health.

NUTRITION; *Two* ;;;; <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is three servings of vegetables per day, with at least one being a dark green or orange vegetable. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help you from chronic diseases and can make make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SLEEP; *Most of the time* ;;;; <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/sleep.aspx>

People who get enough restful sleep are able to concentrate on their activities, have more energy, and generally feel better.

PREGNANCY; *My partner or I are correctly and consistently using birth control ALL the time* ;;;; <http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/contraception.aspx>

There is a wide range of new, safe and effective contraception options available, some that work for years after you have started them. Some are permanent and others are easily and quickly reversible when you are ready to have a baby. But not all forms of contraception are equally effective. It makes sense to carefully consider your parenting plans and get informed about contraception so you and your partner can select the option that works best for you. Be well informed about contraception, and talk with your partner and doctor.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24277977 Primary Dx: Parageusia

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **18 Apr 2016 1344 EDT**
Clinic: **OTOLARYNG CL BE**Appt Type: **T-CON***
Provider: **THOMPSON, DAVID HERRON**

Call Back Phone: [REDACTED]

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 18 Apr 2016 1344 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Note Written by THOMPSON, DAVID HERRON @ 19 Apr 2016 1237 EDTA/P Written by THOMPSON, DAVID HERRON @ 11 Apr 2016 1032 EDT

1. **Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx, prk tooth, admits GI stuff, IBS, ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl, mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvc mobile no edema arytoids

- b12 neg

- HIV neg, 16 Feb 16

- MRI Brain 15 april 16 = normal olfactory nerves and brain

- Trep, lyme, cbc normal

A: ddx olfactory nerve issue, H pylori

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet

2. H pylori

O: positive IGG

A: possible cause of abnormal taste

P: Referred to GI medicine on 13 april

Rad Result Cited by THOMPSON, DAVID HERRON @ 19 Apr 2016 1233 EDT**MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M**

***** MRI, BRAIN W W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, BRAIN W W/O CON
 Event Date: 11-Apr-2016 10:19:00
 Exam #: 16131283
 Exam Date/Time: 15-Apr-2016 04:48:00
 Transcription Date/Time: 15-Apr-2016 08:18:00
 Provider: THOMPSON, DAVID HERRON
 Requesting Location:
 OTOLARYNG CL BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: DEMARCO, JAMES K
 Supervised By: James Demarco K, MD Dept of Radiology
 Approved By: DEMARCO, JAMES K
 Approved Date: 15-Apr-2016 08:18:00
 Supervised By:
 318118 James Demarco K, MD Dept of Radiology

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Supervised By Date: 15-Apr-2016 08:18:00

Amended Report Text:

Brain MRI without and with gadolinium: 04/15/16 04:48:00.

History: 31 y/o M with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad.

Technique: Sagittal T1, axial and coronal T2, axial T2 FLAIR, axial DWI, axial GRE, axial T1, axial post T1 FS, coronal post 3D SPGR of the brain. A total of 16 mL of ProHance was given intravenously as part of the study.

FINDINGS: No focal mass lesion or abnormal enhancement along the expected course of either olfactory bulb or groove is seen. There is normal appearance of both olfactory bulb and nerves.

Acute: No hemorrhage, herniation, or hydrocephalus. No evidence of acute ischemia.

Brain: Brain parenchyma is within normal limits in signal and volume for age.

Vessels: No abnormal intravascular signal to suggest thrombosis. There is note of a tubular enhancing structure posteriorly in the left cerebellar hemisphere compatible with an incidental developmental venous anomaly

Bones: No suspicious lesion in the calvarium or skull base.

Other: Extracranial soft tissues are unremarkable.

IMPRESSION:

1. No enhancing mass lesions along the expected course of either olfactory bulb or groove is seen. Both olfactory bulbs and nerves appear to be normally developed.

2. No intracranial pathology. No abnormal enhancement.

Electronically signed by: Demarco Department of Radiology Walter Reed National Military Medical Center

Date: 04/15/16 Time: 08:18

A/P Written by THOMPSON, DAVID HERRON @ 19 Apr 2016 1251 EDT

1. **Parageusia:** Spoke to patient, no change taste

1. Told MRI brain normal

2. Has appt with GI

3. Will get appt with Dr xydakis

Disposition Written by THOMPSON, DAVID HERRON @ 19 Apr 2016 1252 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 19 Apr 2016 1252

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24217382 Primary Dx: Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 12 Apr 2016 1309 EDT
Clinic: OTOLARYNG CL BEAppt Type: T-CON*
Provider: THOMPSON, DAVID HERRON

Call Back Phone: [REDACTED]

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 12 Apr 2016 1309 EDT

Problems

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- ANXIETY DISORDER NOS
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- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
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- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
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Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

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PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Note Written by THOMPSON, DAVID HERRON @ 13 Apr 2016 0933 EDTA/P Written by THOMPSON, DAVID HERRON @ 11 Apr 2016 1032 EDT**1. Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS , ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvs mobile no edema arytoids

- b12 neg

- HIV neg, 16 Feb 16

- H pylori positive

A: ddx olfactory nerve issue, brain pathology, h pylori, zinc, b12

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet / Refer to Gastroenterology for H pylori Rx

Disposition Written by THOMPSON, DAVID HERRON @ 11 Apr 2016 1034 EDT**Released w/o Limitations****Follow up:** 2 month(s) or sooner if there are problems. - Comments: follow up with Dr Xydakis, c 410 562 5345 w 443 654 5847**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requestedLab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

CBC W/o Diff	Site/Specimen	11 Apr 2016 1043
WBC	BLOOD	4.7
RBC	BLOOD	4.88
Hemoglobin	BLOOD	15.4
Hematocrit	BLOOD	45.0
MCV	BLOOD	92.3
MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	293
RDW CV	BLOOD	13.3
MPV	BLOOD	8.6

Lab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

Basic Metabolic Panel	Site/Specimen	11 Apr 2016 1043
Urea Nitrogen	SERUM	9.7
Carbon Dioxide	SERUM	28
Chloride	SERUM	97 (L)
Creatinine	SERUM	0.87
Glucose	SERUM	92
Potassium	SERUM	4.4
Sodium	SERUM	139
Calcium	SERUM	10.2
Anion Gap	SERUM	15
GFR Calculated Non-Black	SERUM	115.0
GFR Calculated Black	SERUM	132.9 <i>

Lab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

ESR	Site/Specimen	11 Apr 2016 1043
ESR	BLOOD	5

Lab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

Helicobacter pylori Ab IgG	Site/Specimen	11 Apr 2016 1043
Helicobacter pylori Ab IgG	SERUM	7.1 (H) <i>

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 649

AR 0693

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043
Treponema pallidum Ab	SERUM	Negative <i>

Lab Result Cited by THOMPSON, DAVID HERRON @ 13 Apr 2016 0935 EDT

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043
Borrelia burgdorferi Ab	SERUM	Negative <i>

Lab Result Cited by THOMPSON, DAVID HERRON @ 12 Apr 2016 1309 EDT

Helicobacter pylori Ab IgG	Site/Specimen	11 Apr 2016 1043
Helicobacter pylori Ab IgG	SERUM	7.1 (H) <i>

A/P Written by THOMPSON, DAVID HERRON @ 13 Apr 2016 0941 EDT

1. **Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere:** Spoke to patient: has had stomach discomfort and heart burn

1. Told H. Pylori was positive and can cause reflux and throat problems

2. Told to call 301 295 navy for GI consult at WR

3. Told all rest labs are normal

Consult(s): -Referred To: GASTROENTEROLOGY MTF BE (Routine) Specialty: GASTROENTEROLOGY Clinic: GI
CL BE Provisional Diagnosis: Helicobacter pylori [H. pylori] as the cause of diseases classified
elsewhere Order Date: 04/13/2016 09:34

Disposition Written by THOMPSON, DAVID HERRON @ 13 Apr 2016 0942 EDT

Administrative Options: Consultation requested

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 13 Apr 2016 0942

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24134555 Primary Dx: Unspecified disturbances of smell and taste

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 11 Apr 2016 0830 EDT
Clinic: OTOLARYNG CL BEAppt Type: SPEC
Provider: THOMPSON, DAVID HERRON

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 05 Apr 2016 1011 EDT

Problems

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Reason for Appointment:
change in taste**Appointment Comments:**
pb/irmac**Vitals****Vitals Written by** KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

BP: 121/79, HR: 70, RR: 16, T: 98.5 °F, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: 4105625345

nkda

A/P Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1032 EDT**1. Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS , ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvc mobile no edema arytoids

- b12 neg

- HIV neg, 16 Feb 16

A: ddx olfactory nerve issue, brain pathology, h pylori, zinc, b12

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet

Procedure(s): -Fiberoptic Laryngoscopy Flexible (diagnostic) x 1 - After verbal informed consent, topical 4% lidocaine/ afrin mixture was sprayed into the nose bilaterally. The flexible scope was passed through bilateral nares and into hypopharynx with findings as described in above exam. The patient tolerated well without complications.**Note:** Reviewed AHLTA record, and Reviewed with patient: past treatments, laboratory, and Radiological Studies, DDX symptoms, and Planned Management**Laboratory(ies):** -H PYLORI IGG (Routine); ZINC (Routine); BASIC METABOLIC PANEL (Routine); LYME DISEASE AB, TOTAL (Routine); CBC W/O DIFFERENTIAL (Routine); ESR (Routine); TREPONEMA PALLIDUM AB (Routine)**Radiology(ies):** -MRI, BRAIN W W/O CON (Routine) Impression: SM with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad
Comment: Please use gad**Consult(s):** -Referred To: OTOLARYNGOLOGY NCR (Routine) Specialty: OTORHINOLARYNGOLOGY Clinic: RM OTOLARYNGOLOGY IR Provisional Diagnosis: Unspecified disturbances of smell and taste**Disposition Written by** THOMPSON,DAVID HERRON @ 11 Apr 2016 1034 EDT**Released w/o Limitations****Follow up:** 2 month(s) or sooner if there are problems. - Comments: follow up with Dr Xydakis, c 410 562 5345 w 443 654 5847**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Note Written by** KIPTOO,ALEX @ 11 Apr 2016 0907 EDT**Consult Order****Referring Provider:** AUSTIN, MARIE R**Date of Request:** 01 Mar 2016**Priority:** Routine**Provisional Diagnosis:**

change in taste

Reason for Request:

Pt is reporting that all sweet things taste bitter except for artificial sweeteners please eval and treat

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 11 Apr 2016 1035

CHANGE HISTORY

The following Vitals Entry Was Overwritten by KIPTOO,ALEX @ 11 Apr 2016 0909 EDT:

Vitals Written by KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 653

AR 0697

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

05 Apr 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-24131043 Primary Dx: Pain in left ankle and joints of left foot

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **05 Apr 2016 0830 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **FTR**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J @ 05 Apr 2016 0835 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAHR, ROBERT J. @ 05 Apr 2016 0858 EDT**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pain decreases with foot into the neutral position. He states he uses no meds--see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, everters, inverters 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain is now gone. He is training for a marathon and is up to running 25 miles per week. Pt does not want his foot examined today. Plan: discharge PT. F/U pm.

A/P Written by BAHR, ROBERT J @ 05 Apr 2016 0900 EDT**1. Pain in left ankle and joints of left foot**

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAHR, ROBERT J @ 05 Apr 2016 0900 EDT**Released w/o Limitations**Signed By BAHR, ROBERT J (Physical Therapist, wrnmmc) @ 05 Apr 2016 0900

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Mar 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-23804906 Primary Dx: Pain in left ankle and joints of left foot

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Mar 2016 0830 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **FTR**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J @ 07 Mar 2016 0823 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAHR, ROBERT J. @ 07 Mar 2016 0909 EDT**History of present illness**

The Patient is a 31 year old male.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs. Pain decreases with foot into the neutral position. He states he uses no meds—see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, everters, inverters 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain has decreased and his strength is good. Exercise causes pain laterally while doing the exercises but he feels better afterwards. He rates his pain at 1/10 at rest and 3/10 with activity. Pt to do saphenous and peroneal nerve glides throughout the day and to return in two to three weeks for followup.

A/P Written by BAHR, ROBERT J @ 07 Mar 2016 0912 EDT

1. Pain in left ankle and joints of left foot

Procedure(s): -Physical Therapy: ___ Session Segments, 15 Minutes Each x 1
-Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAHR, ROBERT J @ 07 Mar 2016 0912 EDT

Released w/o Limitations

Signed By BAHR, ROBERT J (Physician) @ 07 Mar 2016 0913

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-23726066 Primary Dx: Parageusia

Patient: MERWIN, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 29 Feb 2016 0849 EST
 Clinic: INT MED MEDICAL HOME CL C
 BE

Appt Type: T-CON*
 Provider: AUSTIN, MARIE

Call Back Phone: [REDACTED]

AutoCites Refreshed by AUSTIN, MARIE @ 29 Feb 2016 1704 EST

Allergies

•OTHER: Unknown (SEE MED RECORD)

Other PMHs

No Other PMHs Found.

Social History

No Social History Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015- 16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Labs

16 Feb 2016 1430 Methylmalonic Acid Methylmalonate	Site Specimen SERUM	Result 170	Units nmol/L	Ref Range 0-378
16 Feb 2016 1430 HIV-1/O/2 Ab HIV-1/O/2 Ab	Site Specimen SERUM	Result *****	Units	Ref Range
16 Feb 2016 1430 Vitamin B12 (Cyanocobalamin) Vitamin B12 (Cobalamins)	Site Specimen SERUM	Result 293 <i>	Units pg/mL	Ref Range (211-946)
16 Feb 2016 1430 Homocysteine Homocysteine	Site Specimen SERUM	Result 8.9 <i>	Units mcmol/L	Ref Range (4.0-15.4)
16 Feb 2016 1430 Comprehensive Metabolic Panel Albumin	Site Specimen SERUM	Result 4.7	Units g/dL	Ref Range (3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 658

AR 0702

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

02 Feb 2016 1406

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site Specimen
URINEResult
negative <i>Units
ng/mLRef Range
Cutoff=250

02 Feb 2016 1406

Drug Abuse Screen

Site Specimen

Result

Units

Ref Range

Amphetamines

URINE

negative <i>

(Negative)

Barbiturates

URINE

negative <i>

(Negative)

Benzodiazepines

URINE

negative <i>

(Negative)

Cocaine

URINE

negative <i>

(Negative)

Opiates

URINE

negative <i>

(Negative)

Phencyclidine, UA

URINE

negative <i>

(Negative)

Cannabinoids

URINE

negative <i>

(Negative)

Methadone

URINE

negative <i>

(Not-Detected)

Oxycodone

URINE

negative <i>

ng/mL

(Negative)

Rads

MERWIN, DANIEL DENNIS [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M

***** ANKLE, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: ANKLE, LT 3 VIEWS

Event Date: 16-Feb-2016 14:07:00

Exam #: 16054521

Exam Date/Time: 16-Feb-2016 14:10:00

Transcription Date/Time: 16-Feb-2016 14:55:00

Provider: WILSON, BRYAN JAMES

Requesting Location:

INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: FISHER, ZACHARY ETHAN

Supervised By:

ZACHARY E FISHER, MAJ, MC, Dept of Radiology

Approved By: FISHER, ZACHARY ETHAN

Approved Date: 16-Feb-2016 14:54:00

Supervised By:

92925 ZACHARY E FISHER, MAJ, MC, Dept of Radiology

Supervised By Date: 16-Feb-2016 14:54:00

Amended Report Text:

Comparison: MRI October 5, 2014 and prior radiographs May 6, 2014

Findings: Routine radiographs of the ankle were obtained. Normal alignment is present without evidence for acute fracture or dislocation. There is mild lateral soft tissue swelling present. The ankle mortise and talar dome are intact. The joint spaces are preserved without significant degenerative changes.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Impression: Lateral soft tissue swelling without evidence for acute bony abnormality

Electronically signed by: Dr. ZACHARY ETHAN FISHER Department of Radiology Walter Reed National Military Medical Center

Date: 02/16/16 Time: 14:54

Reason for Telephone Consult: Written by CONRAD, ALLEN C @ 29 Feb 2016 0849 EST

Call pt with test results

Telephone Consult Comments: Written by CONRAD, ALLEN C @ 29 Feb 2016 0849 EST

Pt called this morning requesting Ms. Austin give him a call to discuss test results. Direct number at work is 443-654-5847

Questionnaire AutoCites Refreshed by AUSTIN, MARIE @ 29 Feb 2016 1704 EST

Questionnaires

A/P Written by AUSTIN, MARIE @ 01 Mar 2016 1234 EST

1. Parageusia R43.2

Consult(s):

-Referred To: OTOLARYNGOLOGY NCR (Routine) Specialty: OTORHINOLARYNGOLOGY Clinic: RM
OTOLARYNGOLOGY IR Provisional Diagnosis: change in taste Order Date: 03/01/2016 12:34

Disposition Written by AUSTIN, MARIE @ 01 Mar 2016 1234 EST

Follow up: as needed . - Comments: pt to f/u as discussed with ENT

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 01 Mar 2016 1234

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 660

AR 0704

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

24 Feb 2016 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL

Encounter ID: BETH-23687169 Primary Dx: Anogenital (venereal) warts

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 24 Feb 2016 1300 EST
Clinic: DERMATOLO CL BEAppt Type: SPEC
Provider: MARQUART, JASON DANIEL**Reason for Appointment:**

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

Note Written by LAM, THOMAS KIN @ 24 Feb 2016 1329 EST

CC: Genital warts

HPI: 31 yo man who was referred here by PCM for further evaluation and/or management of warts on penis not responsive to topical Aldara.

Hx of skin cancer: None ☒ BCC ☐ SCC ☐ MM ☐

Family Hx of melanoma: None

Drug Allergies: None

Medication list reviewed ☒

Pain (10-pt scale): 0

Tobacco Use: Y ☐ N ☐Alcohol Use: Y ☐ N ☐**OBJECTIVE:**Fitzpatrick Type: I ☐ II ☒ III ☐ IV ☐ V ☐ VI ☐

Standby: N/A

A focused skin exam was notable for the following:

1. Scattered (~10) skin-colored, verrucous papules on the dorsal penis.

A/P Last Updated by LAM, THOMAS KIN @ 24 Feb 2016 1330 EST**1. Anogenital (venereal) warts:** Lesions on exam c/w warts. Treated today with LN2. Will give Condylox for continued Tx at home. Also counseled Pt on wart clinic on Thursday mornings. Pt voiced understanding and agreement.

Procedure(s): -Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent was received and cryo applied to lesions in standard fashion. Tx was applied in a pulsed fashion to minimize collateral tissue injury. Pt was instructed to use Vaseline ointment to the area(s) until healed. Pt tolerated the procedure well and left in stable condition.

Medication(s): Locations: DORSAL PENIS x8
-PODOFILOX-TOP 0.5% SOLN - APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #1 RF2

Disposition Last Updated by LAM, THOMAS KIN @ 24 Feb 2016 1330 EST

Released w/o Limitations

Note Written by LAM, THOMAS KIN @ 24 Feb 2016 1324 EST

Consult Order

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 661

AR 0705

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Referring Provider: WILSON, BRYAN J
Date of Request: 16 Feb 2016
Priority: Routine

Provisional Diagnosis:

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

1mm x 1mm papules at base of penis previously treated empirically for genital warts, did not respond to Imiquimod. Skin changes are very limited, may be physiologic. Please evaluate and treat.

Note Written by MARQUART, JASON DANIEL @ 24 Feb 2016 1404 EST

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service) @ 24 Feb 2016 1404

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

19 Feb 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-23626266 Primary Dx: Acquired absence of right leg below knee

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **19 Feb 2016 0645 EST**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **SPEC**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J. @ 19 Feb 2016 0928 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	17 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment:

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

S/O Note Written by BAHR, ROBERT J. @ 19 Feb 2016 0912 EST**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 663

AR 0707

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs. Pain decreases with foot into the neutral position. He states he uses no meds—see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, everters, inverters 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good.

A/P Written by BAHR, ROBERT J @ 19 Feb 2016 0930 EST**1. Acquired absence of right leg below knee**

Procedure(s): -Physical Therapy Service Evaluation x 1
 -Physical Therapy: ___ Session Segments, 15 Minutes Each x 1

Disposition Written by BAHR, ROBERT J @ 19 Feb 2016 0930 EST
Released w/o Limitations

Note Written by HARMON, DAVID JR @ 19 Feb 2016 0703 EST**Consult Order**

Referring Provider: WILSON, BRYAN J
Date of Request: 16 Feb 2016
Priority: Routine

Provisional Diagnosis:

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On light duty 30 days. Needs eval and likely graduated exercise.

Signed By BAHR, ROBERT J (Physical Therapist, wrmmmc) @ 19 Feb 2016 0931

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Feb 2016 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-23591652 Primary Dx: Encounter for issue of repeat prescription

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **16 Feb 2016 1438 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **ZEMBRZUSKA, HANNA
DOMINIKA**
Call Back Phone: [REDACTED]AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1438 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs**02 Feb 2016 1406**
ETG/ETS, UA (250 Cut-Off)
Ethyl Glucuronide**Site Specimen**
URINE**Result**
negative <i>**Units**
ng/mL**Ref Range**
Cutoff=250**02 Feb 2016 1406**
Drug Abuse Screen**Site Specimen****Result**
negative <i>**Units****Ref Range**
(Negative)Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Opiates
Phencyclidine, UA
Cannabinoids
Methadone
OxycodoneURINE
URINE
URINE
URINE
URINE
URINE
URINE
URINEnegative <i>
negative <i>
negative <i>
negative <i>
negative <i>
negative <i>
negative <i>
negative <i>

ng/mL

(Negative)
(Negative)
(Negative)
(Negative)
(Negative)
(Negative)
(Negative)
(Not-Detected)
(Negative)**Rads**

No Rads Found.

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST**Subjective**

Contacted pt for checkup; has not been seen in clinic for a few months. Left VM at [REDACTED] number. Other number - cell 850 410 1041 has been disconnected.

A/P Last Updated by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST**1. Encounter for issue of repeat prescription Z76.0**Disposition Last Updated by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 16 Feb 2016 1440

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by WILSON, BRYAN J

Encounter ID: BETH-23581847 Primary Dx: Sprain of other ligament of left ankle, subsequent encounter

Patient: MERWIN, DANIEL DENNIS Date: 16 Feb 2016 0950 EST Appt Type: FTR
 Treatment Facility: WALTER REED Clinic: INT MED MEDICAL HOME CL C Provider: WILSON, BRYAN JAMES
 NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: Outpatient

Reason for Appointment:

Ankle - Extreme pain from previous injury location

Appointment Comments:

Appt self-booked via TOL

Injury/Accident Written by WILSON, BRYAN J @ 16 Feb 2016 1926 EST**Injury Cause/Activity:** W01.0XXD Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter**Date of Injury/Accident:** 16 Feb 2014**Place of Occurrence:** Y92.9 Unspecified place or not applicable**Injury Category for Compensation Code(s):** OA-Other Accident**Vitals****Vitals** Written by WOODS, CHARLENE N @ 16 Feb 2016 1018 ESTBP: 129/80, HR: 78, RR: 20, T: 98.1 °F Oral, HT: 69 in, WT: 175 lbs, SpO₂: 97%, BMI: 25.84, BSA: 1.952 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 3/10 Mild, Pain Scale Comments: LEFT ANKLE**S/O Note** Written by WILSON, BRYAN JAMES @ 16 Feb 2016 1911 EST**Chief complaint**

The Chief Complaint is: Ankle pain.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31M PMH s/f L ankle sprain and GAD in clinic for multiple c/o. 1.) Last 1 mo developed L ankle pain same distribution as ankle sprain 2 yr ago. Initially tripped in hole when playing softball, extensive swelling, bleeding into foot. Underwent physical therapy, fitted for brace. Plain films X2 negative for fx. MRI demonstrates thickening at anterior talofibular joint. Pt subsequently passed multiple PRTs. Now, getting back into shape for upcoming PRT, has developed pain at same site, mild swelling, crepitus. No known reinjury. Currently 2/10 pain, max 4/10. Exacerbated by rolling the ankle and walking. Has not taken any medications for it. 2.) C/o genital warts. Last seen by Marie Austin 9/2015. Was prescribed Imiquimod then 2nd course but no resolution of skin changes. Pt states he has had at least 150 lifetime sexual partners, decreased number of partners recently but using condoms only about 90% of the time. No other lesions. Did not have the Gardasil vaccine. 3.) Saw Marie Austin for dysgeusia 10/2015. At this time he had come off his Zoloft rapidly, did not taper, and his sx were attributed to w/d. He was sent to psychiatry, and restarted on low-dose 25 then tapered to 12.5 and off. The medication changes have not affected his taste, sx persist. In general what used to taste sweet now tastes bitter. Some savory foods also taste bitter. Of note: has low-normal B12. No nasal congestion. Has intact olfaction. No GERD. No change to urine output/appearance. No abdominal pain.

Current medication

Including OTC meds, vitamins, herbals, etc.

Sertraline 25mg daily followed by weaning to 12.5mg daily then off

Melatonin qhs prn

ALL

NKDA.

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

H/o childhood asthma.

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 666

AR 0710

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Personal history

Social history reviewed

Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Physical findings**General:**

• Physical examination GEN: WNWD, no acute distress

HEENT: MMM, no scleral icterus

HEART: RRR, no m/g/r

LUNGS: CTAB

ABD: NABS, soft, NTND, no HSM

EXT: Mild swelling, pain on extreme inversion, plantar flexion and dorsiflexion L ankle; no joint laxity

GENITAL: 1x1mm papules vs. nodule maximum 3-5 at base of penis, no inflammatory changes, no discharge

NEURO: No focal neurologic deficits appreciated.

Practice Management

Preventive medicine services.

A/P Last Updated by WILSON,BRYAN J @ 16 Feb 2016 1940 EST

1. Sprain of other ligament of left ankle, subsequent encounter: Reinjury vs. subtalar OA 2/2 original sprain. Repeat plain films today and restart physical therapy. 30 days light duty until eval by physical therapy. O/w Motrin and graduated exercise. Continue brace. No role for MRI or ortho referral at this time.

Medication(s): -IBUPROFEN-PO 800MG TAB - TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED

FOR PAIN #60 RFO Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Radiology(ies): -ANKLE, LT 3 VIEWS (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Consult(s): -Referred To: PHYSICAL THERAPY MTF BE (Routine) Specialty: THERAPY, PHYSICAL Clinic: PHYS THERAPY CL BE Provisional Diagnosis: Sprain of other ligament of left ankle, subsequent encounter

Ordered By: WILSON,BRYAN J Ordering Provider: WILSON,BRYAN JAMES

Injury -W01.0XXD Fall on same level from slipping, tripping and stumbling without subsequent striking against

Cause(s)/Activity(ies): object, subsequent encounter

2. Other skin changes: Skin changes very limited, and the tiny papules may be physiologic. Did not respond to Imiquimod.

Referral to derm for possible bx vs. reassurance vs. tew bx.

Consult(s): -Referred To: DERMATOLOGY MTF BE (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL BE Provisional Diagnosis: Sprain of other ligament of left ankle, subsequent encounter Ordered By: WILSON,BRYAN J Ordering Provider: WILSON,BRYAN JAMES

3. Parageusia: Did not respond to change in SSRI. Ddx is broad. Given his sexual hx, will draw CMP for possible hepatitis, HIV.

Consider electrolyte abnormalities. Also has low-nl B12. Change may be manifestation of tongue enlargement. B12, MMA, homocysteine today.

Laboratory(ies): -HIV-1/O/2 (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; VITAMIN B12 (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; METHYLMALONATE, SERUM (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; HOMOCYSTEINE (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; COMPREHENSIVE METABOLIC PANEL (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Radiology(ies): -ANKLE, LT 3 VIEWS (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Disposition Last Updated by WILSON,BRYAN J @ 16 Feb 2016 1941 EST**Released w/ Work/Duty Limitations****Administrative Options:** Consultation requested**Note Written by RITTER,JOAN B @ 21 Feb 2016 2305 EST****Co-signer Note**

Case discussed with resident. Agree with assessment and plan as above.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By **WILSON, BRYAN JAMES** (Physician) @ 16 Feb 2016 1941
Co-Signed By **RITTER, JOAN B** (Physician) @ 21 Feb 2016 2305

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

04 Feb 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23502474 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **04 Feb 2016 1345 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P**Reason for Appointment:
SARP/LABSAppointment Comments:
TSB**Lab Result Cited by AILOR, LYNNE P @ 05 Feb 2016 1521 EST**

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 05 Feb 2016 1523 EST1. **Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative, Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 05 Feb 2016 1523 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By AILOR, LYNNE P (Physician) @ 05 Feb 2016 1524**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

02 Feb 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23453438 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **02 Feb 2016 1208 EST**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY**
NAVY YARD
 Patient Status: **Outpatient**

Appt Type: **GRP**
 Provider: **BROWN, CYNTHIA E**

AutoCites Refreshed by BROWN, CYNTHIA E @ 03 Feb 2016 1448 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 02 Feb 2016 1208 EST
 CC GROUP/ CLOSE OUT

Screening Written by MAPLES, MICHAEL J @ 02 Feb 2016 1237 EST**Reason For Appointment:** Notes Entered by: MAPLES, MICHAEL J 02 Feb 2016 1208

CC GROUP/ CLOSE OUT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**

Vitals Written by MAPLES, MICHAEL J @ 02 Feb 2016 1237 EST
 Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 670

AR 0714

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Comments: LAUNGUAGE: ENGLISH
NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by BROWN,CYNTHIA E @ 03 Feb 2016 1448 EST

Reason for Visit

CC Group/Individual.

A/P Last Updated by MAPLES,MICHAEL J @ 02 Feb 2016 1238 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN,CYNTHIA E @ 03 Feb 2016 1457 EST

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP
Daniel arrived on time for group. Daniel is at session #26 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No one in group admitted to drinking or abusing drugs since we last saw them. The facility was closed down last week due to weather so it was 2 weeks since we had seen any of them. The group shared the stress and struggles they have had over the past 2 weeks focusing on if there was a trigger to drink or if they would have in the past. Group closed with a group member sharing one constructive thing the person can do for a better sober lifestyle. Daniel stated that his snow days were on the mountain snowboarding. He stated that he is working to be more social. He shared that he really did not have triggers to drink. He shared with an angry that he was given the tool to see he also makes mistakes. He does not get as angry or for as long if he just can bring to mind the times he has done the thing he is getting mad at. He closed with the group hearing he appears to have made positive changes in his life and his behavior reflects it. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has completed his ITP. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is not scheduled to return and this record is CLOSED.

No evidence of SI/HI during this encounter
Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by BROWN,CYNTHIA E @ 03 Feb 2016 1448 EST

INDIVIDUAL SESSION CC

Daniel arrived Daniel is at session 26 of the 26 scheduled sessions of the Continuing Care treatment program attending from 1400 to 1500, total of 1 hour. Daniel reported the Continuing Care group was helpful in keeping him from drinking. He did state that his has learned the CBT to be the best therapy for him. He shared how he dealing with life better now that he has stopped drinking. He stated that he continues to use his CBT on situations that baffle him. He stated that he will be getting a new roommate. He does see that drinking will be an issue with either of them because they have both been through this program. We reviewed his treatment plan. He cancelled Problem #1 Objectives#7 and 8 because he knows what to do and has heard enough that he could have a sponsor if he wanted one, but he does not. He stated an understanding that he would not be allowed to abuse alcohol again while on active duty and the Navy would like for him to have an alcohol abstinent lifestyle. He does not see where that is a problem for him. Daniel closed his entire open treatment plan Objectives in preparation of closing with this program. Daniel is staying for group today.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 03 Feb 2016 1457

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

19 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23336071 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS

Date: 19 Jan 2016 1208 EST

Appt Type: GRP

Treatment Facility: NBHC WASHINGTON

Clinic: SUBST ABUSE NY

Provider: BROWN,CYNTHIA E

NAVY YARD

Patient Status: Outpatient

AutoCites Refreshed by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by BROWN,CYNTHIA E @ 19 Jan 2016 1208 EST
CC Group/Individual

Screening Written by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST

Reason For Appointment: Notes Entered by: BROWN,CYNTHIA E 19 Jan 2016 1208

CC Group/Individual

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 673

AR 0717

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact Number: [REDACTED]

No vitals taken at SARP treatment

S/O Note Written by BROWN,CYNTHIA E @ 19 Jan 2016 1445 ESTReason for Visit

CC Group/Individual.

A/P Last Updated by BROWN,CYNTHIA E @ 19 Jan 2016 1449 EST**1. Alcohol dependence, uncomplicated**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - Patient attended group from 1230 to 1400 today.
 -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 1100 to 1200 to review and update his treatment plan.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 28 Jan 2016 1325 ESTReleased w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD NOTE SECTION FOR THE INFORMATION ON THIS ENCOUNTER.

Note Written by BROWN,CYNTHIA E @ 28 Jan 2016 1325 EST**INDIVIDUAL SESSION CC Urine test**

Daniel arrived on time to his individual session. He is at session 25 of the 26 scheduled sessions of the Continuing Care treatment program attending from 1100 to 1210, total of 1 hour. He shared how stressful it has been having 4 people in his apartment. He described needing his down time and would go into his walk-in closet to be by himself. He began to describe at length how he was delegating these duties as all 4 of them are partners in his business. When asked if this made him want to drink he responded that the thoughts were there but he would not call them cravings. He shared that drinking would not be the answer for him. He did state that he met a woman not on line. She is a professor and he believes she is interested in having sex with him. He stated that they have not had sex yet. He believes this is a huge step in the right direction for him but he does not see them having a long term relationship. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the day. Daniel extended Problem #1, Objectives #1-4, 6, 7, and 9 to 26 January 2016 and he cancelled Objective #8 as he knows how to get a sponsor already

Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #1-4, 6, 7, and 9 due 26 January 2016. Daniel is schedule to stay for group today.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

CC GROUP

Daniel stayed for group after his individual session. Daniel is at session # 25 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Foul weather and base closure guidelines were discussed. The infections illness of this season was also discussed. Each member was encouraged that if they were contagious they should call their sponsors and let them know why they will not be in group. They were instructed to not come to group is contagious. The group conducted check in process describing if they any thoughts to drink or triggers for

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

relapse. Three members of the group admitted to having fleeting thoughts of drinking during their time from the last group they attended. All group members denied drinking or abusing drugs. Daniel shared that he went snowboarding with some men from work. He met them on the mountain and did the slopes for about half of the day. He shared that it was different because he was not in his own zone with just music in his ears. He shared with the group that he has 4 people in his 1 bedroom apartment right now and they have been for the past 2 weeks. He stated that they are connected to his business. He has found that it was over stimulation for him and he would retreat to closet. He shared they are dirty people but admitted that he was a clean person and will take 2 showers a day. He said that they were flying back to their own homes tomorrow and he just couldn't wait. He stated to the group that he bought a house because he has orders to the same duty station. Daniel did appear to stay on point for most of group today which shows respect for group members and progress for him. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel updated his treatment plan before group. See ADD NOTE section of this encounter for that information. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #1, 2, 3, 4, 6, 7, and 9 due 26 January 2016. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 26 January 2016 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 28 Jan 2016 1327

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

13 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23294815 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **13 Jan 2016 1445 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**
SARP/LABS**Appointment Comments:**
TSB**Lab Result Cited by AILOR, LYNNE P @ 13 Jan 2016 1533 EST**

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	05 Jan 2016 1402	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 13 Jan 2016 1535 EST**1. Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. Result of ETG/ETS was negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 13 Jan 2016 1535 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By AILOR, LYNNE P (Physician) @ 13 Jan 2016 1535**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23235227 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **08 Jan 2016 0830 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 08 Jan 2016 0848 EST

Drug Abuse Screen	Site/Specimen	05 Jan 2016 1402	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

A/P Written by AILOR, LYNNE P @ 08 Jan 2016 0849 EST**1. Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 08 Jan 2016 0850 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up in SARP.**Signed By AILOR, LYNNE P (Physician) @ 08 Jan 2016 0850**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23202652 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NHC QUANTICO
Patient Status: OutpatientDate: 06 Jan 2016 1500 EST
Clinic: BEHAVIORAL HEALTH QUAppt Type: PROC
Provider: AILOR, LYNNE PReason for Appointment:
SARP/LABS
Appointment Comments:
TSB**Lab Result Cited by AILOR, LYNNE P @ 06 Jan 2016 0731 EST**

Drug Abuse Screen	Site/Specimen	29 Dec 2015 1405	Units	Ref Rng
Amphetamines	URINE	NEGATIVE < >		(Negative)
Barbiturates	URINE	NEGATIVE < >		(Negative)
Benzodiazepines	URINE	NEGATIVE < >		(Negative)
Cocaine	URINE	NEGATIVE < >		(Negative)
Opiates	URINE	NEGATIVE < >		(Negative)
Phencyclidine, UA	URINE	NEGATIVE < >		(Negative)
Cannabinoids	URINE	NEGATIVE < >		(Negative)
Methadone	URINE	NEGATIVE < >		(Not-Detected)
Oxycodone	URINE	NEGATIVE < >	ng/mL	(Negative)

A/P Written by AILOR, LYNNE P @ 06 Jan 2016 0733 EST1. **Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 06 Jan 2016 0733 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up in SARP.**Signed By AILOR, LYNNE P (Physician) @ 06 Jan 2016 0733**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

05 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23195319 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS

Date: 05 Jan 2016 1230 EST

Appt Type: GRP

Treatment Facility: NBHC WASHINGTON

Clinic: SUBST ABUSE NY

Provider: BROWN,CYNTHIA E

NAVY YARD

Patient Status: Outpatient

AutoCites Refreshed by BROWN,CYNTHIA E @ 06 Jan 2016 0755 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Loading...

Reason for Appointment: Written by MAPLES, MICHAEL J @ 05 Jan 2016 1230 EST
CC GROUPScreening Written by MAPLES, MICHAEL J @ 05 Jan 2016 1239 ESTReason For Appointment: Notes Entered by: MAPLES, MICHAEL J 05 Jan 2016 1230

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by MAPLES, MICHAEL J @ 05 Jan 2016 1239 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LANGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by BROWN,CYNTHIA E @ 06 Jan 2016 0755 EST**Reason for Visit**

CC Group.

A/P Last updated by BROWN,CYNTHIA E @ 06 Jan 2016 0927 EST

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 679

AR 0723

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN, CYNTHIA E @ 06 Jan 2016 0929 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.Note Written by BROWN, CYNTHIA E @ 06 Jan 2016 0928 EST**CC GROUP (URINE TEST)**

Daniel arrived 45 minutes early to group. Daniel is at session # 24 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group discussed one member's unwillingness to follow through with what he promised to group. The point of trust and making changes is what treatment is about was made. Group debriefed their activities during Christmas and New Year's. No group member admitted to drinking or using drugs. A discussion of euphoria and how childhood experiences with video games was like drinking in losing track of time, food, and human interaction.

Daniel shared that he kept one of his dating sites open for 2 extra days because he had already started a conversation with someone and wanted to complete it. He shared this woman he was having the "conversation" with became his date for New Year's. He stated that it was "lack luster". This was the reason he was taking himself off the dating sites in the first place. He was confronted with lying to the group. He stated that he sees as changing his mind. He failed to see the promise as binding or a commitment. He stated that doing he wanted and necessarily the next right thing gets him trouble. He was able to relate to his production at work being discussed as poor. He stated that he just does not work as hard as he could and senior paygrades are starting to notice. He stated that he wants to do better and will his CBT to make better decisions. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has several treatment plan problem objectives out of date on his treatment plan. He will not be in group next week due to a class he is taking but agreed to an individual session when he returns. Daniel will continue with Continuing Care treatment and has an outdated treatment plan. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 19 January 2016 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 06 Jan 2016 0933**CHANGE HISTORY**The following A/P Note Was Overwritten by BROWN, CYNTHIA E @ 06 Jan 2016 0927 EST:

The A/P section was last updated by BROWN, CYNTHIA E @ 06 Jan 2016 0927 EST - see above. Previous Version of A/P section was entered/updated by MAPLES, MICHAEL J @ 06 Jan 2016 0755 EST.

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 680

AR 0724

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Laboratory(ies):

SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.
-DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 681

AR 0725

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-23146597 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **29 Dec 2015 1223 EST** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1332 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 29 Dec 2015 1223 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 29 Dec 2015 1224 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 29 Dec 2015 1223

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 29 Dec 2015 1224 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Comments: LAUNGUAGE: ENGLISH
 CONTACT NUMBER: [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES,MICHAEL J @ 29 Dec 2015 1227 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 30 Dec 2015 1356 EST

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: See ADD/NOTE section for more information on this encounter.

Note Written by GONZALEZZARAZUA,JORGE A @ 30 Dec 2015 1356 EST

Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ½ hours. Group went over their recent holiday weekend and how they were able to handle any urges or cravings to drink. Members also shared their plans for the upcoming New Year's weekend and how they plan to deal with possible triggers or urges to drink. All members denied consuming alcohol or abusing illegal drugs since their last visit.

Daniel shared that he spent his Christmas holiday working on his computer based game, but at times throughout the night he would check his social media and notice that plenty of his online friends would post pictures of themselves out with family and friends, opening presents or just hanging out celebrating the holiday. He states that he felt envious and lonely and had a craving to want to drink, but instead continued to work on his game and the feeling would pass. He also reports that later in the weekend he became upset because a female friend who he states he was interested in canceled on their date. He states that he was mad about it because he thought they had a good time during their previous date. Daniel states that online dating is taking a lot of his time as he does it often and after receiving feedback from the group states that he will likely delete his online dating profiles and would share with the group during the next session.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel has Problem #5, Objective # 3 overdue 18 December 2015. He will schedule his individual appointment after the New Year's holiday to update his treatment plan with this counselor. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return 05 January 2016 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 30 Dec 2015 1357

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 31 Dec 2015 0747

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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AR 0727

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CHANGE HISTORY**The following Disposition Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST:**

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: See ADD/NOTE section for more information on this encounter.**The following Disposition Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST:**

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1332 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group went over their recent holiday weekend and how they were able to handle any urges or cravings to drink. Members also shared their plans for the upcoming New Year's weekend and how they plan to deal with possible triggers or urges to drink. All members denied consuming alcohol or abusing illegal drugs since their last visit.

Daniel shared that he spent his Christmas holiday working on his computer based game, but at times throughout the night he would check his social media and notice that plenty of his online friends would post pictures of themselves out with family and friends, opening presents or just hanging out celebrating the holiday. He states that he felt envious and lonely and had a craving to want to drink, but instead continued to work on his game and the feeling would pass. He also reports that later in the weekend he became upset because a female friend who he states he was interested in canceled on their date. He states that he was mad about it because he thought they had a good time during their previous date. Daniel states that online dating is taking a lot of his time as he does it often and after receiving feedback from the group states that he will likely delete his online dating profiles and would share with the group during the next session.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel has Problem #5, Objective # 3 overdue 18 December 2015. He will schedule his individual appointment after the New Year's holiday to update his treatment plan with this counselor. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Da

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1355 EST:**Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 30 Dec 2015 1333**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

22 Dec 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-23111240 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **22 Dec 2015 1243 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **HILL, LARRY D**

AutoCites Refreshed by HILL, LARRY D @ 23 Dec 2015 1211 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 22 Dec 2015 1243 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 22 Dec 2015 1317 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 22 Dec 2015 1243

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 22 Dec 2015 1317 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free
 Comments: LAUNGUAGE: ENGLISH

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CONTACT NUMBER: [REDACTED]
NO VITALS TAKEN AT SARP TREATMENTS/O Note Written by HILL, LARRY D @ 23 Dec 2015 1213 ESTHistory of present illness

The Patient is a 30 year old male.

The patient was in attendance for the Continuing Care Support Group.

A/P Last Updated by MAPLES, MICHAEL J @ 22 Dec 2015 1320 EST1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL, LARRY D @ 23 Dec 2015 1211 ESTReleased w/o Limitations

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session 22 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group shared their holiday plans and how Christmas will look through sober eyes, for some the first time in years. No group member admitted to drinking alcohol or abusing drugs since last seen at SARP.

Daniel sat relaxed for the majority of the group, but did provide minimal feedback to others and was observed probing as usual. Daniel was eventually drawn into the group and shared his holiday plans saying "I plan on spending Christmas alone this year and catch up on a lot of work I have to get done in my business. I have to step back and look at myself and identify that I'm choosing to be alone during the holidays due to my business and not because I have nowhere to go. I find myself drinking more when I'm around others for example, last year I was at my mom's house and I drank a lot there more than usual." Daniel wrote that he has not attended any required AA meetings, has no sponsor and is working steps 3&4. Daniels progress reports are contradictory as to his sponsor status and meeting attendance, where some he has a sponsor and others he does not.

Daniel appeared engaged and interested in the treatment process and was appropriate and less active throughout the session. Daniel has several objectives that are overdue and his ITP is out dated. Daniels ITP will be updated during his next individual session 28 December 2015. Daniel will continue with Continuing Care treatment and his record will be updated his next individual session as stated above. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return at 1230 28 December 2015. No evidence of SI/RI during this encounter. Secondary Record maintained at SARP Washington Navy Yard.

Signed By HILL, LARRY D (Physician) @ 23 Dec 2015 1217Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 23 Dec 2015 1415

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

15 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-23038866 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **15 Dec 2015 1223 EST** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 18 Dec 2015 1124 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 15 Dec 2015 1223 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 15 Dec 2015 1227 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 15 Dec 2015 1223

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 15 Dec 2015 1227 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CONTACT NUMBER: [REDACTED]
NO VITALS TAKEN AT SARP TREATMENTA/P Last Updated by MAPLES, MICHAEL J. @ 15 Dec 2015 1228 EST**1. Alcohol dependence, uncomplicated**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 18 Dec 2015 1245 EST**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #19 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. Group opened today by doing their weekly check-in, recapping their week and identifying any possible triggers or cravings. Group also said good bye to a group member by doing a group closing exercise.

Daniel shared that over the past 2 weeks he rekindled an old relationship with one of his ex-girlfriends. He states that she contacted him and invited him to a game and he accepted. While at the game, Daniel reports to have experienced a craving for beer as a lot of people around him were drinking while everyone seemed to be having fun. Daniel states that he was able to control his craving and the rest of the day went on just fine without him drinking. He also states to having had a serious talk with his friend and they were able to shared feelings that they had kept bottled up for over a year since they stopped talking. Daniel states that although nothing serious seems to be coming out from meeting up with her, he liked the fact that they were able to shared insight about each other.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel completed Problem #5, Objectives #1 and 2 of his ITP. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 22 December 2015 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 18 Dec 2015 1245Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 18 Dec 2015 1254

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

14 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23012235 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **14 Dec 2015 0800 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P**Reason for Appointment:
SARP/LABSAppointment Comments:
TSB**Lab Result Cited by AILOR, LYNNE P @ 14 Dec 2015 0727 EST**

Drug Abuse Screen	Site/Specimen	08 Dec 2015 1408	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <=>		(Negative)
Barbiturates	URINE	NEGATIVE <=>		(Negative)
Benzodiazepines	URINE	NEGATIVE <=>		(Negative)
Cocaine	URINE	NEGATIVE <=>		(Negative)
Opiates	URINE	NEGATIVE <=>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <=>		(Negative)
Cannabinoids	URINE	NEGATIVE <=>		(Negative)
Methadone	URINE	NEGATIVE <=>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <=>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	08 Dec 2015 1408	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 14 Dec 2015 0729 EST**1. Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative, Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 14 Dec 2015 0729 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up in SARP.**Signed By AILOR, LYNNE P (Physician) @ 14 Dec 2015 0729**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-22965935 Primary Dx: Alcohol dependence, uncomplicated

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NHC QUANTICO
Patient Status: OutpatientDate: 08 Dec 2015 1515 EST
Clinic: BEHAVIORAL HEALTH QUAppt Type: PROC
Provider: AILOR, LYNNE PReason for Appointment:
SARP/LABSAppointment Comments:
TSB**Lab Result Cited by AILOR, LYNNE P @ 08 Dec 2015 1545 EST**

Drug Abuse Screen	Site/Specimen	01 Dec 2015 1413	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)
ETG/ETS, UA (250 Cut-Off)	Site/Specimen	01 Dec 2015 1413	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 08 Dec 2015 1546 EST1. **Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 08 Dec 2015 1547 EST

Released w/o Limitations

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 08 Dec 2015 1547

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

08 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22959749 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **08 Dec 2015 1155 EST**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY**
 Patient Status: **Outpatient**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 11 Dec 2015 1309 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 08 Dec 2015 1155 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 08 Dec 2015 1236 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 08 Dec 2015 1155

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 08 Dec 2015 1243 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CONTACT NUMBER: [REDACTED]
NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 08 Dec 2015 1246 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 11 Dec 2015 1310 EST

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group performed their check-in reporting changes since last group and thoughts, cravings or triggers; no group member admitted to drinking alcohol or abusing drugs since last seen at SARP. The group shared about challenging family relationship and the newness of holidays without alcohol.

Daniel shared that he believes he is making progress as he is slowly being able to communicate with others and is actually enjoying having others company. He states he continues to work on his personal projects developing software and at this point that continues to be his main priority. Daniel provided feedback to another member, stating he could relate to some of the issues he is confronting as he also faces similar circumstances when he thinks about his past with his father and how hard it is to let go and move forward. Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel appeared quite for most of the group, but seemed to relate to another group member when talking about things that have happened in the past and how hard it is to let go at times. Daniel has no objective due from his ITP. He will continue with Continuing Care treatment and has Problem #5, Objective # 1 and 2 due 11 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 15 December 2015 at 1230 for group. No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 11 Dec 2015 1311

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 11 Dec 2015 1519

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Dec 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-22878128 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **01 Dec 2015 1226 EST** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 04 Dec 2015 0645 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 01 Dec 2015 1226 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 01 Dec 2015 1253 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 01 Dec 2015 1226

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 01 Dec 2015 1253 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Comments: VITALS: LAUNGUAGE: ENGLISH
 CONTACT NUMBER: [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 01 Dec 2015 1254 EST**1. Alcohol dependence, uncomplicated**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS, JAMES @ 04 Dec 2015 0645 EST**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: SEE ADD NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.

Note Written by REGIS, JAMES @ 04 Dec 2015 0647 ESTContinuing Care Group - Tuesday, 01 December 2015

Daniel arrived on time to his Continuing Care Group which was held on Tuesday the 1st of December 2015, from 1230-1400. This is Daniel's 19th of 26 scheduled sessions. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Daniel performed his check-in with the group members going over any triggers or cravings he may have had during the past week and holiday. Afterwards, Daniel said goodbye to a group member who was closing out of group today.

During Daniel's check-in, Daniel shared that he didn't do anything for Thanksgiving. Daniel said that he relaxed all weekend and was able to do a lot of programing on his new computer game. He stated that he was able to go out on a date with one of his female friends but that it was strictly platonic and amicable. He wrote that he was able to become "independent from romantic relationships" a something that he did this week as a positive step towards his recovery. He also wrote how he was able to relate in todays group with the act "revenge seeking" and it's importance at times.

Daniel seemed thoughtful and indifferent about his holiday weekend and up and coming week and events. He wrote that he attended only 1 AA meeting and that he still doesn't have an AA sponsor but that he is working on steps #3 & #4 of the AA 12 Step program while abstaining from alcohol. See "CCG PATIENT ATTENDANCE NOTE" in SARP Patient file for complete information. Daniel has Problem #5 Objectives #1 and #2 of his ITP due next week on the 11th of December 2015. Daniel will return for his next CC treatment group on the 8th of December 2015.

Daniel had no evidence of SI/HI/ATV during this encounter.

Secondary record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 04 Dec 2015 0648Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 04 Dec 2015 0809

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

24 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22825470 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **24 Nov 2015 1218 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 25 Nov 2015 1048 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/.5ML, SYRINGE, INTRAMUSC. CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 24 Nov 2015 1218 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 24 Nov 2015 1300 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 24 Nov 2015 1218

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 695

AR 0739

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 24 Nov 2015 1300 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LAUNGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 24 Nov 2015 1304 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 25 Nov 2015 1049 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group session. He is at session #16 of the scheduled 26 sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. All group members denied drinking or abusing drugs. Group members performed their check-in exercise and identified possible triggers or cravings for the upcoming long holiday weekend. Group also filled out "Types of Relapses Before Chemical Relapse" worksheet and shared their individual answers with the rest of the group.

Daniel shared that he had a trigger yesterday because his friend who he had planned on visiting over the Thanksgiving weekend cancelled on him at the last minute. He states that normally he would just get mad and start drinking, but instead used what he has learned in CBT and was able to fight off the urge to want to drink on impulse. He states that instead he went on a local date and pretty much forgot about the craving and focused on his game developing; reminding himself that staying local is a better option for him because he can get so much more done then going out of town.

Daniel appeared comfortable throughout today's session. He seemed active and willing to engage in discussion with group, sharing and providing feedback. Daniel has no objective due today. He will continue with Continuing Care treatment and has Problem #5, Objectives #1 and 2 from ITP due 11 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 01 December 2015 for her next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 25 Nov 2015 1050**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 25 Nov 2015 1237

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 696

AR 0740

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Nov 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-22796451 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **20 Nov 2015 1545 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 23 Nov 2015 0720 EST

Drug Abuse Screen	Site/Specimen	17 Nov 2015 1405	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)

Site/Specimen	17 Nov 2015 1405	Units	Ref Rng
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 23 Nov 2015 0722 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. Result of ETG/ETS was negative. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 23 Nov 2015 0723 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 23 Nov 2015 0723

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

17 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22743789 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **17 Nov 2015 1326 EST** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 20 Nov 2015 1251 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 17 Nov 2015 1326 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 17 Nov 2015 1344 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 17 Nov 2015 1326

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 17 Nov 2015 1344 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LAUNGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 17 Nov 2015 1345 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 17 Nov 2015 1348 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 20 Nov 2015 1252 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group session. He is at session #15 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group shared updates since last group regarding triggers and cravings during their check-in exercise. Group completed "Positive Influence List" and "Negative Influence List" worksheets and shared their answers with the group. No group member admitted to drinking alcohol or abusing drugs since last seen at SARP. Each group member submitted a sample for testing.

Daniel shared that he has had a good week since his last visit to SARP. He states that he spent some time with friends from work and is looking forward to continue that trend. He also shared that this upcoming weekend he plans to visit a female friend that lives a couple hours from here and might spend the weekend with her. He states that she is also in recovery so drinking while out with her will not be an issue. Daniel identified both his mother and step dad as positive influences toward his recovery. He listed his dad as a positive influence and also had his step mom listed being both, positive and negative depending on what they talk about or her mood.

Daniel appeared appropriate and interested in the treatment process. He seemed active and appropriate throughout today's session. Daniel has no objective due today. Daniel will continue with Continuing Care treatment and has Problem #5, Objective #1 and 2 due 11 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 24 November 2015 at 1230 for group.

No evidence of SI/II during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 20 Nov 2015 1252**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 20 Nov 2015 1520

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

12 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22680652 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **12 Nov 2015 0756 EST**
Clinic: **SUBST ABUSE NY**Appt Type: **FTR**
Provider: **GONZALEZZARAZUA, JORGE A****AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 12 Nov 2015 0759 EST****Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 12 Nov 2015 0756 EST
INDIVIDUAL SESSION**Screening** Written by MAPLES, MICHAEL J @ 12 Nov 2015 0757 EST**Reason For Appointment:** Notes Entered by: MAPLES, MICHAEL J 12 Nov 2015 0756Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 700

AR 0744

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

INDIVIDUAL SESSION**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals****Vitals Written by** MAPLES, MICHAEL J @ 12 Nov 2015 0757 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LANGUAGE: ENGLISH**CONTACT NUMBER:** [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 12 Nov 2015 0757 EST**History of present illness**

The Patient is a 30 year old male.

THE PATIENT ATTENDED AN INDIVIDUAL SESSION FROM 0800-0900.

A/P Last Updated by MAPLES, MICHAEL J @ 12 Nov 2015 0759 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - THE PATIENT ATTENDED GROUP SESSION FROM 0800-0900

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1411 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his monthly individual appointment with this counselor, dressed appropriately in casual civilian attire. Daniel opened by stating that he is doing well and feeling more comfortable in the group setting than he did a few months ago prior to him having to go TAD for school. He also reports that he is seeing his therapist is putting an honest effort on working on his issues, rather than overlooking them.

Daniel shared that he is feeling good and accomplished after having accepted an invite from a male co-worker to attend a BBQ gathering this week. He states that he actually had a good time at the gathering and even met new people who he had conversations with. Daniel admits that it was not easy and at certain points he would wonder if he was being appropriate or too weird, but would then forget about it and just enjoyed most of the evening.

Daniel update his treatment plan by adding 4 more problems to his Master Problems List. He also states that at this time he is unable to complete Problem 1, Objective 7 as he is not comfortable approaching men and being open with them, something he states he is currently working on with his therapist. Daniel and this counselor have agreed to delay Problem 1, Objective 7 until 04 January 2016 and will revisit at that time. Daniel is scheduled to return for his next group session on 17 November 2015 @ 1230Hrs. He has Problem 5, Objectives 1 and 2 due 11 December 2015.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1412**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 13 Nov 2015 1445

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

10 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22671984 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **10 Nov 2015 1300 EST**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY**
NAVY YARD
 Patient Status: **Outpatient**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1356 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 10 Nov 2015 1300 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 10 Nov 2015 1302 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 10 Nov 2015 1300

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 702

AR 0746

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 10 Nov 2015 1302 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LANGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 10 Nov 2015 1303 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 10 Nov 2015 1326 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PROGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #14 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group opened today by welcoming one new member to the group, performing individual introductions and going over group rules. Group also performed their weekly check-in exercise, reporting any current struggles, cravings or triggers that they might have suffered since their last visit.

Daniel shared that he is attending AA again and is currently working on steps 3 and 4 with his home group. He states that he is also trying to overcome his inability to hang-out with other males and will try to attend a BBQ gathering with guys from work. He states that he is often invited to gatherings by his male peers, but normally does not attend as he has always preferred to spend time with women, rather than with men.

Daniel appeared active and comfortable throughout today's group session. He seemed at ease sharing what his goals are and what he is trying to do, without hesitating if anyone was judging him or bothering himself about what anyone else was thinking of him.

Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015 and has scheduled an individual appointment on 12 November 2015 with this counselor to update his treatment plan. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 17 November 2015 for his next scheduled group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1401**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 13 Nov 2015 1410**CHANGE HISTORY****The following Disposition Note Was Overwritten by** GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST:

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1357 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Tiffany arrived on time and is at session #13 of the 40 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group opened today by welcoming one new member to the group, performing individual introductions and going over group rules. Group also performed their weekly check-in exercise, reporting any current struggles, cravings or triggers that they might have suffered since their last visit.

Tiffany shared that she continues to battle her struggles and is doing all the things that are asked of her by her sponsor and other AA members to help her stay sober each day. She reports that this coming weekend she has signed up along with a few of her acquaintances to attend a "Gratitude breakfast" and also a "Step study" group. She also engaged with another member who is having family issues and offered her support, stating she was proud of him for handling his current situation without resorting to drinking. Tiffany report she is feeling better overall and although still feeling lonely at times, it is not as intense as it has been in the past.

Tiffany appeared comfortable and active throughout today's group session. She seemed to care about another group member's current struggles with family issues and offered

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

her support and wished well.

Tiffany has no objective due today. She has Problem #1, Objectives 5, 7 and 8 due 18 December 2015. See Tiffany "Continuing Care Progress Report" for more information on this encounter. Tiffany is scheduled to return on 17 November 2015 for her next group session.

No evidence of SI/Hi during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST.

Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1357

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 704

AR 0748

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

09 Nov 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-22649915 Primary Dx: Parageusia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **09 Nov 2015 1045 EST**
 Clinic: **INT MED MEDICAL HOME CL C**
BE

Appt Type: **FTR**
 Provider: **AUSTIN, MARIE**

Reason for Appointment:

lost taste

Appointment Comments:

clm

Vitals**Vitals Written by TRAN,CAT D @ 09 Nov 2015 1056 EST**

BP: 113/78, HR: 69, RR: 18, T: 97.6 °F, HT: 69 in, WT: 167 lbs, SpO2: 98%, BMI: 24.66,
 BSA: 1.913 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by TRAN,CAT D @ 09 Nov 2015 1057 EST**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 09 Nov 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN,MARIE @ 09 Nov 2015 1155 EST**Chief complaint**

The Chief Complaint is: Evaluating for ageusia.

History of present illness

The Patient is a 30 year old male.
 Autocited allergies verified.

PO1 is 30 y/o male - pt has weaned himself off the zoloft . Saw the psychiatrist and she is weaning him off more slowly . He had been c/o of insomnia - now no insomnia , and lost weight. He was at 125 of zoloft will on a slower taper .

Pt c/o loss of taste x1 month, particularly in detecting sweetness than any others senses. Pt claims the only current med taking is Zoloft. Since he had so many side effects will wait until he is off the zoloft and re- evaluate the taste issue .

General overall feeling /health - Very Good.

admission diagnosis of HPI [use for free text].

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated
 NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.
 Sertraline 50mg one and a half tab a day- weaning off

Past medical/surgical history**Reported:**

Medical: Reported medical history
 GAD
 Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history
 PRK
 Tonsillectomy

AHLTA Problem List Updated. Date:11/2015.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** Otolaryngeal symptoms loss of taste for sugar. No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Decreased appetite sugar taste bitter where as artificial sweeteners

. No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

Oropharynx: • Normal. • Uvula showed no abnormalities. • Base of the tongue was normal. • Tonsils showed no abnormalities.

Hypopharynx: • Mucous membranes had no abnormalities. • Had no swelling. • Had no tenderness.

Test conclusions

Medication list was updated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

A/P Written by AUSTIN, MARIE @ 09 Nov 2015 1155 EST**1. Parageusia R43.2:** Pt reports sugar is tasting bitter not sweet . Pt is waing off zoloft with + side effects due to not tapering . In addition pt takes daily fluoride [water does have fluoride} will stop and wait until he is completely off the zoloft before we reassess .**Disposition Written by AUSTIN, MARIE @ 09 Nov 2015 1159 EST****Released w/o Limitations****Follow up:** as needed . - Comments: pt to continue to wean off zoloft had stop fluoroide

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: discussed the side effects of this current meds
 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By **AUSTIN, MARIE** (Nurse Practitioner, WRNMMC) @ 09 Nov 2015 1200**CHANGE HISTORY**

The following S/O Note Was Overwritten by AUSTIN, MARIE @ 09 Nov 2015 1139 EST:

S/O Note Written by TRAN, CAT D @ 09 Nov 2015 1058 EST

Chief complaint

The Chief Complaint is: Evaluating for ageusia.

History of present illness

The Patient is a 30 year old male.

Pt c/o loss of taste x1 month, particularly in detecting sweetness than any others senses. Pt claims the only current med taking is Zoloft.

General overall feeling /health - Very Good.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tonsillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

03 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22586549 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **03 Nov 2015 1226 EST**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **GONZALEZZARAZUA, JORGE A**AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1258 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 03 Nov 2015 1226 EST
CC GROUPScreening Written by MAPLES, MICHAEL J @ 03 Nov 2015 1228 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 03 Nov 2015 1226

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 708

AR 0753

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals****Vitals Written by** MAPLES, MICHAEL J @ 03 Nov 2015 1228 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LAUNGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 03 Nov 2015 1244 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 03 Nov 2015 1246 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1419 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments:

Daniel arrived on time and is at session #13 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group performed their weekly check-in, reporting their struggles, triggers and cravings. The group was challenged with a scaling question; on a scale from 1-10, 1 being the lowest, 10 being the highest, how dedicated are you to your recovery? The group shared post group feelings from last group after two members shared they suffered a relapse.

Daniel shared that he has taken positive steps since sharing about his relapse during the previous group. He states he attended AA this past week is trying to be more active in managing his anxiety and working with his psychologist. He admitted that at times he does not do or use all the tools he has learned since starting treatment to help him in his sobriety, but last week was a reminder for him and is looking forward to continue in a positive light.

Daniel appeared relaxed and attentive during today's group session. He seemed to connect with the group and provided feedback. He also seemed receptive to what others shared and feedback that was provided. Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015. Daniel will be asked to setup an individual appointment with his counselor to address treatment planning and updating. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 09 November 2015 for his next scheduled group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 06 Nov 2015 1419**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 06 Nov 2015 1422**CHANGE HISTORY****The following Disposition Note Was Overwritten by** GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1419 EST:

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1419 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1258 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #13 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group performed their weekly check-in, reporting their struggles, triggers and cravings. The group was challenged with a scaling question; on a scale from 1-10, 1 being the lowest, 10 being the highest, how dedicated are you to your recovery? The group shared post group feelings from last group after two members shared they suffered a relapse.

Daniel shared that he has taken positive steps since sharing about his relapse during the previous group. He states he attended AA this past week is trying to be more active in managing his anxiety and working with his psychologist. He admitted that at times he does not do or use all the tools he has learned since starting treatment to help him in his sobriety, but last week was a reminder for him and is looking forward to continue in a positive light.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 709

AR 0754

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Daniel appeared relaxed and attentive during today's group session. He seemed to connect with the group and provided feedback. He also seemed receptive to what others shared and feedback that was provided. Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 09 November 2015 for his next scheduled group session.

No evidence of SI/HI during this encounter.
Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1416 EST:
Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 06 Nov 2015 1259

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

03 Nov 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-22583769 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **03 Nov 2015 1030 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **ZEMBRZUSKA, HANNA**
DOMINIKAAutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 03 Nov 2015 1620 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

No Labs Found.

Rads

No Rads Found.

Reason for Appointment:

est

Appointment Comments:

ddr

VitalsVitals Written by NEFF, JOANNE S @ 03 Nov 2015 1042 EST

BP: 125/73, HR: 76, RR: 12, T: 97.2 °F, Pain Scale: 0 Pain Free

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 06 Nov 2015 1312 EST**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt ran out of Zoloft and so for the past 2 weeks he has been off of it. Since Zoloft was discontinued pt has been struggling with some mild withdrawal symptoms, but hypersomnia has resolved. He no longer needs to naps for 30-45 min about three times per day. He is sleeping 6-7 hours per night with Melatonin. He feels much more productive and has lost weight. He is running 25-30 miles per week and is using CBT skills to combat anxiety. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts. Re-enlistment ceremony was on 16OCT and his family came.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- limited impact of these visits.
- * MEDS: Denies other medication trials
- * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Alcohol use Drank one glass of wine recently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed, oriented x3. * No hallucinations. * Memory was unimpaired. * Remote memory was not impaired. * Recent memory was not impaired. * Judgement was not impaired.

Speech: * Normal, regular rate, non-pressured. * Rate was not slowed. * Not pressured. * Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: * Behavior demonstrated no abnormalities - appropriate and cooperative. * No psychomotor retardation. * Behavior demonstrated no psychomotor agitation. * No decreased eye-to-eye contact was observed.

Mood: * Euthymic Able to smile appropriately. * Not depressed. * Not anxious.

Affect: * Normal anxious. * Not labile. * Not flat. * Not constricted. * Showed no irritability.

Thought Processes: * Not impaired, they were linear, logical, and goal directed. * Attention demonstrated no abnormalities. * Attention span was not decreased.

Thought Content: * Insight was intact. * No delusions. * No suicidal ideation. * No suicidal plans. * No suicidal intent. * No homicidal ideations. * No homicidal plans. * No homicidal intent.

Neurovegetative Assessment: * Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Suicidal ideation/plans/intent:N
 Access to Lethal Means:N
 Poor Treatment Compliance:N
 Hopelessness:?
 Psychic Pain/Anxiety:Y
 Acute Event:N
 Insomnia:N
 Low Self-Worth:Y
 Impulsivity:N
 Substance Abuse:Y
 Financial Stress:Y, PAYING OFF DEBT
 Legal Stress:N

Protective:

Strong Therapeutic Alliance:Y
 Positive Coping Skills:Y
 Responsible to/for Family:Y
 Responsible to/for Pet:N
 Frustration Tolerance:Y
 Resilience:Y
 Good Reality Testing:Y
 Amenable to Treatment:Y
 Social Support:Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Therapy

- Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist:TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 11/3/2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u 17DEC at 1400

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, depressed mood, irritability

-

Interventions:

1. Restart Zoloft at 25mg daily to help with withdrawal symptoms. After 7-14 days if pt is doing well decrease Zoloft to 12.5mg daily and then taper off. Discussed r/b/se. Obtained informed consent for medication.
2. Continue SARP. Advised pt to attend an AA or SMART-recovery meeting if he experiences cravings for alcohol or begins to have thoughts of using alcohol to cope with anxiety related to work.
3. Referred pt for individual CBT.

Objective 2 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS pm insomnia

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 03 Nov 2015 1621 EST

1. **Generalized anxiety disorder** F41.1

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 06 Nov 2015 1321 EST

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 17DEC at 1400

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 06 Nov 2015 1322

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Oct 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22501132 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS** Date: **27 Oct 2015 1245 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 30 Oct 2015 1104 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 27 Oct 2015 1245 EDT
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 27 Oct 2015 1300 EDT

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 27 Oct 2015 1245

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals Written by** MAPLES,MICHAEL J @ 27 Oct 2015 1301 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES,MICHAEL J @ 27 Oct 2015 1303 EDT**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES,MICHAEL J @ 27 Oct 2015 1304 EDT**1. Alcohol dependence, uncomplicated****Procedure(s):**

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 30 Oct 2015 1206 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD/NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.**Note Written by** GONZALEZZARAZUA,JORGE A @ 30 Oct 2015 1206 EDT

Daniel arrived on time and is at session #12 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ½ hours. The group processed one member's recent relapse, which sparked another member to admit to a relapse. Several group members provided feedback and reported being envious that the two replaces got to drink and voiced disappointment. No other group members admitted to drinking alcohol or abusing drugs since last seen at SARP. The group was reminded that they are here at SARP for treatment of alcohol/drugs.

Daniel opened group today and revealed that he relapsed. He shared that while out with some friends at a steak house he was offered a glass of wine and he decided to accept without hesitation. He states to have drunk two glasses of red wine with his dinner. Daniel reports that although he knows that he is not allowed to drink while in the program, he chose to do so without real regard to what could happen. When confronted by two counselors as why he decided to drink, Daniel stated he just wanted to and felt as if it should be ok for him to have a couple glasses of wine if he wanted to. Daniel also brought up that he initially self-referred himself for other underlying reasons and not specifically because he thought he had an issue with alcoholism. After hearing from a member who also suffered a relapse in the past week, Daniel shared that there were some underlying reasons as to why he decided to drink. He stated that he was upset because he had family over for his re-enlistment the past week and his father decided to not come. He states that his relationship with his father still affects him to this

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

date and believes that the stress of having everyone around and his father being the one person to not show led him to drink.

Daniel appeared comfortable in today's group, sharing and giving feedback to other members. He seemed to lack any remorse or guilt about why he chose to drink and at points appeared to defend his decision. Daniel seems to not trust the group, stating the dynamics have changed since he first started and not feeling comfortable. A SARP staffing will be scheduled for Daniel and his case will be re-evaluated for treatment update. Daniel has an outdated treatment plan and will be scheduled for an individual appointment following the findings of his SARP staffing for treatment planning and updating. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return on 03 November 2015 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By **GONZALEZZARAZUA, JORGE A** (PARAPROFESSIONAL) @ 30 Oct 2015 1207
Co-Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 30 Oct 2015 1514

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Oct 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-22215056 Primary Dx: Generalized anxiety disorder

Patient: MERWIN, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 01 Oct 2015 1300 EDT
 Clinic: PSYCHIATRY BE

Appt Type: FTR
 Provider: ZEMBRZUSKA, HANNA
 DOMINIKA

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 01 Oct 2015 1308 EDT

Allergies

•OTHER: Unknown (SEE MED RECORD)

Labs

29 Sep 2015 1730 Varicella Zoster Virus DFA Varicella Zoster Virus Ag	Site Specimen SKIN	Result no vz antigen detected <i>	Units	Ref Range
15 Sep 2015 1400 ETG/ETS, UA (500 Cut-Off) Ethyl Glucuronide	Site Specimen URINE	Result negative	Units ng/mL	Ref Range Cutoff=500
15 Sep 2015 1400 Drug Abuse Screen	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	negative <i>		(Negative)
Barbiturates	URINE	negative <i>		(Negative)
Benzodiazepines	URINE	negative <i>		(Negative)
Cocaine	URINE	negative <i>		(Negative)
Opiates	URINE	negative <i>		(Negative)
Phencyclidine, UA	URINE	negative <i>		(Negative)
Cannabinoids	URINE	negative <i>		(Negative)
Methadone	URINE	negative <i>		(Not-Detected)
Oxycodone	URINE	negative <i>	ng/mL	(Negative)
08 Sep 2015 0817 HSV 1 & 2 Abs Indirect Panel	Site Specimen	Result	Units	Ref Range
Herpes Simplex Virus 1 Ab IgM	SERUM	<1:10	Titer units	<1:10
Herpes Simplex Virus 2 Ab IgM	SERUM	<1:10 <i>	Titer units	<1:10
08 Sep 2015 0817 Chlamydia+Gonococcus DNA Panel NAAT	Site Specimen	Result	Units	Ref Range
Neisseria gonorrhoeae DNA	URINE	negative for n.gonorrhoeae <i>		
Chlamydia trachomatis DNA	URINE	negative for c.trachomatis <i>		(Negative)
08 Sep 2015 0817 Herpes Simplex Virus 1+2 Ab IgG	Site Specimen	Result	Units	Ref Range
Herpes Simplex Virus 1 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90
Herpes Simplex Virus 2 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90
08 Sep 2015 0817 Rapid Plasma Reagin	Site Specimen	Result	Units	Ref Range
Reagin Ab	SERUM	nonreactive <i>		(Non-Reactive)
08 Sep 2015 0817 HIV Rapid	Site Specimen	Result	Units	Ref Range
HIV-1 Ab Rapid	BLOOD	*****		(Negative)

Microbiology Results
 Herpes Virus DFA

Order #
 Filler #
 Status:
 Ordering Provider:

150929-09137 (NNMC Bethesda)
 150929 NVI 2333 (NNMC Bethesda)
 Final
 CUNNINGHAM, RACHEL ELIZABETH

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Priority: ROUTINE
 Date Ordered: 29 Sep 2015 1032
 Date Resulted: 30 Sep 2015 0954
 COLLECT_SAMPLE: LESION/WOUND

VIROLOGY RESULT: NEGATIVE DIRECT FLUORESCENT
 ANTIBODY FOR: HSV

Specimen: Wound
 Collected: 29 Sep 2015 1730

Results: Final report

Herpes Virus Culture

Order # 150909-02160 (NNMC Bethesda)
 Filler # 150909 NVI 2193 (NNMC Bethesda)
 Status: Final
 Ordering Provider: FIACCO, NICHOLAS RYAN
 Priority: ROUTINE
 Date Ordered: 09 Sep 2015 0748
 Date Resulted: 14 Sep 2015 1210
 COLLECT_SAMPLE: OTHER SOURCE
 Order Comment: for specimen already in lab

VIROLOGY RESULT: NO HERPES SIMPLEX VIRUS
 ISOLATED.

Specimen: Groin, Left
 Collected: 08 Sep 2015 0819

Results: Final report

Rads

No Rads Found.

Reason for Appointment:

follow-up

Appointment Comments:

jc

VitalsVitals Written by ERICKSON,NANCY A @ 01 Oct 2015 1340 EDT

BP: 132/76, HR: 70, RR: 16, T: 97.8 °F

S/O Note Written by ZEMBRZUSKA,HANNA DOMINIKA @ 02 Oct 2015 1310 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt has been doing well on Zoloft 100mg daily, but has been experiencing anxiety related to work which causes him to think about using alcohol to cope. He has been struggling with hypersomnia rather than insomnia and attended a Sleep Pathways Group. He naps for 30-45 min about three times per day despite sleeping 5-6 hours per night. His PCM referred him to sleep clinic and he has an appt on 17NOV at 10:30AM. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts. Re-enlistment ceremony will be on 16OCT and his family is coming. Pt will be on leave 12-23OCT in the local area.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 719

AR 0764

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Zoloft 100mg daily
 Melatonin for insomnia.

Past medical/surgical history**Reported:**

- Recent Events: Medication compliance.
 Medical: Reported medical history Penile warts (HPV)
 Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)
 and psychiatric history
- * THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.
 - * MEDS: Denies other medication trials
 - * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
 - * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself ul experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Alcohol use Has drank a few beers recently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic Able to smile appropriately. ° Not depressed. ° Not anxious.

Affect: ° Normal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N

Access to Lethal Means: N

Poor Treatment Compliance: N

Hopelessness: ?

Psychic Pain/Anxiety: Y

Acute Event: N

Insomnia: N

Low Self-Worth: Y

Impulsivity: N

Substance Abuse: Y

Financial Stress: Y, PAYING OFF DEBT

Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y

Positive Coping Skills: Y

Responsible to/for Family: Y

Responsible to/for Pet: N

Frustration Tolerance: Y

Resilience: Y

Good Reality Testing: Y

Amenable to Treatment: Y

Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

[X] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other:

Therapy

• Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Treatment Team Members -

Individual Therapist: SARP
Medication Prescriber: ZEMBRZUSKA
Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 10/1/2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 4 weeks

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft to 150mg daily. Discussed r/b/se. Obtained informed consent for medication.

2. Continue SARP. Advised pt to attend an AA or SMART-recovery meeting if he experiences cravings for alcohol or begins to have thoughts of using alcohol to cope with anxiety related to work.

3. Referred pt for individual CBT.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft to 150mg daily. Discussed r/b/se. Obtained informed consent for medication.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia

2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 01 Oct 2015 1309 EDT

1. Generalized anxiety disorder F41.1

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 02 Oct 2015 1319 EDT

Released w/o Limitations

Follow up: 4 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 02 Oct 2015 1320

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

30 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by FALKNER, RACHEL E

Encounter ID: BETH-22196001 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Sep 2015 1027 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **T-CON***
 Provider: **CUNNINGHAM,RACHEL ELIZABETH**
 Call Back Phone: [REDACTED]

AutoCites Refreshed by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1028 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015
BENZONATATE, 100 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #0 RF0	NR	28 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015

Reason for Telephone Consult:Written by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1027 EDT labLab Result Cited by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT**Herpes Virus DFA**

Order # 150929-09137 (NNMC Bethesda)
 Filler # 150929 NVI 2333 (NNMC Bethesda)
 Status: Final
 Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH
 Priority: ROUTINE
 Date Ordered: 29 Sep 2015 1032
 Date Resulted: 30 Sep 2015 0954
 COLLECT_SAMPLE: LESION/WOUND

VIROLOGY RESULT: NEGATIVE DIRECT FLUORESCENT ANTIBODY FOR: HSV

Specimen: Wound
 Collected: 29 Sep 2015 1730

Results: Final report

Lab Result Cited by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT

Varicella Zoster Virus DFA Site/Specimen 29 Sep 2015 1730
 Varicella Zoster Virus Ag SKIN NO VZ ANTIGEN DETECTED <i>

A/P Written by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

1. **Visit for: administrative purpose:** DFA negative for HSV1/2 and VZV, confirming previous testing negative for herpetic infection. STD testing in previous month also negative, at this time etiology for ulcerations does not reveal any infectious etiology. Will recommend patient to stop any topical irritant for treatment of molluscum as not demonstrated on clinical exam. Follow up with PCM for repeat exam in 2-3 weeks if new ulcerations or erosions present. If resolving then continue with gentle skin care recommended today. May be due to irritant from alclara used for HPV condyloma. Consider retesting RPR for false negative as syphilitic chancre may still be in differential. If new primary lesions occurring PCM to send back to derm for potential biopsy.

Disposition Written by CUNNINGHAM, RACHEL E @ 30 Sep 2015 1037 EDT

Follow up: 2 week(s) with PCM or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By CUNNINGHAM, RACHEL E (Physician) @ 30 Sep 2015 1037

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 724

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA

Encounter ID: BETH-22183712 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**Date: **29 Sep 2015 1315 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **MANTANONALEE,CHRISTY LIA**Patient Status: **Outpatient****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1530 EDT

Drug Abuse Screen	Site/Specimen	15 Sep 2015 1400
Amphetamines	URINE	NEGATIVE <=>
Barbiturates	URINE	NEGATIVE <=>
Benzodiazepines	URINE	NEGATIVE <=>
Cocaine	URINE	NEGATIVE <=>
Opiates	URINE	NEGATIVE <=>
Phencyclidine, UA	URINE	NEGATIVE <=>
Cannabinoids	URINE	NEGATIVE <=>
Methadone	URINE	NEGATIVE <=>
Oxycodone	URINE	NEGATIVE <=>

ETG/ETS, UA (500 Cut-Off)	Site/Specimen	15 Sep 2015 1400
Ethyl Glucuronide	URINE	Negative

A/P Written by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1532 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative. Drug Abuse Screen was negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1533 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: FOLLOW UP WITH SARP AS SCHEDULED**Signed By MANTANONALEE, CHRISTY LIA (Physician) @ 29 Sep 2015 1533**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL

Encounter ID: BETH-22176596 Primary Dx: SKIN NEOPLASM GROIN

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Sep 2015 1000 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **MARQUART, JASON DANIEL**

AutoCites Refreshed by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1031 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015
BENZONATATE, 100 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #0 RF0	NR	28 Sep 2015
Imiquimod 5%, Cream, Topical	Active	APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS #0 RF3	3 of 3	28 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015

Reason for Appointment:
MOLLUSCUM CONTAGIOSUM
Appointment Comments:
 LCR

S/O Note Written by CUNNINGHAM, RACHEL ELIZABETH @ 29 Sep 2015 1037 EDT**Chief complaint**

The Chief Complaint is: Rash.

Reason for Visit

Visit for: STAFFED WITH DR. [] HANDFIELD [] GRATRIX [] GREEN [] LACKEY [] KENTOSH [x] MARQUART [] MEYERLE [] STEARNS [] SPERLING [] DARLING

30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, STD workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses alda on them but has not been using it on the areas in question. Partner currently does not have any STD or similar rash. Uses condoms. Has recently had bronchitis with subjective fevers which began before the papules appeared. HIV testing recently negative.

History of present illness

The Patient is a 30 year old male.

He reported: Past medical history reviewed and updated dermatology problem list.

No previous history of skin symptoms. Rash:

Visit is not deployment-related.

Past medical/surgical history

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 726

AR 0771

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Reported:

Surgical / Procedural: Surgical / procedural history reviewed and updated in patient's Problem List.
 Medications: Medication history was reviewed and updated in patient medication list as needed.

Diagnoses:

No eczema
 No psoriasis.
 No malignant skin neoplasm
 No basal cell carcinoma of the skin
 No squamous cell carcinoma of the skin.
 No malignant melanoma of the skin

Personal history

Behavioral: No tobacco use.
 Alcohol: No consumption of alcohol.

Family history

Family medical history: Reviewed in Problem List.

Review of systems

Systemic: No systemic symptoms and no night sweats.

Skin: Skin scaling.

Physical findings**General Appearance:**

• General appearance: ° Alert.

Neurological:

• Oriented to time, place, and person.
 Speech: ° Normal.

Skin:

• Multiple skin lesions. • Lesions located. • Lesions on the scalp Vertex scalp with short vellus hairs, mild boggy scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp. • Perineal lesions. • Lesions in the inguinal region Punched out erythematous eroded papules on L and R groin without papules on the penis or scrotum on exam.
 • Lesions on the right side of the groin. • Lesions on the left side of the groin. • General appearance was normal.
 • Mobile. • Texture was normal. • Turgor was normal. • Color and pigmentation were normal. • Moisture was normal.
 • Temperature was normal. • No lesions on the ear. • No lesions on the face. • No lesions on the neck. • No lesions on the upper extremities. • No lesions on the scrotum. • No lesions on the penile shaft. • No lesions on the buttocks. • No lesions on the lower extremities.

Hair:

• Quantity and distribution were abnormal.

Nails:

• Normal.

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

HIV Rapid	Site/Specimen	08 Sep 2015 0817
HIV-1 Ab Rapid	BLOOD	NEGATIVE-ONBOARD QC ACCEPTED <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Rapid Plasma Reagin	Site/Specimen	08 Sep 2015 0817
Reagin Ab	SERUM	NONREACTIVE <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Chlamydia+Gonococcus DNA Panel NAAT	Site/Specimen	08 Sep 2015 0817
Neisseria gonorrhoeae DNA	URINE	NEGATIVE FOR N.GONORRHOEAE <i>
Chlamydia trachomatis DNA	URINE	NEGATIVE FOR C.TRACHOMATIS <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Herpes Simplex Virus 1+2 Ab IgG	Site/Specimen	08 Sep 2015 0817
Herpes Simplex Virus 1 Ab IgG	SERUM	<0.91 <i>
Herpes Simplex Virus 2 Ab IgG	SERUM	<0.91 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT

HSV 1 & 2 Abs Indirect Panel	Site/Specimen	08 Sep 2015 0817
Herpes Simplex Virus 1 Ab IgM	SERUM	<1:10
Herpes Simplex Virus 2 Ab IgM	SERUM	<1:10 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT**Herpes Virus Culture**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Order # 150909-02160 (NNMC Bethesda)
 Filler # 150909 NVI 2193 (NNMC Bethesda)
 Status: Final
 Ordering Provider: FIACCO, NICHOLAS RYAN
 Priority: ROUTINE
 Date Ordered: 09 Sep 2015 0748
 Date Resulted: 14 Sep 2015 1210
 COLLECT_SAMPLE: OTHER SOURCE
 Order Comment: for specimen already in lab

VIROLOGY RESULT: NO HERPES SIMPLEX VIRUS ISOLATED.

Specimen: Groin, Left
 Collected: 08 Sep 2015 0819

Results: Final report

A/P Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT

1. SKIN NEOPLASM GROIN: Given punched out erosions on groin hx of multiple sexual partners, will get DFA today to rule out HSV infection. Previous tests showed non acute phase of HSV (IgG positive, IgM negative). Has had course of valtrex 500 twice daily for 10 days 1 month ago but did not resolve, may not have been correct treatment or may represent atypical presentation of another herpetic infection. Rest of STD workup negative.

Laboratory(ies): -HERPES DFA ~ (Routine) Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH; VARICELLA DFA (Routine) Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo.

Medication(s): -FLUOCINOLONE-TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

Disposition Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**Released w/o Limitations**

Follow up: as needed in the DERMATOLO CL BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by RANDOLPH,CANDICE M @ 29 Sep 2015 0955 EDT**Consult Order**

Referring Provider: AUSTIN, MARIE R

Date of Request: 28 Sep 2015

Priority: Routine

Provisional Diagnosis:

MOLLUSCUM CONTAGIOSUM

Reason for Request:

Pt was worked up for herpes and it was negative suspect active molluscum contagiosum please evla and treat confirm DX I am going to start aldera

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT**Additional A/P Information:**

Discontinued IMIQUIMOD-TOP 5% PACK - APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT**Additional A/P Information:**

Discontinued IMIQUIMOD-TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS

Note Written by MARQUART,JASON DANIEL @ 29 Sep 2015 1132 EDT

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service) @ 29 Sep 2015 1132

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

28 Sep 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-22165018 Primary Dx: MOLLUSCUM CONTAGIOSUM

Patient: **MERWIN, DANIEL DENNIS** Date: **28 Sep 2015 1045 EDT** Appt Type: **24HR**
 Treatment Facility: **WALTER REED** Clinic: **INT MED MEDICAL HOME CL C** Provider: **AUSTIN, MARIE**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient**

Reason for Appointment:

Followup, Genital Warts / Herpes and Bronchitis

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals Written by TRAN, CAT D @ 28 Sep 2015 1035 EDT**

BP: 122/87, HR: 79, RR: 16, T: 97.8 °F, HT: 69 in, WT: 165 lbs, SpO₂: 97%, BMI: 24.37,
 BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by TRAN, CAT D @ 28 Sep 2015 1051 EDT**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 28 Sep 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN, MARIE @ 28 Sep 2015 1205 EDT**Chief complaint**

The Chief Complaint is: Bronchitis & Re-evaluate STD.

History of present illness

The Patient is a 30 year old male.

Pt reported that he came to BAZC on 18Aug2015 to evaluate Bronchitis and Herpes. He states his lab tests came back negative for all speculated STDs, but warts remain on his left genital area.

Pt states that he went to Occ Health, in Fort Meade, apprx 1 week ago to evaluate his bronchitis and he received Mucinex and Zpack but the bronchitis remains. Continues to cough, he is taking his albuterol and ran out of mucinex. He does not have a cough medicine.

General overall feeling /health - Very Good.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 729

AR 0774

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History**ANNUAL QUESTIONS**Preferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever. Chills. No recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache. Nasal discharge and nasal passage blockage (stuffiness). No sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** Dyspnea controlled on albuterol and cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Skin:** Skin lesion:**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: • PERRL. • Size of the pupil was normal. • Pupil accommodation was not impaired.

External: • Eyelids showed no abnormalities. • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Right Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Left Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • Nasal discharge seen.

External Deformities: • No external nose deformities.

Cavity: • Nasal turbinate erythematous. • Nasal turbinate swollen. • Nasal septum normal. • Nasal mucosa normal.

Sinus Tenderness: • No sinus tenderness.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 730

AR 0775

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Oral Cavity:

Lips: ° Showed no abnormalities.
 Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: • Abnormal cobblestone red, no papules or pustules. No drainage. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.
 ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Neurological:

° Oriented to time, place, and person.
 Balance: ° Normal.
 Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.
 Affect: ° Normal.

Skin:

• Skin: folliculitis barbae on the lower abd where he shaved. • Lesions on the left thigh, circular 0.02 cm lesions with indwelling centers. • Molluscum contagiosum.

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Lab Result Cited by AUSTIN, MARIE @ 28 Sep 2015 1142 EDT

HIV Rapid	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
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Herpes Virus Culture

Order #	150909-02160 (NNMC Bethesda)
Filler #	150909 NVI 2193 (NNMC Bethesda)
Status:	Final
Ordering Provider:	FIACCO, NICHOLAS RYAN
Priority:	ROUTINE
Date Ordered:	09 Sep 2015 0748
Date Resulted:	14 Sep 2015 1210
COLLECT_SAMPLE:	OTHER SOURCE
Order Comment:	for specimen already in lab
VIROLOGY RESULT:	NO HERPES SIMPLEX VIRUS ISOLATED.
Specimen:	Groin, Left
Collected:	08 Sep 2015 0819

Lab Result Cited by AUSTIN, MARIE @ 28 Sep 2015 1141 EDT

HSV 1 & 2 Abs Indirect Panel	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Herpes Simplex Virus 1 Ab IgM	SERUM	<1:10	Titer units	<1:10
Herpes Simplex Virus 2 Ab IgM	SERUM	<1:10 <i>	Titer units	<1:10

Chlamydia+Gonococcus DNA Panel NAAT	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Neisseria gonorrhoeae DNA	URINE	NEGATIVE FOR N.GONORRHOEAE <i>		
Chlamydia trachomatis DNA	URINE	NEGATIVE FOR C.TRACHOMATIS <i>		

(Negative)

Herpes Simplex Virus 1+2 Ab IgG	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Herpes Simplex Virus 1 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90
Herpes Simplex Virus 2 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90

Rapid Plasma Reagin	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Reagin Ab	SERUM	NONREACTIVE <i>		(Non-Reactive)

HIV Rapid	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
HIV-1 Ab Rapid	BLOOD	NEGATIVE-ONBOARD QC ACCEPTED <i>		

(Negative)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by AUSTIN, MARIE @ 28 Sep 2015 1204 EDT**1. MOLLUSCUM CONTAGIOSUM 078.0**

Medication(s): -IMQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS #1 RF3

Consult(s): -Referred To: DERMATOLOGY MTF BE (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL BE Provisional Diagnosis: MOLLUSCUM CONTAGIOSUM

2. CHRONIC BRONCHITIS 491.9: Resolving, asthma as a child

Medication(s): -FLUTICASONE--PO 220MCG/PUFF MDI - INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #1 RF3

-BENZONATATE--PO 100MG CAP - TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #60 RF0

-GUAIFENESIN--PO 600MG TBSR - TAKE ONE TABLET BY MOUTH TWICE A DAY #90 RF0

Disposition Written by AUSTIN, MARIE @ 28 Sep 2015 1211 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: Pt to f/u as advised . USE condoms**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 28 Sep 2015 1211**CHANGE HISTORY***The following S/O Note Was Overwritten by AUSTIN, MARIE @ 28 Sep 2015 1137 EDT:**S/O Note Written by TRAN, CAT D @ 28 Sep 2015 1052 EDT***Chief complaint**

The Chief Complaint is: Bronchitis & Re-evaluate STD.

History of present illness

The Patient is a 30 year old male.

Pt came to BAZC on 18Aug2015 to evaluate Bronchitis and Herpes. He states his lab tests came back negative for all speculated STDs, but warts remain subsisted on his left genital area. Pt states that he went to Occ Health, in Fort Meade, approx 1 week ago to evaluate his bronchitis and he received Mucinex.

General overall feeling /health - Very Good.

AllergiesAllergies Verified and Updated
NKDA**Current medication**NO OTC meds, vitamins, herbals, etc.
Sertraline 50mg one and a half tab a day**Past medical/surgical history****Reported:**Medical: Reported medical history
GAD
Alcohol dependence in remissionSurgical / Procedural: Surgical / procedural history
PRK
Tonsillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History**ANNUAL QUESTIONS**Preferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family historyFamily medical history
DM father, PGM
MI father
hypertension father
melanoma father**Practice Management**

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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AR 0777

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

23 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-22126215 Primary Dx: Sleep disturbances

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **23 Sep 2015 1000 EDT**
Clinic: **INTEGRATIVE HLTH & WELL BE**
Appt Type: **GRP**
Provider: **JARRETT, ERICA M.**AutoCites Refreshed by JARRETT, ERICA M @ 23 Sep 2015 1551 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Sleep Pathways II

Appointment Comments:

coa

Questionnaire AutoCites Refreshed by JARRETT, ERICA M @ 23 Sep 2015 1551 EDT
QuestionnairesS/O Note Written by JARRETT, ERICA M. @ 23 Sep 2015 1551 EDT**Chief complaint**

The Chief Complaint is: Sleep pathways.

History of present illness

The Patient is a 30 year old male.

This is the patient's second visit to the IBHC clinic.

<<Note accomplished in TSWF-IBHC Group/Class tab>>

Pt attended the second of two Sleep Pathway Shared Medical Appointments.

The following topics were covered: sleep restriction, connections between anxiety/worry and insomnia; beliefs and attitudes that contribute to insomnia; worry management strategies; relaxation/imagery strategies; and relapse prevention.

Reviewed pt's sleep diary. Pt advised . Pt expressed understanding of these recommendations.

Sleep enhancement class, Getting a Good Night's Sleep, offered as part of Women's Health Week.

Discussed: Basics of sleep and treatment for insomnia: stimulus control, sleep hygiene, relaxation strategies, sleep restriction, beliefs and attitudes that contribute to insomnia, and worry management strategies. Provided handouts on the covered topics. Practiced diaphragmatic breathing and provided a brief demonstration of progressive muscle relaxation. Provided information about the CBTi Coach application for smart phones which has a sleep diary and sleep enhancement tools. Reviewed audio downloads for relaxation on the WRNMMC Medical Home, IHWS, Mind-Body Skills Program website.

Recommendations: 1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

....

Group/Class Intervention

See above.

....

Counseling/Education

Group/Class recommendations for patient:

1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

Group/Class recommendations for PCM Team:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

☒ Reinforce recommendations for patient.
☐ Consider medication for patient.
☐ Other:

A/P Last updated by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT**1. Sleep disturbances**

Procedure(s): -Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 4

Disposition Last updated by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT**Released w/o Limitations**Signed By JARRETT, ERICA M (Clinical Health Psychologist, NNMCM Bethesda, MD) @ 23 Sep 2015 1553**CHANGE HISTORY**The following Disposition Note Was Overwritten by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT:

The Disposition section was last updated by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT - see above. Previous Version of Disposition section was entered/updated by NEKVASIL, ERIN K @ 23 Sep 2015 1332 EDT.

Released w/o LimitationsThe following A/P Note Was Overwritten by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT:

The A/P section was last updated by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT - see above. Previous Version of A/P section was entered/updated by NEKVASIL, ERIN K @ 23 Sep 2015 1331 EDT.

1. Sleep disturbances**-> Unassociated Orders, Procedures and Injuries/Accidents <-**

Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 1

The following S/O Note Was Overwritten by JARRETT, ERICA M @ 23 Sep 2015 1552 EDT:S/O Note Written by NEKVASIL, ERIN K @ 23 Sep 2015 1327 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-IBHC Group/Class tab>>

Pt attended the second of two Sleep Pathway Shared Medical Appointments.

The following topics were covered: sleep restriction, connections between anxiety/worry and insomnia; beliefs and attitudes that contribute to insomnia; worry management strategies; relaxation/imagery strategies; and relapse prevention.

Reviewed pt's sleep diary. Pt advised . Pt expressed understanding of these recommendations.

Sleep enhancement class, Getting a Good Night's Sleep, offered as part of Women's Health Week.

Discussed: Basics of sleep and treatment for insomnia: stimulus control, sleep hygiene, relaxation strategies, sleep restriction, beliefs and attitudes that contribute to insomnia, and worry management strategies. Provided handouts on the covered topics.

Practiced diaphragmatic breathing and provided a brief demonstration of progressive muscle relaxation. Provided information about the CBT Coach application for smart phones which has a sleep diary and sleep enhancement tools. Reviewed audio downloads for relaxation on the WRNMMC Medical Home, IHWS, Mind-Body Skills Program website.

Recommendations: 1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

....
Group/Class Intervention

See above.

Counseling/Education

Group/Class recommendations for patient:

1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

Group/Class recommendations for PCM Team:

☒ Reinforce recommendations for patient.
☐ Consider medication for patient.
☐ Other:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 735

AR 0780

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA

Encounter ID: BETH-22077716 Primary Dx: Laboratory Studies

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NHC QUANTICODate: 18 Sep 2015 1300 EDT
Clinic: BEHAVIORAL HEALTH QUAppt Type: PROC
Provider: MANTANONALEE,CHRISTY LIA

Patient Status: Outpatient

Reason for Appointment:
SARP/LABS
Appointment Comments:
TSB**Lab Result Cited by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1320 EDT**

Drug Abuse Screen	Site/Specimen	15 Sep 2015 1400
Amphetamines	URINE	NEGATIVE < >
Barbiturates	URINE	NEGATIVE < >
Benzodiazepines	URINE	NEGATIVE < >
Cocaine	URINE	NEGATIVE < >
Opiates	URINE	NEGATIVE < >
Phencyclidine, UA	URINE	NEGATIVE < >
Cannabinoids	URINE	NEGATIVE < >
Methadone	URINE	NEGATIVE < >
Oxycodone	URINE	NEGATIVE < >

A/P Written by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1321 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I(OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition Written by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1322 EDT****Released w/o Limitations****Follow up:** as needed . - Comments: FOLLOW UP WITH SARP AS SCHEDULED**Signed By MANTANONALEE, CHRISTY LIA (Physician) @ 18 Sep 2015 1322**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

15 Sep 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-22034781 Primary Dx: ALCOHOL DEPENDENCE (ALCOHOLISM)

Patient: MERWIN, DANIEL DENNIS Date: 15 Sep 2015 1205 EDT Appt Type: GRP
 Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: BROWN,CYNTHIA E
 NAVY YARD
 Patient Status: Outpatient

AutoCites Refreshed by BROWN,CYNTHIA E @ 15 Sep 2015 1221 EDT

Problems

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VALACYCLOVIR HCL, 500 MG, TABLET, ORAL	Active	TAKE 1 TABLET TWICE EVERY DAY FOR 10 DAYS #0 RF0	NR	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015

Reason for Appointment:Written by PATSOS,ASHLEY N @ 15 Sep 2015 1205 EDT
 CC GROUP

Screening Written by PATSOS,ASHLEY N @ 15 Sep 2015 1206 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 15 Sep 2015 1205

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 15 Sep 2015 1206 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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 Page 737

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Comments: Language:English
 Contact #: 850-969-7239
 No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 Sep 2015 1207 EDT

History of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last updated by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.
 Laboratory(ies): -ETG/ETS, UA (500 CUT-OFF) (Routine) Ordered By: BROWN,CYNTHIA E Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: BROWN,CYNTHIA E Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN,CYNTHIA E @ 16 Sep 2015 0711 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP URINE TEST
 Daniel arrived on time to group. Daniel is at session # 12 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. The group discussed "drunk dreams" and control issues. They also discussed how hard it is to be vulnerable. Daniel shared that he has been really sick with a cold. He did admit that he drank cough medicine with alcohol in it. This was revealed after he was told that he has a urine test today. He stated during group he took it Sunday but admitted that he took it yesterday. He shared how he is struggling with control issues. The girl that he is seeing now made him dinner and he was not appreciative but was more critical. The group encouraged him to respect what others do for him. As he spoke group members were seen as checking out by looking around the group and not at him. He monopolized only a few minutes of the group and cut off to allow the group to give feedback. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and overly active throughout the session. Daniel moved Problem #1, Objective #7 from his ITP to 20 October 2015. Daniel will continue with Continuing Care treatment and has Problem #1, Objective #7 due 20 October 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 20 October 2015 at 1230 for group. DANIEL WILL NOT BE IN GROUP FOR THE NEXT 4 WEEKS DUE TO LEAVE AND TRAINING.
 No evidence of SI/Hi during this encounter
 Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 16 Sep 2015 0711

CHANGE HISTORY

The following A/P Note Was Overwritten by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT:

The A/P section was last updated by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS,ASHLEY N @ 15 Sep 2015 1208 EDT.

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 738

AR 0783

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

09 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by CORSO, MEGHAN L

Encounter ID: BETH-22059314 Primary Dx: Lack of adequate sleep

Patient: **MERWIN, DANIEL DENNIS** Date: **09 Sep 2015 1000 EDT** Appt Type: **GRP**
 Treatment Facility: **WALTER REED** Clinic: **INTEGRATIVE HLTH & WELL BE** Provider: **CORSO, MEGHAN L**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

AutoCites Refreshed by CORSO, MEGHAN L @ 17 Sep 2015 0858 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

sleep pathway I

Appointment Comments:

skj

S/O Note Written by CORSO, MEGHAN L @ 17 Sep 2015 0858 EDT**History of present illness**

The Patient is a 30 year old male.

He reported: Encounter Background Information: Pt attended the first class of a two part series on sleep. This class opened with a basic discussion on sleep and the physiological effects of sleep deprivation. We also explored sleep disorders including sleep apnea and insomnia as well as treatment for both sleep apnea and insomnia. We covered topics such as: sleep hygiene, stimulus control, fight or flight response and relaxation techniques (deep breathing and PMR). Pt participated in a deep breathing exercise. Instructor also introduced the CBTi app and demonstrated how to use this app for relaxation exercises. Pt instructed to complete sleep diary (instructor walked through in detail) and the online questionnaire.

A/P Written by CORSO, MEGHAN L @ 17 Sep 2015 0859 EDT

1. **Lack of adequate sleep:** Pt goals:
 1) complete sleep questionnaire online
 2) complete sleep diary using CBTi app or paper version
 3) identify 3 areas of sleep habits and set SMART goal
 4) attend class #2 in two weeks

Procedure(s): -Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 3

Disposition Written by CORSO, MEGHAN L @ 17 Sep 2015 0859 EDT**Released w/o Limitations****Follow up:** as needed with PCM.Signed By CORSO, MEGHAN L (Licensed Clinical Psychologist, NNMC Bethesda) @ 17 Sep 2015 0900

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 739

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Sep 2015 at WRNMMC, Int Med Cons/Spec Care Cl Be by FIACCO, NICHOLAS RYAN

Encounter ID: BETH-21951516 Primary Dx: Penile lesion

Patient: MERWIN, DANIEL DENNIS Date: 08 Sep 2015 0724 EDT Appt Type: 24HR
 Treatment Facility: WALTER REED Clinic: INT MED CONS/SPEC CARE CL Provider: FIACCO, NICHOLAS RYAN
 NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: Outpatient

Reason for Appointment: Written by HERNANDEZ, DARROCQUES D @ 08 Sep 2015 0724 EDT
 fever, swollen knee

Vitals**Vitals** Written by HERNANDEZ, DARROCQUES D @ 08 Sep 2015 0728 EDT

BP: 132/90, HR: 94, RR: 16, T: 97.8 °F, HT: 69 in, WT: 158 lbs, BMI: 23.33, BSA: 1.869 square meters,
 Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 4/10 Moderate, Pain Scale Comments: throat

S/O Note Written by FIACCO, NICHOLAS RYAN @ 09 Sep 2015 1615 EDT**History of present illness**

The Patient is a 30 year old male.
 Patient is a 30 yo male with no significant PMH who presents to sick call for concern over STI. He reports having had 140 sexual partners in his lifetime - 6 since March of this year. He has been monogamous for the past month. He reports sex only with females. He developed a pustular rash and what he describes as ulcerations on his penis and left groin since Saturday. Reports subjective fever. The pustules on groin are tender and the lesions on penis are non tender. No urethral discharge or dysuria.
 <<Note accomplished in TSWF-CORE>>

Fever.

Current medication

Including OTC meds, vitamins, herbals, etc.
 none.

Past medical/surgical history**Reported:**

Medical: Reported medical history
 none.

Personal history

Social history reviewed No alcohol - prior inpatient alcohol rehab. Denies tobacco.

Review of systems**Systemic:** Not feeling tired (fatigue). No chills, no night sweats, and no recent weight loss.**Otolaryngeal:** No earache and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Gastrointestinal:** No dysphagia and no heartburn. No nausea and no bright red blood per rectum.**Genitourinary:** No urinary loss of control and no testicular symptoms were present. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

Oropharynx: • Normal. • Tonsils showed no abnormalities.

Lymph Nodes:

• Cervical lymph nodes were not enlarged. • Submandibular lymph nodes were not enlarged. • Supraclavicular lymph nodes were not enlarged.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 740

AR 0785

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lungs:

- ° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.
- ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

- Heart Rate And Rhythm: ° Normal.
- Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.
- Murmurs: ° No murmurs were heard.

Urinary System:

- ° Urinary system: normal male genitalia, circumcized penis. two very superficial ulcerations/abrasions on underside of shaft. 3-6 erythematous macules that appear similar to ruptured vesicles, no intact vesicles.

Musculoskeletal System:

- Functional Exam:
- General/bilateral: ° Mobility was not limited.

Neurological:

- ° Oriented to time, place, and person.

Psychiatric:

- Mood: ° Euthymic.
- Affect: ° Normal.

Skin:

- ° Lesions. ° A macule was seen.

Note Written by SALUJA, SHUCHI M @ 15 Sep 2015 0732 EDT

Discussed pt with Dr Fiacco, agree with a&p as documented. all labs and herpes culture negative at time of signing encounter

A/P Last Updated by FIACCO, NICHOLAS @ 09 Sep 2015 1628 EDT

1. **Penile lesion:** Concern is for STI and differential is broad. HIV, syphilis are possible. Given reprot of pustular lesions HSV is of concern. He may also just have irritated hair follicles. Counseled patient regarding safe sexual practices to include discretion regarding number of new partners. Will evaluate with HSV culture, HIV rapid, RPR, GC/Chlamydia, HSV IgG/IgM. Will treat empirically for HSV with valtrex twice daily x 10 days.

Medication(s): -valACYclovir-PO 500MG TAB - TAKE 1 TABLET TWICE EVERY DAY FOR 10 DAYS #20 RF0
 Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN

Laboratory(ies): -VIRAL IDENTIFICATION 6 (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; GC/CHLAMYDIA NAAT (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HSV 1 AND 2 IGM ABS, INDIRECT (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HSV 1 AND 2 SPECIFIC AB IGG (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HIV RAPID (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; RAPID PLASMA REAGIN (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN

Disposition Last Updated by FIACCO, NICHOLAS @ 09 Sep 2015 1629 EDT**Released w/o Limitations**

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By FIACCO, NICHOLAS RYAN (Physician) @ 09 Sep 2015 1629**Co-Signed By SALUJA, SHUCHI M (Physician, General Internal Medicine, WRAMC) @ 15 Sep 2015 0733****CHANGE HISTORY***The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by SALUJA, SHUCHI M @ 15 Sep 2015 0732 EDT:*

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Aug 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-21860535 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 27 Aug 2015 1400 EDT
Clinic: PSYCHIATRY BEAppt Type: FTR
Provider: ZEMBRZUSKA, HANNA
DOMINIKAAutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 27 Aug 2015 1355 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

No Labs Found.

Rads

No Rads Found.

Reason for Appointment:

Follow-up

Appointment Comments:

Jnb

VitalsVitals Written by NEFF, JOANNE S @ 27 Aug 2015 1346 EDT

BP: 137/79, HR: 80, RR: 12, T: 99.3 °F, Pain Scale: 0 Pain Free

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1547 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt after Zoloft was increased to 100mg daily. Pt has been taking Zoloft 100mg daily without side effects. He did run out of the Zoloft a few weeks ago and was without the medication for 26 hours which caused him to feel dizzy and have flu-like symptoms. These symptoms resolved once he resumed Zoloft. Pt reports that his depressive and anxiety symptoms have been stable. He has been struggling with hypersomnia rather than insomnia recently. He wants to nap throughout the day despite sleeping 6-7 hours per night. His PCM referred him to sleep clinic. He is in a romantic relationship that is going well. He was separated from his shop at work which has worked out well. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 100mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 742

AR 0787

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

- * THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.
- * MEDS: Denies other medication trials
- * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself ul experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. Total.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Did consume alcohol on 27 May 2015.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed, oriented x3. * No hallucinations. * Memory was unimpaired. * Remote memory was not impaired. * Recent memory was not impaired. * Judgement was not impaired.

Speech: * Normal, regular rate, non-pressured. * Rate was not slowed. * Not pressured. * Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: * Behavior demonstrated no abnormalities - appropriate and cooperative. * No psychomotor retardation. * Behavior demonstrated no psychomotor agitation. * No decreased eye-to-eye contact was observed.

Mood: * Euthymic Able to smile appropriately. * Not depressed. * Not anxious.

Affect: * Normal anxious. * Not labile. * Not flat. * Not constricted. * Showed no irritability.

Thought Processes: * Not impaired, they were linear, logical, and goal directed. * Attention demonstrated no abnormalities. * Attention span was not decreased.

Thought Content: * Insight was intact. * No delusions. * No suicidal ideation. * No suicidal plans. * No suicidal intent. * No homicidal ideations. * No homicidal plans. * No homicidal intent.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 743

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide/Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y
 Positive Coping Skills: Y
 Responsible to/for Family: Y
 Responsible to/for Pet: N
 Frustration Tolerance: Y
 Resilience: Y
 Good Reality Testing: Y
 Amenable to Treatment: Y
 Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

☒ [X] Released without limitations. Advised of emergency procedures.
☐ [] SM released to Chain of Command with the following limitations:
☐ [] SM sent to ER for evaluation for admission to inpatient psychiatry
☐ [] Other:

Therapy

• Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 8/27/2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 4-5 weeks

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Continue Zoloft 100mg daily. Discussed r/b/se. Obtained informed consent for medication.
2. Continue SARP.
3. Referred pt for individual CBT today.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Continue Zoloft 100mg daily. Discussed r/b/se. Obtained informed consent for medication.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS pm insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1558 EDT1. **GENERALIZED ANXIETY DISORDER** 300.02

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. **ALCOHOL DEPENDENCE (ALCOHOLISM)** 303.903. **Patient Education - Medication** V65.49 1(MEDICATION EDUCATION)Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1601 EDT**Released w/o Limitations****Follow up:** 4 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 31 Aug 2015 1602

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 745

AR 0790

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

25 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21829481 Primary Dx: ALCOHOL DEPENDENCE (ALCOHOLISM)

Patient: MERWIN, DANIEL DENNIS Date: 25 Aug 2015 1218 EDT Appt Type: GRP
Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: HILL, LARRY D
NAVY YARD
Patient Status: Outpatient

AutoCites Refreshed by HILL, LARRY D @ 26 Aug 2015 1443 EDT

Problems

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	11 Aug 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 25 Aug 2015 1218 EDT
CC GROUP

Screening Written by PATSOS, ASHLEY N @ 25 Aug 2015 1228 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 25 Aug 2015 1218

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 25 Aug 2015 1229 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 746

AR 0791

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 25 Aug 2015 1230 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 25 Aug 2015 1232 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 26 Aug 2015 1444 EDT**Released w/o Limitations****Discussed:** Alternatives with Patient who indicated understanding. - Comments: "SEE ADD NOTE SECTION FOR FURTHER INFORMATION CONCERNING THIS ENCOUNTER."**Note Written by HILL,LARRY D @ 26 Aug 2015 1446 EDT****Daniel CC note**

Daniel arrived on time. Daniel is at session # 11 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group was allowed to process and lead the discussion. There was tension in the group and the discussion turned to planning a group social event. Several options were discussed with no definite plan was decided upon. It came to a discussion of what the group was about and how group members supported each other. The group appeared to be storming and by the end of group they began to be more cohesive and a working group. Group went over by 4 minutes because the discussion became about their recovery and how the group can help.

Daniel sounded disappointed as he said "I just do not share in group anymore because I believe no one cares about me and what is going on." Another group member spoke up in the group process saying "this is my therapy and I'm here to use it to help me with my issues because I don't have anything else." Daniel was observed validating her saying "thank you for having the balls to say what I could not." The tension in the room was high as Daniel and another group member had a disagreement with each other. Another group member told Daniel "it sounds like you are always talking out your ass." Daniel sounded defensive in his tone and then brought up an old issue that was processed and gone to take a jab back at this other group member." At this point the group almost completely shut down and the counselors took over to help group member's process what was happening in group. Daniel reported the strength of another group member saying what she felt helped him learn how to deal with and handle situations in group where he is uncomfortable.

Daniel appeared engaged and interested in the treatment process. Daniel appeared annoyed, engaged and was appropriate and active throughout the session. Daniel had no current problems or objectives due from his ITP. Daniel will continue with Continuing Care treatment and has an outdated treatment plan and will schedule an individual session on 1 Sep 15 for review and update. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 1 September 2015 at 1230 for group. No evidence of SI/HI during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 26 Aug 2015 1446**Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 27 Aug 2015 1247**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 747

AR 0792

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

18 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21756984 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARDDate: 18 Aug 2015 1224 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: HILL, LARRY D

Patient Status: Outpatient

AutoCites Refreshed by HILL, LARRY D @ 19 Aug 2015 1303 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	11 Aug 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 18 Aug 2015 1224 EDT
CC GROUPScreening Written by PATSOS, ASHLEY N @ 18 Aug 2015 1247 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 18 Aug 2015 1224

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 18 Aug 2015 1247 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 748

AR 0793

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 18 Aug 2015 1248 EDT

History of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 18 Aug 2015 1248 EDT

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 19 Aug 2015 1351 EDT

Released w/o Limitations

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session # 10 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. Group rules were read and explained for clarification. The entire group denied drinking or using drugs. Group discussed places and events that remind them to drink and the coping skills they are using now. Group processed the worksheet "Create a Friend" and shared how they compared to it in being friends with others. Daniel opened group up with what he called a "new addiction" in his life McDonald's hamburgers. He said "I do not know why I like them they are just good." This counselor helped him understand with a short brief of the brain reward pathway and addiction, helping his understanding. Daniel was observed relating to another group member sharing about relaxing on her patio with a cigar and drink and how hard it is to change places and things related to drinking. Daniel said "I still cannot go out on my patio due to the drinking relationship I had out there. Daniel sounded excited as he reported he no longer uses his old on-line dating sights. At some point in the group Daniel was in the role of a junior counselor and asking opened questions to other group member. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has no current problems or objectives due from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 4, Objective # 2 due 25 Aug 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 08 September 15 for group. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 2024337577

Signed By HILL, LARRY D (Physician) @ 19 Aug 2015 1353

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 19 Aug 2015 1441

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 749

AR 0794

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

11 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-21685479 Primary Dx: ALCOHOL DEPENDENCE (ALCOHOLISM)

Patient: MERWIN, DANIEL DENNIS

Date: 11 Aug 2015 1232 EDT

Appt Type: GRP

Treatment Facility: NBHC WASHINGTON

Clinic: SUBST ABUSE NY

Provider: BROWN,CYNTHIA E

NAVY YARD

Patient Status: Outpatient

AutoCites Refreshed by BROWN,CYNTHIA E @ 12 Aug 2015 1327 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Loading...

Reason for Appointment: Written by PATSOS,ASHLEY N @ 11 Aug 2015 1232 EDT
CC GROUPScreening Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDTReason For Appointment: Notes Entered by: PATSOS,ASHLEY N 11 Aug 2015 1232

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 750

AR 0795

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 12 Aug 2015 1331 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 12 Aug 2015 1341 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for group. Daniel is at session # 9 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No group member admitted to using alcohol or drugs since last seen at SARP. The group began with each member identifying their current feeling in one word. Several group members shared of current struggles including; work, stress, PCS and family issues. The group closed with one group member using the closing exercise.

Daniel was very subdued in the group today. He did not appear to have a need to counsel any other group member which is his normal mode of operando. He only really shared with the group that he has a girlfriend now. They have been together for about 10 days and she makes him really happy. He heard in the closing that he should slow down with the dating scene. The closing member shared that he did not have relationship happiness until his second marriage. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has Problem #1, Objective #8 overdue from his ITP. This will addressed upon his return 17 July 2015. Daniel will continue with Continuing Care treatment and has Problem # 4 Objective #2 due 24 August 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 18 August at 1230 for group.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 12 Aug 2015 1341

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 751

AR 0796

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

11 Aug 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-21682013 Primary Dx: PENILE WARTS

Patient: **MERWIN, DANIEL DENNIS** Date: **11 Aug 2015 1015 EDT** Appt Type: **EST**
 Treatment Facility: **WALTER REED** Clinic: **INT MED MEDICAL HOME CL C** Provider: **AUSTIN, MARIE**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient**

Reason for Appointment:

STD Screening/Possible Genetal Warts

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by NEWMAN, BRENDA W @ 11 Aug 2015 1023 EDT

BP: 122/82 Left Arm, Adult Cuff, HR: 73, RR: 16, T: 98.2 °F, HT: 69 in, WT: 163.8 lbs Upright Scale, Actual, With Shoes,
 SpO2: 97%, BMI: 24.19, BSA: 1.898 square meters, Pain Scale: 3/10 Mild, Pain Scale Comments: Headache

Questionnaire AutoCites Refreshed by NEWMAN, BRENDA W @ 11 Aug 2015 1026 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 11 Aug 2015

The Selected Provider is AUSTIN, MARIE R in the Int Med Medical Home CL C Be clinic.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Several days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN, MARIE @ 11 Aug 2015 1103 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-CORE>>

PO1 Merwin is a 30 y/o CM who presents to clinic for 2 concerns

1. STD check- penile warts with exposure to HPV in previous partner
2. PT wakes up 2-3 times a night to go to the BR. Sleep apnea his Epworths score is 18/21 . Autocited allergies verified.

Visit is not deployment-related.

admission diagnosis of HPI (use for free text).

Pain Severity 0 / 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 752

AR 0797

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 11Aug2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria and no testicular symptoms were present.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety. Not thinking about suicide. No homicidal thoughts.**Skin:** Skin lesion: penile wart s.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Genitalia:

Penis: • Abnormal 4 warts on the shaft of the penis, aprox 0.01 cm- 0.02 cm, skin colored, on the lower third of the shaft . Pt is shaving the shaft advised against that .

Scrotum: • Normal.

Testes: • Normal.

Neurological:

• Oriented to time, place, and person.

Sensation: • No sensory exam abnormalities were noted.

Balance: • Normal.

Gait And Stance: • Normal.

Reflexes: • Deep tendon reflexes were normal.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Test conclusions

Medication list was updated at the beginning of the visit.

The provider compared the medication list against any orders, and resolved any discrepancies (if required).

A written list of medications was given to the patient.

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 753

AR 0798

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by AUSTIN, MARIE @ 18 Aug 2015 1714 EDT**1. PENILE WARTS 078.11**

Medication(s): -IMQUIMOD—TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE TIMES A WEEK #1 RF1
 Patient Instruction(s): -Instructions: Use A Condom During Sexual Intercourse
 -Guidance: Concerns About Unsafe Sexual Practices

2. MAJOR DEPRESSION RECURRENT MODERATE 296.32

Medication(s): -sertraline—PO 100MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF2
 Patient Instruction(s): -Community Programs
 -Limitations / Risks General - Complications from Medication
 -Patient Education - Medication

3. ORGANIC SLEEP APNEA 327.20: Scored 18/21 on the Epworth's sleepiness scale . Give handout to go to the sleep pathways clinic

Patient Instruction(s): -Instructions For Patient

Disposition Written by AUSTIN, MARIE @ 18 Aug 2015 1715 EDT**Released w/o Limitations**

Follow up: as needed . - Comments: pt to f/u as advised

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: education and counseling on STDs

40 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 18 Aug 2015 1715**CHANGE HISTORY**

The following S/O Note Was Overwritten by AUSTIN, MARIE @ 11 Aug 2015 1047 EDT:

S/O Note Written by NEWMAN, BRENDA W @ 11 Aug 2015 1029 EDT

History of present illness

The Patient is a 30 year old male.

He reported: Visit is not deployment-related.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.
 Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated
 NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.
 Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history
 GAD
 alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history
 PRK
 Tonsillectomy

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

History**ANNUAL QUESTIONS**

Preferred language (written or spoken): ☒ English ☐ Other:
 What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):
 Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:
 Advance directives completed? ☐ Yes ☒ No
 Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact preference: 410-562-5345
 PCM:

Annual Questions Date: 11Aug2015.

Family history

Family medical history
 DM father, PGM
 MI father
 hypertension father
 melanoma father

Practice Management

Preventive medicine services
 Lipid Screening -
 Diabetes Screening -
 Aspirin Prophylaxis -
 HIV Screen -
 Colonoscopy -

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 754

AR 0799

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Tetanus (Td/Tdap) - 2013
Influenza Vaccine - oct 2014
Zoster Vaccine -
Pneumococcal Vaccine -
HPV Vaccine -

Men:
Aortic Aneurysm Screen (if ever a smoker) -
.....

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 755

AR 0800

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

28 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-21539829 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS Date: 28 Jul 2015 1158 EDT Appt Type: GRP
Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: BROWN, CYNTHIA E
NAVY YARD
Patient Status: Outpatient

AutoCites Refreshed by BROWN, CYNTHIA E @ 29 Jul 2015 1243 EDT

Problems

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 28 Jul 2015 1158 EDT
CC GROUP

Screening Written by PATSOS, ASHLEY N @ 28 Jul 2015 1159 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 28 Jul 2015 1158

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 28 Jul 2015 1159 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 28 Jul 2015 1200 EDT

History of present illness

The Patient is a 30 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Page 756

AR 0801

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 28 Jul 2015 1201 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 29 Jul 2015 1243 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP

Daniel arrived on time for group. Prior to group we discussed his need to have the attention of a female in group. We discussed how this was his issue and it needed to not interfere with the group process for him or for her. He was cautioned about being a Junior Counselor trying to give advice to group members instead of keeping the focus on his self. He began to discuss how he was having a female recently and she wanted to touch him but it turned him off. He is not in talk therapy and only does medication management. He was told he would best deal with these issues with Mental Health and he agreed to speak to his medication manager. Daniel is at session # 8 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The entire group denied that they drank alcohol or abused drugs. The group seemed very future oriented speaking of what is coming up for them in the next weeks and months. All group members were encouraged to make their individual treatment planning sessions prior to leaving today.

Daniel did not appear engaged or interested in the treatment process. He noted as having a side conversation with a group and making inappropriate comments to him. He appeared to provide advice to other group members again that had nothing to do with his own experience. Daniel rescheduled Problem #4, Objective #2 stating he needed more time from his ITP. He is late also on Problem #1 Objective #8 and that will be addressed next week. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 4 August 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 29 Jul 2015 1243

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 757

AR 0802

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

21 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA EEncounter ID: BETH-21467538 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS Date: 21 Jul 2015 1219 EDT Appt Type: GRP
 Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: BROWN,CYNTHIA E
 NAVY YARD
 Patient Status: Outpatient

AutoCites Refreshed by BROWN,CYNTHIA E @ 22 Jul 2015 0837 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment: Written by PATSOS,ASHLEY N @ 21 Jul 2015 1219 EDT
 CC GROUP

Screening Written by PATSOS,ASHLEY N @ 21 Jul 2015 1222 EDTReason For Appointment: Notes Entered by: PATSOS,ASHLEY N 21 Jul 2015 1219

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS,ASHLEY N @ 21 Jul 2015 1222 EDT

Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 21 Jul 2015 1223 EDT**History of present illness**

The Patient is a 30 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 758

AR 0803

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 21 Jul 2015 1230 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 22 Jul 2015 0838 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for group today. Daniel is at session # 7 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. The group denied drinking or abusing drugs since their last report to this group. The group reviewed euphoric recall as a relapse trigger. We discussed the engagement to 12 step meetings or other supportive activities and found most group members reduced the number of meetings attended since starting this program. The entire group was encouraged to make individual session to speak with their primary counselor about the requirements of this group and program.

Daniel shared that he had run out of his Zoloft and went several days without it. He described having withdrawal but stated he is back on it now. He stated that he feels better and knows that the medication is necessary for him. Daniel stated that his only 1 AA meeting and he keeps himself busy the rest of the time. He admitted that he is required to attend more AA meetings (3) by his treatment plan. Daniel appeared engaged and interested in in what the female group member was doing and not the group. He was noted as playing "jr. counselor" in stating that attending AA meetings helps others. Daniel appeared upset at the end of the session and stated that he is using his CBT to assist in his behaviors. Daniel did have Problem 4 Objective 2 due today but failed to forward it. Daniel will continue with Continuing Care treatment and has Problem #4, Objective #2 to be completed next week. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 28 July 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 22 Jul 2015 0838

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

15 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA EEncounter ID: BETH-21402674 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **15 Jul 2015 0711 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **BROWN,CYNTHIA E**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by BROWN,CYNTHIA E @ 17 Jul 2015 0728 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment: Written by PATSOS,ASHLEY N @ 15 Jul 2015 0711 EDT
 CC GROUP

Screening Written by PATSOS,ASHLEY N @ 15 Jul 2015 0718 EDTReason For Appointment: Notes Entered by: PATSOS,ASHLEY N 15 Jul 2015 0711

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS,ASHLEY N @ 15 Jul 2015 0718 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 Jul 2015 0719 EDT**History of present illness**

The Patient is a 30 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 15 Jul 2015 0721 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 17 Jul 2015 0728 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP

Daniel arrived on time to group. Daniel is at session #6 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No one in group admitted to drinking or abusing drugs. The group welcomed a new group member using the introduction exercise. The group shared the struggles of the last week and any triggers to drink or abuse drugs in the past week. Group completed and discussed the worksheet "Supportive Relationships."

Daniel took up most the group talking in circles. Even when confronted he continued to contradict himself. The group was noted as checking out but no group confronted him this defensive behavior. He did report a childhood incident but did not recall the details enough to assure that the situation happened. He reported on his worksheet that he did not share about this but did. Not enough detail in this and he stated that his parents were notified. Daniel appeared monopolize the group impeding the treatment process. Daniel did not completed any treatment plan objectives and did not have any due. Daniel will continue with Continuing Care treatment and has Problem #4, Objectives #2 and 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 21 July 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 17 Jul 2015 0730

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 761

AR 0806

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

08 Jul 2015 at WRNMMC, Dermatology Clinic Bethesda by TAYLOR, BRADLEY MICHAEL

Encounter ID: BETH-21343480 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Jul 2015 1923 EDT**
Clinic: **DERMATOLO CL BE**Appt Type: **T-CON***
Provider: **TAYLOR, BRADLEY MICHAEL**

Call Back Phone: [REDACTED]

AutoCites Refreshed by TAYLOR, BRADLEY M @ 08 Jul 2015 1923 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Lab Result Cited by TAYLOR, BRADLEY M @ 08 Jul 2015 1924 EDT**Tissue Exam**

Date Collected: 23 Jun 2015 1131
 POC Enc: E4520771
 Enc Fac: WRNMMC
 Clinician: TAYLOR, BRADLEY MICHAEL
 Status: Certify
 Procedure: TISSUE EXAM
 Order #: 150702-23826
 Provider: TAYLOR, BRADLEY MICHAEL
 Ordered Date: 02 Jul 2015 1925
 Priority: ROUTINE
 Specimen: TISSUE
 Resulted Date: 02 Jul 2015 1925.1-0400
 Col: 23Jun15@1131 TISSUE(TISSUE)
 Hcp: TAYLOR, BRADLEY MICHAEL Req Loc: DERMATOL
 Performing Lab: NMMC AP LAB, BETHESDA, MD
 150626 NSP 11753
 LRS02Jul15@1925
 CoPath Report
 Patient: MERWIN, DANIEL DENNIS Specimen #: NS15-11753
 Accessioned: 06/26/15
 Pathologist: Laurel R. Stearns, MAJ, MC, USA
 SPECIMEN:
 A: Skin, Scalp, Punch B: Skin, Left scalp, Punch

FINAL DIAGNOSIS:

A. SKIN, SCALP, PUNCH BIOPSY:

- MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA.
(SEE COMMENT)

B. SKIN, LEFT SCALP, PUNCH BIOPSY:

- NORMAL SCALP.

COMMENT: The sections were difficult to interpret due to processing

and

orientation. In part A, the sections show a normal number of terminal

hair

follicles with a slightly increased number of vellus hairs. Mild
superficial perifollicular lymphocytic inflammation is present.

Evidence

of scarring alopecia is not present in multiple additional step

sections.

If clinically indicated additional biopsies may be helpful.

Irs/07/02/15 ** Report Electronically Signed Out **

Laurel R. Stearns, MAJ, MC, USA

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

CLINICAL DIAGNOSIS AND HISTORY:

-==

overlying mild

30 y/o M, tufted, scarring alopecia on scalp after reported infection about six years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents

elected to

seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient

Perilesional and

proceed with biopsy. Two punch biopsies completed today.

LPP v

normal posterior scalp. Tolerated well. Wound care discussed. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v

PRE-OPERATIVE DIAGNOSIS:

other scarring etiologies.

other

A) Mature scar w/overlying seb derm v folliculitis decalvans v LPP v

POST-OPERATIVE DIAGNOSIS:

scarring etiology. B) Normal scalp.

GROSS DESCRIPTION:

Operative Findings: SAA
Post-operative Diagnosis: SAA

name

A. The specimen is received in formalin, labeled with the patient's

0.6 cm.

Merwin, Daniel, and designated "Punch, Scalp". It consists of a tan, hair-bearing punch of skin that is previously horizontally sectioned measuring 0.4 cm in diameter and excised to a maximum depth of

name

B. The specimen is received in formalin, labeled with the patient's

tan,

Merwin, Daniel, and designated "Punch, Left Scalp". It consists of a

previously

hair-bearing punch of skin measuring 4.0 cm in diameter that is

The

horizontally sectioned and excised to a maximum depth of 0.6 cm.

(Sponge)

specimen is submitted in its entirety in one cassette. 3/1/NG

CLP/PDP/LRS

CLP/mrg

CPT Codes:

; 88305 ; 88305 (LEVEL 4)

; 88305 ; 88305 (LEVEL 4)

A/P Written by TAYLOR, BRADLEY M @ 08 Jul 2015 1925 EDT

1. Visit for: administrative purpose: Left VM for patient regarding above results. Number provided to call back for questions or concerns.

Disposition Written by TAYLOR, BRADLEY M @ 08 Jul 2015 1925 EDT

Follow up: as needed with PCM.

Signed By TAYLOR, BRADLEY M (Physician/Workstation) @ 08 Jul 2015 1925

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 763

AR 0808

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

30 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21269597 Primary Dx: ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC DAHLGREN
Patient Status: OutpatientDate: 30 Jun 2015 1157 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: HILL, LARRY DAutoCites Refreshed by HILL, LARRY D @ 01 Jul 2015 1330 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 30 Jun 2015 1157 EDT
CC GROUPScreening Written by PATSOS, ASHLEY N @ 30 Jun 2015 1211 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 30 Jun 2015 1157

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 30 Jun 2015 1211 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 30 Jun 2015 1212 EDT**History of present illness**

The Patient is a 30 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 30 Jun 2015 1218 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 01 Jul 2015 1347 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: "SEE ADD NOTE SECTION FOR FURTHER INFORMATION CONCERNING THIS ENCOUNTER."

Note Written by HILL,LARRY D @ 01 Jul 2015 1416 EDT**Daniel CCG note**

Daniel arrived on time and is at session 5 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group performed the check-in process identifying changes or events since last group. The group discussed pleasurable activities that they already do and identified one new activity to do before next group. They discussed common styles of thinking and how they apply to themselves and identified individuals who support their addiction and those who support their recovery. No group member admitted to drinking or using since last group. Daniel appeared tense as group began dressed in shorts and a button up shirt. Daniel sounded pained as he addressed another female group member who said she felt uncomfortable with Daniel and said he is a pervert. Daniel reported feeling judge and looked discouraged at the accusations due to their brief contact outside group. They processed these feelings and safety, respect and non-judgmental behaviors for other group members and seemed able to work through their differences. Daniel has a co-occurring sex addiction and seems to be a driving factor in their personal issues that Daniel reports he is working on. Daniel reported meeting a new girl and spending the night with her jumping head first into a relationship knowing this in in direct violation of his own efforts to find a loving relationship. Daniel was able to identify those working against his recovery saying "I'm the number one problem", he additionally identified his sober network those individuals he can call when he struggles. Daniel reported he would like to cook a surprise food for the group, prior to next group.

Daniel appeared uneasy, engaged, interested and was appropriate and active throughout the session even when processing tension between group members. Daniel addressed Problem #1, Objective #1, 4 & 6 from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 7 July 2015 for group. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 01 Jul 2015 1417Co-Signed By SPADARO, SHELLIE S (Physician) @ 01 Jul 2015 1525**CHANGE HISTORY**The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by HILL,LARRY D @ 01 Jul 2015 1416 EDT:Signed HILL, LARRY D (Physician) @ 01 Jul 2015 1348

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 765

AR 0810

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

26 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-21238834 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **26 Jun 2015 1430 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**

Procedure - SARP LABS

Appointment Comments:

brh

Lab Result Cited by AILOR, LYNNE P @ 26 Jun 2015 1451 EDT

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	23 Jun 2015 1404	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 26 Jun 2015 1453 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Results of ETG/ETS were negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition Written by AILOR, LYNNE P @ 26 Jun 2015 1453 EDT****Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By AILOR, LYNNE P (Physician) @ 26 Jun 2015 1454**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

25 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-21224749 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **25 Jun 2015 1100 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P**Reason for Appointment:
Procedure - SARP LABS
Appointment Comments:
brh**Lab Result Cited by AILOR, LYNNE P @ 25 Jun 2015 1543 EDT**

Drug Abuse Screen	Site/Specimen	23 Jun 2015 1404	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

A/P Written by AILOR, LYNNE P @ 25 Jun 2015 1545 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition Written by AILOR, LYNNE P @ 25 Jun 2015 1546 EDT****Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By AILOR, LYNNE P (Physician) @ 25 Jun 2015 1546**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

23 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21198244 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC DAHLGREN
Patient Status: OutpatientDate: 23 Jun 2015 1203 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: HILL, LARRY D**AutoCites** Refreshed by HILL, LARRY D @ 25 Jun 2015 1207 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 23 Jun 2015 1203 EDT
CC GROUP**Screening** Written by PATSOS, ASHLEY N @ 23 Jun 2015 1216 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 23 Jun 2015 1203

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 23 Jun 2015 1216 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 23 Jun 2015 1218 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 768

AR 0813

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 23 Jun 2015 1237 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -DRUG ABUSE SCREEN (Routine) Ordered By: PATSOS,ASHLEY N Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: PATSOS,ASHLEY N Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by HILL,LARRY D @ 25 Jun 2015 1230 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session # 4 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group checked-in and reintroduced themselves to a member that had been absent. They processed cravings and shared about how they sleep now compared to when they were drinking. One group member reported struggling with lack of motivation and not caring about anything. No group member reported drinking or using since last seen at SARP WYN.

Daniel appeared frustrated as he reported feeling judged as another member reported sharing not being comfortable sharing intimate details of her life with men. Daniel said "I feel judge as a man and like you don't trust me, and I'm more comfortable sharing with women than a man." This counselor had to block this interaction noticing some tension between these two group members and identified this to them and both members decided to just drop it and not process this tension. Daniel was observed providing positive feedback to another group member struggling with motivation and not caring saying "it sounds like you could be depressed and should get seen for it." Daniel seems to struggle with female interactions in the group and is noted from him in his past relationships. Daniel wrote "I could relate to everyone today and felt a myriad of feeling."

Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem # 1, Objective # 1 & 4 from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 & 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 30 June 2015 for group. No evidence of SI/Hi during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by HILL,LARRY D @ 25 Jun 2015 1231 EDT

Shellie will co-sign note in absence of program director.

Signed By HILL, LARRY D (Physician) @ 25 Jun 2015 1231Co-Signed By SPADARO, SHELLIE S (Physician) @ 25 Jun 2015 1441

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Jun 2015 at WRNMMC, Dermatology Clinic Bethesda by STEARNS, LAUREL R

Encounter ID: BETH-21190437 Primary Dx: Alopecia

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **22 Jun 2015 1430 EDT**
Clinic: **DERMATOLO CL BE**Appt Type: **SPEC**
Provider: **STEARNS, LAUREL**
REINHARTAutoCites Refreshed by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

alopecia areata

Appointment Comments:

anb

S/O Note Written by TAYLOR, BRADLEY MICHAEL @ 23 Jun 2015 0724 EDT**Chief complaint**

The Chief Complaint is: Scalp.

History of present illness

The Patient is a 30 year old male.
30 y/o male. Per patient, has history of MRSA infection on scalp about 5 to 6 years ago. Hair has never completely grown back. More recently has started to develop scale in same area as well as other areas of scalp. Unsure if area has remained the same size. He feels it has been getting larger.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Allergies

Current Allergies Reviewed.

Past medical/surgical history**Reported:**

Medical: Reported medical history reviewed

Review of systems**Systemic:** No fever and no chills.**Skin:** Pruritus and skin lesion: rash.**Physical findings****General Appearance:**

° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° Oriented to time, place, and person.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

• Skin: Scalp: Approx 1.5 to 2 cm annular patch of noticeably decreased hair density on posterior apex scalp. Smaller but also annular area next to it. Slightly raised scar like plaque. Follicle drop and tufting of hair noted. Mild erythema and scale.

Note Written by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT

Medical Record

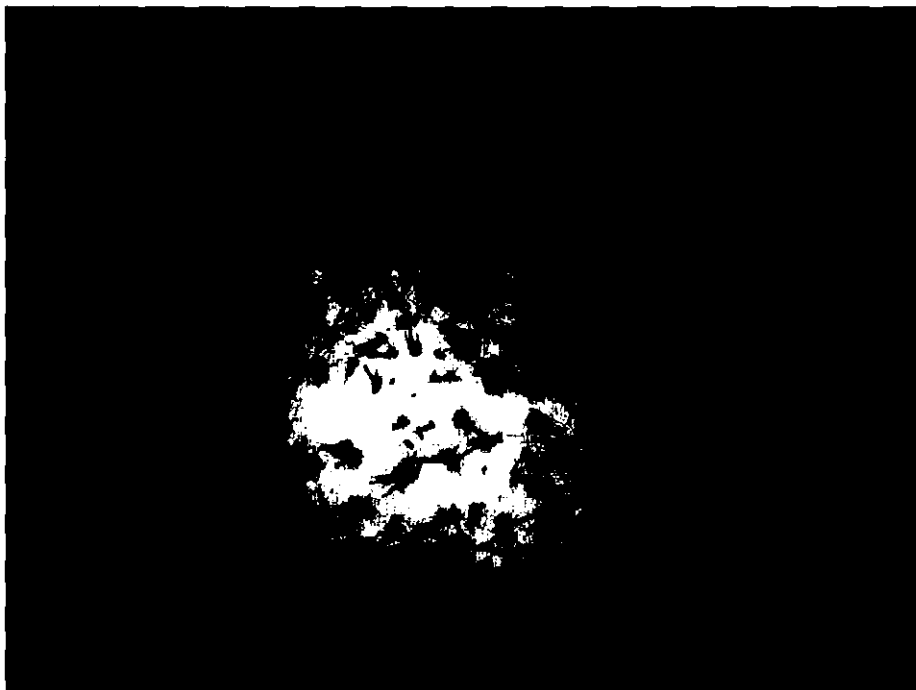
Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

A/P Last Updated by TAYLOR, BRADLEY M @ 23 Jun 2015 1135 EDT

1. **Alopecia:** Tufted, scarring alopecia on scalp after reported infection about 6 years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well. Wound care discussed. Follow up in 10 to 14 days for suture removal and biopsy results. Sooner for concerns. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v LPP v other scarring etiologies.

Seen and d/w Dr. Stearns.

Procedure(s):

-Biopsy Skin x 1 - Universal protocol requirements were met per WRNMMC Policy. Patient's identification was checked (name & birthdate). procedure and site, side matches the consent form. the lesion was prepped with alcohol. local anesthesia was provided by local injection with a 30g needle of 1ml of 1% lidocaine with epinephrine. a 4 mm punch biopsy was then performed. estimated blood loss was negligible. the wound was closed with 4 -0 suture, and a sterile dressing applied. wound care discussed, f/u 10 days for suture removal and discussion of path results.

Laboratory(ies):

-Biopsy Skin Each Additional Lesion x 1

-TISSUE EXAM (Routine) Start Date: 06/23/2015 Order Date: 06/23/2015 11:35 Ordered By: TAYLOR, BRADLEY M Ordering Provider: TAYLOR, BRADLEY MICHAEL

Disposition Last Updated by TAYLOR, BRADLEY M @ 23 Jun 2015 1136 EDT**Released w/o Limitations****Follow up:** in the DERMATOLOGY CL BE clinic. - Comments: 10 to 14 days**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT**Consult Order****Referring Provider:** ARGUINZONI, JUAN B.**Date of Request:** 07 May 2015**Priority:** Routine**Provisional Diagnosis:****Reason for Request:**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

30 y/o male with alopecia areata. Please evaluate and treat as needed; thanks.

Note Written by STEARNS, LAUREL R @ 23 Jun 2015 1537 EDT

I have seen and evaluated the patient and agree with the findings as documented in the note.

Signed By STEARNS, LAUREL R (Cpt, USA, MC, NPI 1356491393, Staff Dermatologist, Dermatology, WHMC/BAMC) @ 23 Jun 2015 1537

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

16 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21126679 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC DAHLGREN
Patient Status: OutpatientDate: 16 Jun 2015 1202 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: HILL, LARRY DAutoCites Refreshed by HILL, LARRY D @ 17 Jun 2015 1433 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 16 Jun 2015 1202 EDT
CC GROUPScreening Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 16 Jun 2015 1202

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 16 Jun 2015 1221 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 17 Jun 2015 1450 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #3 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group started with checking in on happenings since last group, the group welcomed one new member and closed with two group members using the introduction and closing exercises. The group shared about life struggles while the where drinking and how they affect them now. No group member admitted to drinking or abusing drugs since last seen at SARP.

Daniel appeared interested as another group member frustratedly listed many reasons why she felt she should drink, use drugs and return to old habits. Daniel was observed relating her struggles to his own life saying "I use to think the same way and when I was drinking I would over use my prescription pain meds knowing I should not but would do it anyways." "I'm disappointed in myself because I continually struggle with relationships and have been with 126 women and had been doing very good but I had sex with two women in the past two days. This to me is my old behavior but it was worse when I was drinking." "I want a health relationship but struggle and don't know how to have one, I'm very picky." Daniel seems to be struggling with a sex addiction and dealing with a myriad of feeling including shame, guilt and disappointment in himself for lack of control.

Daniel appeared engaged and was appropriate and active throughout the session. Daniel addressed Problem #1, Objectives # 1, 4, & 6 from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objective #2 due 21 July 2015. See Daniel's "Continuing Care Progress Report" for more information on this encounter. No evidence of SI/Hi during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 17 Jun 2015 1450Co-Signed By SPADARO, SHELLIE S (Physician) @ 18 Jun 2015 0905

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 Jun 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-21077936 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Jun 2015 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **ZEMBRZUSKA, HANNA**
DOMINIKA

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 11 Jun 2015 0905 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

18 May 2015 1107
ETG/ETS, UA (250 Cut-Off)
 Ethyl Glucuronide

Site Specimen	Result	Units	Ref Range
URINE	negative	ng/mL	Cutoff=250

18 May 2015 1107
Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Not-Detected)
URINE	negative <i>	ng/mL	(Negative)

Rads

No Rads Found.

Reason for Appointment:

follow up

Appointment Comments:

nae

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0728 EDTHistory of present illness

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt has been taking Zoloft 75mg daily without side effects. Pt reports that he continues to be happier more often, but it is not consistent. He reports no difference in his anxiety. He continues to have anxious ruminations about work which lead to initial insomnia. He has been taking Melatonin a few times a week at bedtime, but does not want to take it every night. He is implementing the skills he learned in CBT-I group and using the CBT-I app. Sleeping about 7 hours per night, but finds himself tired in the afternoon and will sometimes take a 30-60min nap. He reports consuming 1/2 pint of alcohol on 27May due to feeling stressed about work and interpersonal difficulty in romantic relationship. He is a people pleaser and has a hard time saying no. He may be separated from his shop at work which he thinks will be better because he does not like his current job. He needs to pick up collateral duties to pick up next rank.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 re on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged at the end of April 2015.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 75mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself unable to experience from the past or avoid having feelings related to it?

[1] Avoid activities or situations because they remind you of a stressful experience from the past?

[0] Trouble remembering important parts of a stressful experience from the past?

[0] Loss of interest in things that you used to enjoy?

[0] Feeling distant or cut off from other people?

[2] Feeling emotionally numb or being unable to have loving feelings for those close to you?

[0] Feeling as if your future will somehow be cut short?

[0] Trouble falling or staying asleep?

[1] Feeling irritable or having angry outbursts?

[1] Having difficulty concentrating?

[1] Being 'super alert' or watchful on guard?

[0] Feeling jumpy or easily startled?

Add point values from each response. Total:

Behavioral: Caffeine use tea and coffee 1-2x/wk. Never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Did consume alcohol on 27 May 2015.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Page 776

AR 0821

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Anxious. ° Euthymic Able to smile appropriately. ° Not depressed.

Affect: ° Abnormal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N

Access to Lethal Means: N

Poor Treatment Compliance: N

Hopelessness: ?

Psychic Pain/Anxiety: Y

Acute Event: N

Insomnia: N

Low Self-Worth: Y

Impulsivity: N

Substance Abuse: Y

Financial Stress: Y, PAYING OFF DEBT

Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y

Positive Coping Skills: Y

Responsible to/for Family: Y

Responsible to/for Pet: N

Frustration Tolerance: Y

Resilience: Y

Good Reality Testing: Y

Amenable to Treatment: Y

Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:☒ [X] Released without limitations. Advised of emergency procedures.☐ [] SM released to Chain of Command with the following limitations:☐ [] SM sent to ER for evaluation for admission to inpatient psychiatry

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

[] Other:

Therapy

- Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
Medication Prescriber: ZEMBRZUSKA
Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 11JUN2015
Reviewed with patient on: same
Does patient agree with plan? Yes
If not, what part?
Projected date of next treatment plan update: f/u in 1 month
Discussion of risk of assessment and intervention
Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft to 100mg daily. Pt's depressive symptoms appear to have responded to Zoloft, but anxiety is still not under good control. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft to 100mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS pm insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0739 EDT**1. GENERALIZED ANXIETY DISORDER 300.02**

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0740 EDT**Released w/o Limitations****Follow up:** 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 12 Jun 2015 0740

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

09 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21053074 Primary Dx: ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **09 Jun 2015 1200 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **HILL, LARRY D**
 Patient Status: **Outpatient**

AutoCites Refreshed by HILL, LARRY D @ 10 Jun 2015 0932 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 09 Jun 2015 1200 EDT
CC GROUP**Screening** Written by PATSOS, ASHLEY N @ 09 Jun 2015 1219 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 09 Jun 2015 1200

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 09 Jun 2015 1219 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 779

AR 0824

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 09 Jun 2015 1219 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 09 Jun 2015 1221 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 10 Jun 2015 1356 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time. Daniel is at session 2 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group welcomed one new group member using the introduction exercise. The group closed with 2 group members. One group member admitted to drinking while in treatment which led to another group mentioning he drank also. The group processed how they could these struggling group members.

Daniel reported doing well during the check in process and said "I have to be honest with the group; I also had a lapse 2 weeks ago and drank most of pint of vodka. I have been struggling with a female friend that wants to be more than a friend and ended up in a liquor store and bought the bottle. I had unopened cranberry juice at home and mixed them and ended up pouring out some of it." Daniel reported feeling guilty concerning his lapse. Daniels honesty seemed to be brought forward from another group member he knows that shared of a recent lapse. Daniel seems to struggle with self-image and puts a lot of his time and efforts into others writing "I have not been worrying about others and what they think of me." Daniel reports working the 12 steps but has no sponsor. Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 and 4 attending group and sharing from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 16 June 2015 at 1230 for group. No evidence of SI/HI during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 10 Jun 2015 1356Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 10 Jun 2015 1417**CHANGE HISTORY**The following Disposition Note Was Overwritten by HILL,LARRY D @ 10 Jun 2015 1356 EDT:

The Disposition section was last updated by HILL,LARRY D @ 10 Jun 2015 1356 EDT - see above. Previous Version of Disposition section was entered/updated by HILL,LARRY D @ 10 Jun 2015 0932 EDT.

Released w/o Limitations

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time. Daniel is at session 2 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group welcomed one new group member using the introduction exercise. The group closed with 2 group members. One group member admitted to drinking while in treatment which led to another group mentioning he drank also. The group processed how they could these struggling group members.

Daniel reported doing well during the check in process and said "I have to be honest with the group; I also had a lapse 2 weeks ago and drank most of pint of vodka. I have been struggling with a female friend that wants to be more than a friend and ended up in a liquor store and bought the bottle. I had unopened cranberry juice at home and mixed them and ended up pouring out some of it." Daniel reported feeling guilty concerning his lapse. Daniels honest seemed to be brought forward from another group member he knows that shared of a recent lapse. Daniel seems to struggle with self-image and puts a lot of his time and efforts into other writing "I have not been worrying about others and what they think of me." Daniel reports working the 12 steps but has no sponsor.

Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 and 4 attending group and sharing from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 16 June 2015 at 1230 for group. No evidence of SI/HI during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by HILL,LARRY D @ 10 Jun 2015 1355 EDT:

Signed HILL, LARRY D (Physician) @ 10 Jun 2015 0934

Co-Signed BROWN, CYNTHIA E (Paraprofessional) @ 10 Jun 2015 1004

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 780

AR 0825

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

02 Jun 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-20970182 Primary Dx: ALCOHOL DEPENDENCE (ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS** Date: **02 Jun 2015 0935 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **BROWN,CYNTHIA E**
 Patient Status: **Outpatient**

AutoCites Refreshed by BROWN,CYNTHIA E @ 03 Jun 2015 0742 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 02 Jun 2015 0935 EDT
 CC INTAKE/CC GROUP

Screening Written by PATSOS,ASHLEY N @ 02 Jun 2015 0937 EDTReason For Appointment: Notes Entered by: PATSOS,ASHLEY N 02 Jun 2015 0935

CC INTAKE/CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS,ASHLEY N @ 02 Jun 2015 0937 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
 THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED. **Page 781**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 02 Jun 2015 0939 EDTHistory of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 02 Jun 2015 0940 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

- BEHAVIORAL HEALTH SCREEN DETERMINE ELIGIBILITY, ADM TX PRGM x 1 - Met with patient one-on-one from 0930-1030 to discuss Individual Treatment Plan.
- ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.
- ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by BROWN,CYNTHIA E @ 03 Jun 2015 0801 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP
Daniel is at session # 1 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1415, total of 1 1/2 hours. All members of the group denied that they drank or used drugs. The group welcomed a new group member using the introduction exercise. The group discussed in depth what they have gotten out of treatment so far. The group closed with a patient.

Daniel was introduced to the group. He appeared very comfortable with the format and other group members. He shared his coping skill as CBT. He stated that it helps him to regulate his emotions. At one point he engaged in friendly banter with a group member and other group members responded that he will fit in this group. He smiled and appeared to enjoy the engagement. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 by attending group from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #2 and 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 9 June 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by BROWN,CYNTHIA E @ 03 Jun 2015 1342 EDT**INDIVIDUAL SESSION CC FOR GROUP INTAKE**

Daniel is at session 1 of the 26 scheduled sessions of the Continuing Care treatment program attending from 0930 to 1030, total of 1 hour. Daniel and I reviewed his treatment plan with the basic requirements for the Continuing Care group. He agreed to all of the terms and conditions. We will establish his goal for treatment when he returns on 9 June 2015 for group at 1230. We reviewed the limitations of confidentiality and he indicated he understood. He indicated that he enjoys using the CBT to regulate his emotion. He admitted that he struggles to find a long term relationship and finds most women to be objectionable in one major way or another. The large number (126) women that he has been with have been disappointing to his standard but he feels very lonely. Daniel appeared engaged and interested in the treatment process. Daniel is to start working on his treatment plan today for the CC group. He addressed Problem #1, Objective #1 by attending this appointment from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #2 and 8 due 21 July 2015. Daniel is scheduled to stay today for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 03 Jun 2015 1354

CHANGE HISTORY

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by BROWN, CYNTHIA E @ 03 Jun 2015 1342 EDT:

Signed BROWN, CYNTHIA E (Paraprofessional) @ 03 Jun 2015 0801

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20911738 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARD
Patient Status: OutpatientDate: 27 May 2015 0859 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: GONZALEZZARAZUA, JORGE
AAutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 29 May 2015 1310 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 27 May 2015 0859 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 27 May 2015 1017 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 27 May 2015 0859

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 27 May 2015 1017 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 27 May 2015 1017 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 27 May 2015 1018 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 29 May 2015 1311 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 4, Day 1 of OP treatment attending from 0900-1100, total of 2 hours. This will be Daniel's last OP session. Today's session opened up with 3 members closing with the group as well as the other group members closing with the departing members.

Daniel performed his closing with the group prior to departing the OP group for the last time and shared that he is doing well and hopes to continue to improve and maintain his sobriety. He states that the skills he has learned are paying dividends for him and wants to use them going forward to maintain a more balanced lifestyle.

Daniel seemed at ease and comfortable performing his closing from OP group. He will be attending an intake appointment with a counselor to commence his Continuing Care.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 02 June 2015 @ 1030.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 29 May 2015 1311**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 29 May 2015 1312

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20884609 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **22 May 2015 0849 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 22 May 2015 1538 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 22 May 2015 0849 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 22 May 2015 0850 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 22 May 2015 0849

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 22 May 2015 0850 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Questionnaire AutoCites Refreshed by REGIS.JAMES @ 22 May 2015 1538 EDT
Questionnaires**S/O Note** Written by PATSOS.ASHLEY N @ 22 May 2015 0850 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS.ASHLEY N @ 22 May 2015 0851 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by REGIS.JAMES @ 22 May 2015 1539 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 3 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 12th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in with the group members going over any triggers or cravings he may have had during the past couple of days

During Daniel's check-in, Daniel stated that he's looking forward to this weekend because he has plans with the girl that he's been hanging out with. He stated that they hung out last night and that he made dinner for her at his place and the watched a movie together. Daniel also stated that he plans on seeing her tonight and on Sunday where they're supposed to go to Kings Dominion amusement park and spend the day together. This he says will be a huge test for them because it's going to determine if they can spend an entire day together.

Daniel seemed optimistic but challenged about his new girl "friend". He appeared relaxed as if there's no pressure because he's not seeking a girlfriend but mentions several times how these encounters are measures of whether or not they can get along. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 27th of May 2015 @ 0900 to close out of OP group and start his process to CCG.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

To be reviewed by NBHC-WNY SARP Program Manager on Tuesday 26th of May 2015.

Note Written by REGIS.JAMES @ 22 May 2015 1540 EDT

To be reviewed by NBHC-WNY SARP Program Manager on Tuesday 26th of May 2015.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 22 May 2015 1540

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-20871983 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **21 May 2015 1100 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**
Procedure - SARP LABS
Appointment Comments:
BRH**Lab Result Cited by AILOR, LYNNE P @ 21 May 2015 1411 EDT**

Drug Abuse Screen	Site/Specimen	18 May 2015 1107
Amphetamines	URINE	NEGATIVE < >
Barbiturates	URINE	NEGATIVE < >
Benzodiazepines	URINE	NEGATIVE < >
Cocaine	URINE	NEGATIVE < >
Opiates	URINE	NEGATIVE < >
Phencyclidine, UA	URINE	NEGATIVE < >
Cannabinoids	URINE	NEGATIVE < >
Methadone	URINE	NEGATIVE < >
Oxycodone	URINE	NEGATIVE < >

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	18 May 2015 1107
Ethyl Glucuronide	URINE	Negative

A/P Written by AILOR, LYNNE P @ 21 May 2015 1414 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested. Results of ETG/ETS were negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition Written by AILOR, LYNNE P @ 21 May 2015 1415 EDT****Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By AILOR, LYNNE P (Physician) @ 21 May 2015 1416**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

20 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20856489 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **20 May 2015 0804 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 21 May 2015 1440 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 20 May 2015 0804 EDT
 OP GROUP/EST

Screening Written by PATSOS, ASHLEY N @ 20 May 2015 0805 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 20 May 2015 0804

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 20 May 2015 0805 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 20 May 2015 0805 EDTHistory of present illness

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 20 May 2015 0810 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

- BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.
- ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
- ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 21 May 2015 1441 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 11th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in with the group members going over any triggers or cravings he may have had during the past couple of days

During Daniel's check-in, Daniel stated that he was looking forward to going on a date again tonight with the same girl he went out with the other day. He also mentioned during group discussion that before he gets to the point of hating anything, that he uses his cognitive tools that he learned in residential treatment to better assess what he is going through and to try to find out what the root of his hatred is all about.

Daniel seemed indifferent regarding his date tonight but became very empathetic and inspired to question and express his thoughts on the need to not have hateful sentiments towards others. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/II/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 22nd of May 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Note Written by REGIS,JAMES @ 21 May 2015 1441 EDT**Individual 1-on-1 session w/Counselor for OP Level 1 Step-Down Treatment**

Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 20th of May 2015 from 08:00 to 09:00 (1 hour). This is Daniel's 1-on-1 Individual session for Week #4 of his OP Level 1 Step-Down Treatment at SARP WNY. He stated that he had a stomach ache and that he believes that there's something wrong with his digestive system. Daniel also stated that his Performance Evaluation for this year continues to be a source of stress for him

because, although they're not received until November 15th, he has to submit it to his CoC by August (which is just a couple of months away). He said that he needs to start doing "stuff" so that he can get a decent evaluation; which is important for him for his career.

Daniel seemed worried and concerned regarding his evaluation. He appears to be putting a lot of anxiety on himself to start doing stuff that can positively reflect on his evaluation. At times, he justified his emotions by saying that if he gets a "Promotable" evaluation (which is a lower evaluation than the "Must Promote" last year) he can still pick-up the next rank in his rate even with that "Promotable" evaluation.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/II/ATV

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 20th 2015 @ 09:00

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 21 May 2015 1443

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 21 May 2015 1451

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20841809 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 19 May 2015 0823 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 19 May 2015 0826 EDT**Group Therapy Note****Date: 18 May 15****Time w/Patient 1300-1400****Purpose of Group:**

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #4- last session:

Members discussed past week and changes/challenges they have made and come across with incorporating CBTi components, sleep hygiene, completing sleep log and keeping to their calculated sleep window.

Agenda for session four: briefly discussed how thinking influences sleep and how to think in ways that promote sleep, discussed changing dysfunctional core beliefs, ways to quiet the mind (buffer zone). Continued to discuss sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality. Reviewed sleep log, how to calculate Sleep Efficiency for using sleep training/restriction and completed Sleep Need Questionnaire in order to identify if sleep widow should be modified. Encouraged group members to cont to use sleep log and calculate SE on their own if needed. Gave group members as needed extra sleep logs, Sleep need questionnaires, and Addressing Insomnia in the Future handout.

Summary of Patient Information and Participation:

SM reports he continues to use the CBTi app on his phone which helps him record his sleep and automatically calculates his sleep efficiency. Reports his sleep efficiency is ~ 92% and his sleep widow is 930pm-530am. Reports the behavioral and cognitive changes he has made has helped him get better quality and quantity sleep. He cont to reports getting out of bed at the scheduled time is somewhat difficult, but is trying to make it a habit.

He reports he is not as tired throughout the day. Reports he will cont to use the CBTi app and has found it helpful.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: last session- informed group members of future CBTi group sessions and encouraged members to attend for refresher or contact group leader for questions/concerns
Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 19 May 2015 0825 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 19 May 2015 0826 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 793

AR 0838

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By **MELTON, APRIL M** (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 19 May 2015 0827

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20826838 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **18 May 2015 0848 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1033 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 18 May 2015 0848 EDT
OP GROUP**Screening** Written by PATSOS, ASHLEY N @ 18 May 2015 0937 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 18 May 2015 0848

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 18 May 2015 0937 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 18 May 2015 0938 EDT**History of present illness**

The Patient is a 30 year old male.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

The patient attended the Outpatient Treatment Program (OP).

A/P Last updated by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: GONZALEZZARAZUA, JORGE A Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: GONZALEZZARAZUA, JORGE A Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS, JAMES @ 19 May 2015 1224 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 10th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his introduction to 2 new group members followed by his check-in going over any triggers or cravings he may have had during the past couple of days

During Daniel's check-in, Daniel stated that he went on another date to a bar last week with another young lady that he met on line. Daniel stated that he found himself again sitting at a bar conversing with his date who was drinking and that he had no desire to drink. Daniel also stated that he really likes this girl because she is into sci-fi like he is which he says is rare. Daniel later said that he knew he cared about this girl because he became nervous around her which showed him that he really liked her. Daniel seemed delighted and peaceful about his date and how successful it turned out. He continues to ask inquisitive and detailed questions in group. Daniel remains adamant when it comes to his programming project. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 20th of May 2015 @ 0800
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 19 May 2015 1224

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 19 May 2015 1347

CHANGE HISTORY

The following A/P Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT:

The A/P section was last updated by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS, ASHLEY N @ 18 May 2015 0939 EDT.

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 796

AR 0841

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

15 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20811912 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **15 May 2015 0818 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 15 May 2015 1319 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 15 May 2015 0818 EDT
 OP GROUP

Screening Written by PATSOS,ASHLEY N @ 15 May 2015 0824 EDTReason For Appointment: Notes Entered by: PATSOS,ASHLEY N 15 May 2015 0818

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS,ASHLEY N @ 15 May 2015 0825 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 May 2015 0825 EDT**History of present illness**

The Patient is a 30 year old male.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 15 May 2015 0827 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 15 May 2015 1320 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 3 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 9th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in to the group members going over any triggers or cravings he may have had during the past couple of days. During Daniel's check-in, Daniel stated that he went to a bar last night on a date with a young lady that he met on line. Daniel stated that this was the first time that he found himself actually sitting at a bar conversing with his date who was drinking. Daniel stated even though the bartenders came around a couple of time asking him if he wanted a drink, he insisted on just water. Regarding the topic of Peer Pressure that came up in group today, Daniel stated that he too would use a lie as a way to defuse him not drinking. Specifically, Daniel said that he would say he has "diabetes" and that he cannot drink. Daniel seemed blissful about his night and the fact that he didn't have any urge to drink. He stated that he was able to concentrate on his date and getting to befriend her. Daniel continues to appear self-reliant and assertive when it comes to his programming project. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 18th of May 2015 @ 0900
Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 15 May 2015 1320

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 15 May 2015 1346

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

14 May 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-20800148 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 May 2015 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **ZEMBRZUSKA, HANNA**
DOMINIKA

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 14 May 2015 1622 EDT

Allergies

•OTHER: Unknown (SEE MED RECORD)

Labs

04 May 2015 0922
ETG/ETS, UA (250 Cut-Off)
 Ethyl Glucuronide

Site Specimen	Result	Units	Ref Range
URINE	negative	ng/mL	Cutoff=250

04 May 2015 0922
Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Negative)
URINE	negative <i>		(Not-Detected)
URINE	negative <i>	ng/mL	(Negative)

28 Apr 2015 0958
Comprehensive Metabolic Panel

Site Specimen	Result	Units	Ref Range
SERUM	5.1	g/dL	(3.5-5.2)
SERUM	70	U/L	(40-129)
SERUM	33	U/L	(0-41)
SERUM	0.3	mg/dL	(0-1.2)
SERUM	13.4	mg/dL	(6-20)
SERUM	9.9	mg/dL	(8.6-10.2)
SERUM	29	mmol/L	(22-29)
SERUM	101	mmol/L	(98-107)
SERUM	0.97	mg/dL	(0.7-1.2)
SERUM	90	mg/dL	(74-106)
SERUM	4.6	mmol/L	(3.5-5.1)
SERUM	7.7	g/dL	(6.6-8.7)
SERUM	143	mmol/L	(136-145)
SERUM	13	mmol/L	(7-16)
SERUM	104.3	mL/min	(60->=60)
SERUM	120.6 <i>	mL/min	(60->=60)
SERUM	26	U/L	(0-40)

20 Apr 2015 0012
ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen	Result	Units	Ref Range
URINE	negative <o>	ng/mL	Cutoff=500

20 Apr 2015 0012 <o>
Drug Abuse Screen

Site Specimen	Result	Units	Ref Range
URINE	not detected <i>		(Not-detected)
URINE	not detected <i>		(Not-detected)
URINE	not detected <i>		(Not-detected)
URINE	not detected <i>		(Not-detected)
URINE	not detected <i>		(Not-detected)
URINE	not detected <i>		(Not-detected)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Cannabinoids	URINE	not detected <i>	(Not-detected)
Methadone	URINE	not detected <i>	(Not-detected)
Oxycodone	URINE	not detected <i>	(Not-detected)

Rads

No Rads Found.

Reason for Appointment:

est

Appointment Comments:

ddr

Vitals**Vitals** Written by NEFF, JOANNE S. @ 14 May 2015 0908 EDT

BP: 121/79, HR: 69, RR: 16, T: 97.2 °F

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 15 May 2015 0806 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt after Zoloft was increased to 75mg daily and he was started on Melatonin. Pt reports that his depressed mood has lifted and he is happier more often, but it is not consistent. He reports no difference in his anxiety, however, he has become more focused and productive. He wants to be a positive role model for others struggling with alcohol. He is again interested in volunteering which is something he did at the prime of his military career. He has been working on his computer game, created an LLC, and is tracking his hours working on the game. He continues to have anxious ruminations about work which lead to initial insomnia. He has been taking Melatonin at bedtime, but does not want to take it every night. He has been attending CBT-I group and using the CBT-I app both of which he has found helpful. He no longer reads his phone prior to bedtime. Sleeping about 7 hours per night. He reports sexual side effects (decreased interest) from Zoloft, but feels that this is beneficial since sex has been a distraction for him in the past.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 re on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged at the end of April 2015.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 75mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 800

AR 0845

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself ul experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use 16 oz tea/day and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Additional Screening Questions:

Are you having any thoughts about harming another person? Denies

Do you feel like you are at risk for workplace violence? Denies

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Dysthymic. ° Anxious. ° Not depressed.

Affect: ° Abnormal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 801

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide/Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y
 Positive Coping Skills: Y
 Responsible to/for Family: Y
 Responsible to/for Pet: N
 Frustration Tolerance: Y
 Resilience: Y
 Good Reality Testing: Y
 Amenable to Treatment: Y
 Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

- ☒ [X] Released without limitations. Advised of emergency procedures.
☐ [] SM released to Chain of Command with the following limitations:
☐ [] SM sent to ER for evaluation for admission to inpatient psychiatry
☐ [] Other:

Therapy

- Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: MELTON FOR CBT-I

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 14MAY2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 1 month

Discussion of assessment and intervention

Tx Plan cont'd:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

(23APR2015) PHQ-9 = 4, GAD-7 = 5, PCL-C = 13

Diagnosis

Generalized Anxiety Disorder
Alcohol Use Disorder, moderate to severe

Active Problem List:

1. Anxiety, worry, irritability
2. Depressed/apathetic mood
3. Insomnia

Long-Term Goals:

1. Improve relationship/increase social support from mother and sister
 2. Improve financial knowledge/pay off debts
- Discussion of risk of assessment and intervention
Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

Interventions:

1. Continue Zoloft 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

Interventions:

1. Continue Zoloft 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

Interventions:

1. Continue Melatonin QHS pm insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts
3. Continue CBT-I group with Ms. Melton at WRNMMC.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 15 May 2015 0802 EDT

1. GENERALIZED ANXIETY DISORDER 300.02

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90

Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 15 May 2015 0807 EDT

Released w/o Limitations

Follow up: 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 15 May 2015 0807

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

13 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20783265 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS Date: 13 May 2015 0800 EDT Appt Type: GRP
 Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: REGIS, JAMES
 NAVY YARD
 Patient Status: Outpatient

AutoCites Refreshed by REGIS, JAMES @ 15 May 2015 0758 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 13 May 2015 0800 EDT
OP GROUP/ESTScreening Written by PATSOS, ASHLEY N @ 13 May 2015 0801 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 13 May 2015 0800

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 13 May 2015 0802 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 13 May 2015 0802 EDTHistory of present illness

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 13 May 2015 0804 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.
 -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 15 May 2015 0759 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 8th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in to the group members going over any triggers or cravings he may have had during the past couple of days. During Daniel's check-in, Daniel stated how excited he was because he had just set up a date for after group with a girl that he's been talking to online. He stated that whether anything happens with her or not, he is OK with that fact. Daniel also mentioned how the Navy is his only family and it's what has validated him throughout these years. He continued to say that the Navy is "all that he has".

Daniel seemed very suspicious and cynical while describing his date. He showed signs of why he has very little belief in his self-worth. However, while he was describing his programing abilities, Daniel continues to appear self-reliant and assertive. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/II/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 15th of May 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Note Written by REGIS,JAMES @ 15 May 2015 0800 EDT

Individual 1-on-1 session w/Counselor for Week #3 OP Level 1 Treatment

Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 13th of May 2015 from 08:00 to 09:00 (1 hour). This is Daniel's 1-on-1 Individual session for Week #3 of his OP Level 1 Treatment at SARP WNY. He stated that he just set up a lunch date with a friend of his. Daniel then stated that, although he is looking forward to seeing his date that he doesn't think she will find him to be "her type" nor like him because she's very attractive. This he explains is directly attributed to his concerns of self-worth along with his anxiety issues that he feels he has to continue working on. Daniel also stated that he continues to write the program for his game which he admits will give him recognition and will validate him as being essential.

Daniel seemed excited and enthusiastic about his lunch date but immediately appeared cautious suspicious when thoughts of his self-worth arose. He continues to show passion for his company and the development of his gaming software along with extreme eagerness to succeed and to be validated.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/II/ATV

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 11th 2015 @ 09:00

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By **REGIS, JAMES** (Para-Professional, SARP WNY) @ 15 May 2015 0803

Co-Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 15 May 2015 0827

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

11 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20774303 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 12 May 2015 1135 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 12 May 2015 1138 EDT**Group Therapy Note**

Date: 11 May 15
 Time w/Patient 1300-1400

Purpose of Group:

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #3:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Members discussed past week and changes/challenges they have made and come across with incorporating CBTi components, sleep hygiene, completing sleep log and keeping to their calculated sleep window. Agenda for session three: discussed how thinking influences sleep and how to think in ways that promote sleep, discussed changing dysfunctional core beliefs, ways to quiet the mind (buffer zone) and practiced and provided hand out of pleasant imagery exercise. Continued to discuss sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality. Reviewed sleep log, how to calculate Sleep Efficiency for using sleep training/restriction this week and identified sleep window for several members to begin sleep restriction.

Summary of Patient Information and Participation:

SM reports he continues to use the CBTi app on his phone which helps him record his sleep and automatically calculates his sleep efficiency. Reports his sleep efficiency is ~ 92% and his sleep window is 930pm-5am. Reports he is having a hard time getting out of bed in the morning when his alarm wakes up and is not going to bed every night when he is at scheduled time. He reports he is not as tired throughout the day. Reports he will work on this but notices that he is getting to sleep faster, as he is not using his phone to watch news or be stimulated right before bed.

Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings 4 weeks

Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 12 May 2015 1137 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 12 May 2015 1137 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1wk

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 12 May 2015 1139

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

11 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20756996 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARD
Patient Status: OutpatientDate: 11 May 2015 1055 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: REGIS, JAMESAutoCites Refreshed by REGIS, JAMES @ 15 May 2015 0746 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by BROWN, CYNTHIA E @ 11 May 2015 1055 EDT
OP GROUPScreening Written by BROWN, CYNTHIA E @ 11 May 2015 1127 EDTReason For Appointment: Notes Entered by: BROWN, CYNTHIA E 11 May 2015 1055

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by BROWN, CYNTHIA E @ 11 May 2015 1127 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact Number: [REDACTED]

No vitals taken at SARP

S/O Note Written by BROWN, CYNTHIA E @ 11 May 2015 1128 EDTReason for Visit

OP Group.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 809

AR 0854

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by BROWN, CYNTHIA E @ 11 May 2015 1131 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS, JAMES @ 15 May 2015 0747 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 7th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the introduction of 1 new group member and a review of group rules followed by a brief discussion concerning phobias and pet peeves of the group.

During Daniel's introduction, Daniel stated that although he bites his nails and picks at his hair, that he is very conscious when other people do that around him. He stated that he doesn't bite them as much now because of his braces but before he had his braces; he explained how he was always doing it. Daniel went on to tell another group member that she would have hated him because he would be biting his nails all the time.

Daniel continues to appear very attentive to the groups needs by continuing to take on the "fixer" role and attempting to solve different issues that arises in group. He seems very insightful on both his current situation and that of the group. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 13th of May 2015 @ 08:00
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 15 May 2015 0747Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 15 May 2015 0751**CHANGE HISTORY**

The following Disposition Note Was Overwritten by REGIS, JAMES @ 15 May 2015 0747 EDT:

The Disposition section was last updated by REGIS, JAMES @ 15 May 2015 0747 EDT - see above. Previous Version of Disposition section was entered/updated by BROWN, CYNTHIA E @ 11 May 2015 1131 EDT.

Released w/o Limitations

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 810

AR 0855

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20738346 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARD
Patient Status: OutpatientDate: 08 May 2015 0853 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: GONZALEZZARAZUA, JORGE
AAutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 08 May 2015 1424 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 08 May 2015 0853 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 08 May 2015 0907 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 08 May 2015 0853

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 08 May 2015 0908 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 08 May 2015 0911 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 08 May 2015 0912 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 08 May 2015 1425 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 2, Day 3 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with a feeling word. Daniel and the rest of the group member also shared their respective plans for the upcoming weekend, providing insight and support to each other. Daniel shared that he is excited about his upcoming weekend and states that he has quite a bit of work planned. He shared that he is working on developing a computer game and has set aside a few hours each morning and afternoon to sit down and write code for his game. He also states that he will be attending a Nerf gun event called Zombies vs Humans on Saturday which is a fun way to do Nerf gun battles. He also mentioned that he will be attending a couple self-help meetings each day to satisfy the requirements of his ITP.

Daniel appears comfortable in the group setting, engaging well with others and being vocal about what others are sharing or planning on doing. His check-in and sharing are mostly on the short side and rather vague. Daniel addressed Problem 1, Objective 1 and 2 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 11 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 08 May 2015 1426Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 08 May 2015 1506

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 May 2015 at WRNMMC, Int Med CL C Medical Home BE by ARGUINZONI, JUAN B.

Encounter ID: BETH-20730612 Primary Dx: ALCOHOL ABUSE - IN REMISSION

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 May 2015 1330 EDT**
 Clinic: **INT MED MEDICAL HOME CL C**
BE

Appt Type: **EST**
 Provider: **ARGUINZONI, JUAN B.**

AutoCites Refreshed by OYAWALE, BIDEMI R @ 07 May 2015 1304 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Physical Exam (SARP Related - Navy Yard), Dermatology issue as well

Appointment Comments:

Appt self-booked via TOL

VitalsVitals Written by OYAWALE, BIDEMI R @ 07 May 2015 1302 EDT

BP: 122/72, HR: 76, RR: 16, T: 97.8 °F, HT: 69 in, WT: 161 lbs, SpO₂: 99%, BMI: 23.78,
 BSA: 1.884 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by OYAWALE, BIDEMI R @ 07 May 2015 1304 EDT**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 07 May 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Not at all
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Not at all
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by ARGUINZONI, JUAN B. @ 07 May 2015 1835 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-CORE>>

30 y/o male (PCM Ms Austin) who comes to clinic for physical exam for SARP (Substance Abuse Rehabilitation Program). Patient used to drink 7-8 mixed drinks a day (rum, vodka) and was hospitalized for inpatient program at Fort Belvoir and discharged on 22 april 15 (his last etoh intake was 25 march 15). At present is on SARP program at Navy Yard. He takes sertraline for generalized anxiety disorder. Has had patches of dry skin on scalp and is requesting dermatology consult. Feels fine otherwise and has no other complaints.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated
 NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.
 Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history
 GAD
 alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history
 PRK

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Tosillectomy

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Family history

Family medical history
 DM father, PGM
 MI father
 hypertension father
 melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: • PERRL. • Size of the pupil was normal. • Pupil accommodation was not impaired.

External: • Eyelids showed no abnormalities. • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Right Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Left Ear:

External Auditory Canal: • Normal.

Tympanic Membrane: • No bulging tympanic membrane. • Not erythematous.

Middle Ear: • No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • No nasal discharge seen.

External Deformities: • No external nose deformities.

Cavity: • Nasal septum normal. • Nasal mucosa normal. • Nasal turbinate not erythematous. • Nasal turbinate not swollen.

Sinus Tenderness: • No sinus tenderness.

Oral Cavity:

Lips: • Showed no abnormalities.

Buccal Mucosa: • Examination showed no abnormalities.

Pharynx:

Oropharynx: • Normal. • Tonsils showed no abnormalities.

Lymph Nodes:

• Cervical lymph nodes were not enlarged. • Submandibular lymph nodes were not enlarged. • Supraclavicular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 814

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: ° Mobility was not limited.

Other:

General/bilateral: ° No muscle tenderness.

Neurological:

Sensation: ° No sensory exam abnormalities were noted.

Motor (Strength): ° Strength of the upper extremities was normal. ° No lower extremity weakness was observed.

Balance: ° Normal.

Gait And Stance: ° Normal.

Reflexes: ° Deep tendon reflexes were normal.

Skin:

° Skin: two areas of alopecia on scalp.

Practice Management

Preventive medicine services

Lipid Screening -

Diabetes Screening -

Aspirin Prophylaxis -

HIV Screen -

Colonoscopy -

Tetanus (Td/Tdap) - 2013

Influenza Vaccine - oct 2014

Zoster Vaccine -

Pneumococcal Vaccine -

HPV Vaccine -

Men:

Aortic Aneurysm Screen (if ever a smoker) -

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT

Comprehensive Metabolic Panel	Site/Specimen	28 Apr 2015 0958
Albumin	SERUM	5.1
Alkaline Phosphatase	SERUM	70
Alanine Aminotransferase	SERUM	33
Bilirubin	SERUM	0.3
Urea Nitrogen	SERUM	13.4
Calcium	SERUM	9.9
Carbon Dioxide	SERUM	29
Chloride	SERUM	101
Creatinine	SERUM	0.97
Glucose	SERUM	90
Potassium	SERUM	4.6
Protein	SERUM	7.7
Sodium	SERUM	143
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	104.3
GFR Calculated Black	SERUM	120.6 <i>
Aspartate Aminotransferase	SERUM	26

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT

Drug Abuse Screen	Site/Specimen	04 May 2015 0922
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Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 815

AR 0860

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Amphetamines	URINE	NEGATIVE < >
Barbiturates	URINE	NEGATIVE < >
Benzodiazepines	URINE	NEGATIVE < >
Cocaine	URINE	NEGATIVE < >
Opiates	URINE	NEGATIVE < >
Phencyclidine, UA	URINE	NEGATIVE < >
Cannabinoids	URINE	NEGATIVE < >
Methadone	URINE	NEGATIVE < >
Oxycodone	URINE	NEGATIVE < >

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	04 May 2015 0922
Ethyl Glucuronide	URINE	Negative

A/P Written by ARGUINZONI, JUAN B. @ 07 May 2015 1848 EDT

1. **ALCOHOL ABUSE - IN REMISSION:** Physical exam form for SARP filled and signed. Continue in substance abuse rehab program.
2. **GENERALIZED ANXIETY DISORDER:** Continue sertraline
3. **ALOPECIA AREATA:** Referral to dermatology clinic

Disposition Written by ARGUINZONI, JUAN B. @ 07 May 2015 1851 EDT**Released w/o Limitations****Follow up:** with PCM. - Comments: Referral to dermatology.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ARGUINZONI, JUAN B. (Physician) @ 07 May 2015 1851

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20709936 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARD
Patient Status: OutpatientDate: 06 May 2015 0911 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: GONZALEZZARAZUA, JORGE
AAutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 08 May 2015 1429 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 06 May 2015 0911 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 06 May 2015 0912 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 06 May 2015 0911

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 06 May 2015 0912 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 06 May 2015 0912 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 06 May 2015 0913 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 08 May 2015 1430 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 2, Day 2 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with a feeling word. The group was also reminded by this counselor about abiding by group rules as well as emphasized the importance of owning their own statements.

Daniel shared that he went on a date with a lady he met online. He states that this is the norm for him and that he had no triggers since his last session. He states that he also went to a meeting with a member of his old group in residential treatment after she called him to invite him to a meeting. Daniel also shared with other group members that he thought they were glamorizing their relationship with alcohol versus looking at their current situation.

Daniel appears comfortable in the group setting, engaging with other group members and providing feedback as he sees necessary. However, after his check-in this counselor noticed that Daniel focused largely on everyone else's issues, trying to help out and provide feedback, but did very little sharing of his own. Daniel addressed Problem 1, Objective 1 and 2 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 08 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 08 May 2015 1430**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 08 May 2015 1509

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20707909 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **06 May 2015 0808 EDT** Appt Type: **EST**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 06 May 2015 0910 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RFO	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 06 May 2015 0808 EDT
ESTScreening Written by PATSOS, ASHLEY N @ 06 May 2015 0809 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 06 May 2015 0808

EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 06 May 2015 0809 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 819

AR 0864

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Questionnaire AutoCites Refreshed by REGIS.JAMES @ 06 May 2015 0910 EDT
Questionnaires**A/P Last Updated by PATSOS.ASHLEY N @ 06 May 2015 0810 EDT****1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by REGIS.JAMES @ 06 May 2015 0910 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 06th of May 2015 at 08:00. This is Daniel's 1-on-1 Individual session for Week #2 of his OP Level 1 Treatment at SARP WNY. He stated that he was put on night shift at his job which with treatment has become an issue for him to stay on. He stated that he is worried about how his command is going to react when he tells them that he cannot work the night schedule because of his treatment program. Daniel also stated that he realizes that his taking Zoloft has diminished his sexual turn-on which he read is a side effect. Daniel mentioned that he is getting very involved in his game writing these days and is thinking about establishing contract with different people in the industry to help with his company. He realizes that he is driving more these days (over 100 miles this past week) to support his treatments in the DMV area.

Daniel seemed indifferent when talking about his treatment plan. However, when explaining his company and the development of his gaming software, Daniel seemed extremely enthusiastic and ecstatic. His job continues to be a source of frustration for him as he deal with a civilian counterpart that is out of the loop of his treatment needs.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 06th 2015 @ 09:00

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 06 May 2015 0911

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-20693884 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **05 May 2015 0930 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR, LYNNE P****Reason for Appointment:**
PROCEDURE - SARP LABS
Appointment Comments:
BRH**Lab Result Cited by AILOR, LYNNE P @ 05 May 2015 1523 EDT**

Drug Abuse Screen	Site/Specimen	04 May 2015 0922
Amphetamines	URINE	NEGATIVE <i>
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine, UA	URINE	NEGATIVE <i>
Cannabinoids	URINE	NEGATIVE <i>
Methadone	URINE	NEGATIVE <i>
Oxycodone	URINE	NEGATIVE <i>

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	04 May 2015 0922
Ethyl Glucuronide	URINE	Negative

A/P Written by AILOR, LYNNE P @ 05 May 2015 1526 EDT**1. Laboratory Studies**

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME): Labs were reviewed by undersigned provider per SARP protocol. Results of ETG/ETS and Drug Abuse Screen were negative.**Disposition Written by AILOR, LYNNE P @ 05 May 2015 1526 EDT****Released w/o Limitations****Signed By AILOR, LYNNE P (Physician) @ 05 May 2015 1526**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20705236 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 05 May 2015 1604 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 05 May 2015 1620 EDT**Group Therapy Note**

Date: **04 May 15**
 Time w/Patient **1300-1400**

Purpose of Group:

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #2:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Due to several new group member, Facilitator and co-facilitator provided information from session one to assist new group members in obtaining and understanding CBTi group. Participants introduced themselves, offered personal treatment goals. Agenda for session two discussed and handouts given to group members focusing on sleep guidelines, habits that influence sleep. Discussed sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality, by utilizing learned skills and adhering by sleep guidelines. Reviewed sleep log, how to calculate sleep Sleep Efficiency for using sleep training/restriction this week.

Summary of Patient Information and Participation:

SM reports this week he used the CBTi app on his phone which helped him record his sleep and automatically calculated his sleep efficiency for him. Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings 4 weeks

Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Last Updated by MELTON, APRIL M @ 05 May 2015 1605 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Last Updated by MELTON, APRIL M @ 05 May 2015 1607 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1 wk for group

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 05 May 2015 1621

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

04 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20678033 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **04 May 2015 0846 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 04 May 2015 0908 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 04 May 2015 0846 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 04 May 2015 0857 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 04 May 2015 0846

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 04 May 2015 0858 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 824

AR 0869

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 04 May 2015 0859 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last updated by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: GONZALEZZARAZUA,JORGE A Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: GONZALEZZARAZUA,JORGE A Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS,JAMES @ 06 May 2015 1225 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 2, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's 4th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the introduction of 2 new group members and a review of group rules followed by Daniel performing his check-in to the group going over any triggers or cravings he may have had during the past couple of days.

During Daniel's check-in, Daniel stated that he had a productive weekend even though he didn't get a chance to work on his gaming program that much. Daniel stated that he is looking forward to going on a date in Baltimore with a young lady whom he met on a dating website. He stated that she is a software programmer which intrigues him because of his own interest in writing gaming programs.

Daniel seemed indifferent and cautious regarding his leisure activities during this past weekend. He seems to understand how to apply his sobriety tools in different situations even though he appears to question himself. In regards to his date, Daniel looked to be very confident and interested in its outcome. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 06th of May 2015 @ 0800
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 06 May 2015 1225**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 07 May 2015 0627**CHANGE HISTORY****The following A/P Note Was Overwritten by** GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT:

The A/P section was last updated by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS,ASHLEY N @ 04 May 2015 0900 EDT.

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 825

AR 0870

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

01 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20662019 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **01 May 2015 0758 EDT** Appt Type: **GRP**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
 Patient Status: **Outpatient**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 01 May 2015 1444 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 01 May 2015 0758 EDT
 OP GROUP/EST

Screening Written by PATSOS,ASHLEY N @ 01 May 2015 0800 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 01 May 2015 0758

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 01 May 2015 0800 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 826

AR 0871

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 01 May 2015 0805 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0830 to review Individual Treatment Plan.
 -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 01 May 2015 1445 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 1, Day 3 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with one feeling word. The group was also reminded by this counselor about abiding by group rules as well as emphasized the importance of owning their own statements.

Daniel shared that being in OP group has been good for him as he believes there are still more things he wants to work on, pertaining to his recovery and why he used alcohol to cope with life. He states that he is getting back into the swing of things back at work and is trying to not allow himself to get stressed. He states that for the weekend, he has a trip planned to King's Dominion water park with a friend, allowing him some "fun time" and just relaxing in his place.

Daniel appears comfortable and willing to be an active participant in OP treatment. He seems to want to take charge of his recovery and used some of the tools he learned while in residential treatment. Daniel addressed Problem 1, Objective 1 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 04 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 01 May 2015 1445Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 01 May 2015 1453

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 827

AR 0872

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

30 Apr 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20652494 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Apr 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 30 Apr 2015 1032 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 30 Apr 2015 1034 EDT**Group Therapy Note****Date: 27 April 15****Time w/Patient 1300-1400****Purpose of Group:**

Group members will learn and utilize CBTi components to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 828

AR 0873

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Brief Summary of content of session #1:

Facilitator and co-facilitator introduced themselves and provided information regarding CBTi group agenda. Participants introduced themselves, offered personal treatment goals and were asked to complete Insomnia Severity Index, Restless Leg Syndrome Assessment, STOP questionnaire and Dysfunctional Beliefs about Sleep survey. Education on sleep, sleep stages, insomnia and CBTi components provided. Discussed sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality.

Summary of Patient Information and Participation:

Pt presents with a formal diagnosis of GAD and was referred to group by Dr. Zembrzka. Pt stated mood today is good and participated in the group, offering personal treatment goals and reason for attending the group; he wants to improve quality of sleep. Reports he sleeps about 5hrs per night but is in bed for a total of 8hrs. Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in military uniform. His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings for ~4 weeks. Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 30 Apr 2015 1032 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 30 Apr 2015 1032 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1 wk

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 30 Apr 2015 1035

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 829

AR 0874

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

29 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20634025 Primary Dx: ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC WASHINGTON
NAVY YARD
Patient Status: OutpatientDate: 29 Apr 2015 0854 EDT
Clinic: SUBST ABUSE NYAppt Type: GRP
Provider: REGIS, JAMESAutoCites Refreshed by REGIS, JAMES @ 29 Apr 2015 1426 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 29 Apr 2015 0854 EDT
OP GROUPScreening Written by PATSOS, ASHLEY N @ 29 Apr 2015 0924 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 29 Apr 2015 0854

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 29 Apr 2015 0924 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 830

AR 0875

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL & DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 29 Apr 2015 1427 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 1, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's 2nd day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the review of group rules followed by Daniel performing his check-in to the group going over any triggers or cravings he may have had during the past couple of days.

During Daniel's check-in, Daniel stated that he was feeling apathetic because he spoke to his step mother who gave him news about his father's postings on Facebook. Daniel went on to say that he thought his father's actions were childish and that he didn't care about it. He said that his triggers usually involved his being disappointed in relationships which would lead him to drinking. The group asked him about his disappointed relationship with his father and whether or not that's ever caused him to drink; to which he said no.

Daniel seemed perplexed and disappointed when explaining his relationship and arguments with his father. He appears withdrawn and exasperated regarding his rapport with his father. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 1st of May 2015 @ 0800
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 29 Apr 2015 1428**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 29 Apr 2015 1430**CHANGE HISTORY***The following S/O Note Was Deleted by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT:***History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 831

AR 0876

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

28 Apr 2015 at WRNMMC, Medical Readiness Clinic Bethesda by PARSON, MARSHEA S

Encounter ID: BETH-20618206 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **28 Apr 2015 0900 EDT**
 Clinic: **MEDICAL READINESS CL BE**

Appt Type: **WELL**
 Provider: **PARSON, MARSHEA S**

AutoCites Refreshed by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Procedures

- Postoperative Visit, Without Charge (06 Jun 2011)
- Postoperative Visit, Without Charge (06 Jun 2011)
- Ophthalmological Prior Patient Start Comprehensive Care (04 May 2011)
- Postoperative Visit, Without Charge (26 Apr 2011)
- Postoperative Visit, Without Charge (22 Apr 2011)
- PHOTOREFRACTIVE KERATECTOMY (PRK) (21 Apr 2011)
- Computerized Corneal Topography (29 Mar 2011)
- Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral (29 Mar 2011)
- Corneal Pachymetry Both Eyes (29 Mar 2011)
- Determination Of Refractive State (29 Mar 2011)
- Ophthalmological New Patient Start Comprehensive Care (29 Mar 2011)
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) (24 Mar 2011)
- Spirometry Pre-bronchodilator (24 Mar 2011)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- 2011)
- Spirometry Post-bronchodilator (24 Mar 2011)
- Bronchial Challenge With Methacholine (24 Mar 2011)
- Special Dr. Services Analysis Of Computerized Data (24 Mar 2011)
- Pulmonary Function FRC (% Predicted Normal) (24 Mar 2011)
- Pulmonary Function MVV (24 Mar 2011)
- Pulse Oximetry (24 Mar 2011)
- Determination Of Refractive State (16 Mar 2011)
- Ophthalmological Prior Patient Start Intermediate Level Care (16 Mar 2011)
- Corneal Pachymetry Both Eyes (17 Feb 2011)
- Ophthalmological Prior Patient Start Comprehensive Care (17 Feb 2011)
- Biopsy Skin (24 Nov 2010)
- Immunization Administration One Vaccine (15 Nov 2010)
- Influenza Virus Vaccine Live Intranasal (15 Nov 2010)
- Biopsy Skin (28 Sep 2010)
- Biopsy Skin Each Additional Lesion (28 Sep 2010)
- Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia) (23 Apr 2010)
- Determination Of Refractive State (23 Apr 2010)
- Spectacles Services Fitting Monofocals (Not For Aphakia) (23 Apr 2010)
- Ophthalmological New Patient Start Comprehensive Care (23 Apr 2010)
- Anthrax Vaccine, For Subcutaneous Use (09 Mar 2010)
- Influenza Virus Vaccine Pandemic Formulation (22 Dec 2009)
- Immunization Administration One Vaccine (22 Dec 2009)
- Immunization Administration One Vaccine (23 Sep 2009)
- Influenza Virus Vaccine Live Intranasal (23 Sep 2009)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

pha/navy

Appointment Comments:

ash8056967239

Screening Written by POND, BRANDON J @ 28 Apr 2015 0910 EDT**Reason For Appointment:** pha/navy

Allergen information verified by POND, BRANDON J @ 28 Apr 2015 0910 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals** Written by POND, BRANDON J @ 28 Apr 2015 0924 EDT

BP: 129/76, HR: 61, RR: 14, T: 98.1 °F, HT: 69 in, WT: 150 lbs, Uncorr OD: 20/25, Uncorr OS: 20/25, Uncorr OU: 20/25, BMI: 22.15,
 BSA: 1.828 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free
 Comments: EPWORTH SLEEP: 8

Questionnaire AutoCites Refreshed by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT
Questionnaires

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 28 Apr 2015

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis (i.e. with persistent cough, weight loss, night sweats, and/or fever)? No
2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations? No
3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: N/A
4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No
5. Have you had a prior history of TB or prior treatment for Latent TB?: No
6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No
7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade?: No
8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use?: No

EPWORTH Sleepiness Scale Version: 1 Completed On: 28 Apr 2015

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3
2. How likely are you to doze off or fall asleep while WATCHING TV?: 1
3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 0
4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3
5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 0
6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 0
7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 1
8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 0

S/O Note Written by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT**Chief complaint**

The Chief Complaint is: FACE TO FACE PHA, ACTIVE DUTY.

Reason for Visit

Visit for: FACE TO FACE PHA.

History of present illness

The Patient is a 30 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Past medical history reviewed, problem list reviewed, medication list reviewed, family history reviewed, and surgical history reviewed.

Military service [] Y [X] N Deployed since previous PHA
 [] Y [X] N Post-Deployment Health Assessment completed
 [] Y [X] N Post-Deployment Health Reassessment completed
 [] Y [X] N Post-Deployment labs/tests completed
 [] Y [X] N Deployment/Shipboard limiting conditions identified
 . Currently on active duty.
 No systemic symptoms.

Navy ADASM educated to the Face to Face PHA. Ft Meade, CTN1. Denies new behavioral health, new medical health complaints. Reviewed problem list. No deployment limiting conditions. Reviewed and educated to Framingham and survey results.

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [X] No. No chronic illness. An allergy SEE ABOVE.

Medications: Medication history SEE ABOVE. Not taking medication for high blood pressure.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- 2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No
 3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No
 4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No
 5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [X] No.

SEE ABOVE.

Family history

No family history of cancer
 Mental illness (not retardation) MATERNAL
 Heart disease PATERNAL GF, Father
 Diabetes mellitus PATERNAL GF and Father.

Review of systems

Head: No head symptoms.
Neck: No neck symptoms.
Eyes: No eye symptoms.
Otolaryngeal: No otolaryngeal symptoms.
Breasts: No breast symptoms.
Cardiovascular: No cardiovascular symptoms.
Gastrointestinal: No gastrointestinal symptoms.
Genitourinary: No genitourinary symptoms.
Endocrine: No endocrine symptoms.
Hematologic: No hematologic symptoms.
Musculoskeletal: No musculoskeletal symptoms.
Neurological: No neurological symptoms.

Physical findings**Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing.

Head:

Appearance: ° Head normocephalic.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.

Neurological:

° Level of consciousness was normal.
 Speech: ° Normal.
 Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.
 Balance: ° Normal.
 Gait And Stance: ° Normal.

Psychiatric:

Affect: ° Normal.
 Thought Processes: ° Not impaired.
 Thought Content: ° Revealed no impairment.

Objective

Health Record [] Reviewed [X] Not available [] Remarkable for:
 Dental Classification [X] Reviewed [] Not available [] See Plan:
 Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status
 IMR Category:
 Fully Medically Ready (X)
 Partially Medically Ready ()
 Not Medically Ready ()
 Medical Readiness Indeterminant ()
 Comments:

Therapy

• No electronic medical alert pendant in possession as indicated.

Plan

• Referred elsewhere for the options include referral
 [] Physical Activity
 [] Safety
 [] Diabetes Counseling
 [] Cholesterol
 [X] Nutrition
 [X] Sexuality

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 835

AR 0880

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- [] Other:
 • Referred elsewhere for patient counseling
 [] Tobacco Use
 [] Alcohol Use
 [] Weight Management
 [] Dental Care
 [] Mental Health
 [] Hypertension
 [X] Other: STRESS MANAGEMENT, SLEEP

Updated DD 2766 Sections: NO RECORD

Health counseling performed or scheduled documented on the DD 2766 and for additional topics below:

Notes

Follow-up in one year.

Practice Management

Risk factor counseling individual, 30 minutes.

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0920 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0914 EDT

Comprehensive Metabolic Panel	Site/Specimen	27 Mar 2015 1600
Albumin	SERUM	4.9
Alkaline Phosphatase	SERUM	71
Alanine Aminotransferase	SERUM	29 <i>
Bilirubin	SERUM	0.3
Urea Nitrogen	SERUM	14
Calcium	SERUM	10.0
Carbon Dioxide	SERUM	29
Chloride	SERUM	98
Creatinine	SERUM	0.9
Glucose	SERUM	82
Potassium	SERUM	4.7
Protein	SERUM	7.9
Sodium	SERUM	139
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	114.7
GFR Calculated Black	SERUM	132.6 <i>
Aspartate Aminotransferase	SERUM	<5

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0913 EDT

HIV-1/O/2 Ab	Site/Specimen	27 Mar 2015 1600
HIV-1/O/2 Ab	SERUM	*****

A/P Last updated by PARSON, MARSHEA S @ 28 Apr 2015 0950 EDT**1. Visit for: military services physical (PERIODIC PREVENTION EXAMINATION):** PHA updated in MRRS.

Procedure(s): -Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S):

PONDS, BRANDON J

Laboratory(ies): -HEPATITIS C AB (Routine) Ordered By: PONDS, BRANDON J Ordering Provider: PARSON, MARSHEA S

2. ASTHMA (ASTHMA, UNSPECIFIED, MILD): See Pulmonary SF 600 Written by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1135 CDT

1. ASTHMA (ASTHMA, UNSPECIFIED, MILD): Pt with a symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. His symptoms are confined to allergen exposure, particularly to cats. Given the mild

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 836

AR 0881

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS. Follow up in 6 months.

3. **ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR:** SM recently discharged for inpatient for alcohol abuse.
4. **MAJOR DEPRESSION RECURRENT MODERATE:** SM is being followed in Behavioral Health. Being seen every three weeks.
5. **ANXIETY DISORDER NOS**
6. **ESSENTIAL HYPERTRIGLYCERIDEMIA:** SM had lifestyle change to decrease levels. See lipid panel 2014.
7. **POSTSURGICAL STATE OF EYE AND ADNEXA:** SM had PRK, OU. No complications.
8. **ROSACEA:** SM states working diagnosis. He was in Florida and had redness when in sun.
9. **Patient Education(OTHER SPECIFIED COUNSELING):** SM educated to the PHA visit. Reviewed HRA survey results, discussed, education provided. Epworth Sleepiness Scale review and discussed. Update PHA in birth month.

Disposition Last updated by PARSON,MARSHEA S @ 28 Apr 2015 0950 EDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by PONDS,BRANDON J @ 28 Apr 2015 0928 EDT

Thank You for Completing the Fleet and Marine Corps Health Risk Assessment

You rated your health as Good. Personal perception about how healthy you are is usually quite accurate. Your Personal Health Risk Appraisal Report identified 4 risk categories from the answers you provided that relate to overall health, which places you in a **MEDIUM** risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the "low risk" category by reducing the number of behavioral risks, and for those already at low risk, to avoid increasing the number of risk factors over time.

<table border="1"> <tr> <td>High Risk</td> <td>= 5 or more risk categories</td> </tr> <tr> <td>Medium Risk</td> <td>= 3-4 risk categories</td> </tr> <tr> <td>Low Risk</td> <td>= 0-2 risk categories</td> </tr> </table>	High Risk	= 5 or more risk categories	Medium Risk	= 3-4 risk categories	Low Risk	= 0-2 risk categories	<p>You reported 4 categories, which places you at MEDIUM risk.</p> <p>The categories you scored "unhealthy" on included:</p> <ul style="list-style-type: none"> • Stress Management • Sexual Health • Nutrition • Sleep
High Risk	= 5 or more risk categories						
Medium Risk	= 3-4 risk categories						
Low Risk	= 0-2 risk categories						

 **Body Mass Index (Note the limitations of BMI below) — Normal Weight**

http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm


YOUR BODY MASS INDEX = 22.1.

Both being overweight or being underweight are related to increased risk of disease and death. Among most Americans, BMI is a reliable indicator of total body fat. It is an inexpensive and easy-to-perform method of screening for weight categories that may


Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

lead to health problems. Limitations of BMI are that it may overestimate body fat in athletes and others who have a muscular build or underestimate body fat in individuals who lack lean muscles mass.

 **TOBACCO USE—** *Never used tobacco* <http://www.ucanquit2.org>
<http://betobaccofree.hhs.gov/>

You are doing the single most important thing to stay healthy! Not smoking saves you money (over \$2000/year for one pack per day), helps you avoid many tobacco related diseases, and adds to your fitness level and overall health.


 **TOBACCO USE—** *Never used tobacco* <http://www.ucanquit2.org>
<http://betobaccofree.hhs.gov/>

Not using smokeless tobacco is a great choice. You can avoid oral cancer, tooth and gum disease, and maintain a fresh and clean mouth.

 **ALCOHOL USE—** *No* <http://www.nlm.nih.gov/medlineplus/alcoholconsumption.html>

 **ALCOHOL USE—** *Never* <http://www.rethinkingdrinking.niaaa.nih.gov/>

You indicate a healthy choice not to drink heavily, even during celebrations. Sailors and Marines also look out for their shipmates and fellow Marines who have been drinking.

 **ALCOHOL USE—** *Never (i.e. not during the past year)*
<http://www.rethinkingdrinking.niaaa.nih.gov/>

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol related incidents by looking out for those who try to drink and drive - and help them get home safely.

 **INJURY PREVENTION—** *Always* <http://www.nhtsa.gov/Driving+Safety>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

 **INJURY PREVENTION—** *Always* <http://www.nhtsa.gov/Driving+Safety>

Your use of a protective helmet provides significant protection against head injury or death. Wearing other protective gear, maintaining control of your vehicle, and driving defensively can also reduce your risk.

 **INJURY PREVENTION—** *Always* <http://www.cdc.gov/niosh/topics/safety.html>

You are protecting yourself against injuries and disease at your worksite by using appropriate safety equipment

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

STRESS MANAGEMENT— *Somewhat satisfied*<http://www.nlm.nih.gov/medlineplus/stress.html> <http://afterdeployment.dcoe.mil>

You are only somewhat satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationships and social activities can all contribute to life satisfaction. Look to these sources for improving your level of satisfaction.

STRESS MANAGEMENT— *Sometimes*<http://www.med.navy.mil/sites/nmcscd/nccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx> <http://startmovingforward.dcoe.mil>

Occasional stress in your work or at home is common. Problem-solving or discussing possible solutions with someone else may help reduce or eliminate some of your stress.

STRESS MANAGEMENT— *Sometimes*<http://www.helpguide.org/topics/relationships.htm> <http://afterdeployment.dcoe.mil>

Finding someone with whom you can talk can help you see that you are not alone in how you feel. Talking with others can also provide you with strategies to successfully manage your concerns. Counselors and chaplains are available to assist you. .

SEXUAL HEALTH— *Most of the time*[http://www.med.navy.mil/sites/nmcphc/health-](http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/condoms.aspx)[promotion/reproductive-sexual-health/Pages/condoms.aspx](http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/condoms.aspx)

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection

PHYSICAL ACTIVITY— *3 weeks per month*<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

To promote and maintain health, all healthy adults aged 18-64 years need moderate-intensity aerobic activity for a minimum of 150 minutes each week or vigorous-intensity aerobic activity for 75 minutes each week. Combinations of moderate- and vigorous-intensity activity can be performed to meet this recommendation. Exercise sessions can be broken up into as little as 10 minutes at a time.

PHYSICAL ACTIVITY— *2 days per week*<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

Muscle-strengthening activities should work all the major muscle groups of your body (legs, hips, back, chest, abdomen, shoulders, and arms). To gain health benefits, muscle-strengthening activities need to be done to the point where it is hard for you to do another repetition without help. Adding muscle allows you to do more activities, improves appearance, and reduces the risk of several chronic diseases.

NUTRITION— *At least 3-5 times per week or more*<http://www.cdc.gov/nutrition/everyone/basics/fat/index.html>

Some dietary fat is needed for good health, but high levels of fat in your diet may lead to excessive weight gain and increase your risk of certain cancers. Eating foods high in saturated and trans-fats also increases your risk of heart disease. Select foods low in

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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DoD ID: 1286180538

Created: 30 Oct 2017

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Page 839

AR 0884

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

saturated fats, trans fats, and cholesterol; eat plenty of whole grains, fruits and vegetables; and choose low fat milk products and lean meats.

NUTRITION— Two <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is to consume at least two servings of fruits per day. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SUPPLEMENTS— Never <http://humanperformancecenter.org/dietary-supplements>

People choosing to supplement their diets with herbals, vitamins, minerals, or other substances need to know about the products they choose so that they can make informed decisions about them. The choice to use a dietary supplement can be a wise decision that provides health benefits. However, under certain circumstances, these products may be unnecessary for good health or they may even create unexpected risks or interact with medications. It is wise to ask your physician or pharmacist before taking supplements.

DENTAL— Daily <http://www.ada.org/public.aspx>

You are to be commended for flossing your teeth daily. Daily flossing is recommended to remove plaque and food particles from between the teeth and under the gum line, which prevents gum disease, tooth loss, decay, and bad breath. In addition to flossing, the American Dental Association recommends brushing your teeth twice a day with fluoride toothpaste to achieve good dental health.

NUTRITION— Two <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is three servings of vegetables per day, with at least one being a dark green or orange vegetable. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help you from chronic diseases and can make make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SLEEP— Sometimes <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/sleep.aspx>

People who get enough restful sleep are able to concentrate on their activities, have more energy, and generally feel better. For many people with busy schedules, it is important to set aside enough time for sleep and to avoid issues at bedtime that can interfere with sleep. Talk with your physician if you are frequently unable to achieve restful sleep.

PREGNANCY— My partner or I are correctly and consistently using birth control ALL the time <http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive->

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

sexual-health/Pages/contraception.aspx

There is a wide range of new, safe and effective contraception options available, some that work for years after you have started them. Some are permanent and others are easily and quickly reversible when you are ready to have a baby. But not all forms of contraception are equally effective. It makes sense to carefully consider your parenting plans and get informed about contraception so you and your partner can select the option that works best for you. Be well informed about contraception, and talk with your partner and doctor.

Signed By **PARSON, MARSHEA S** (Advanced Nurse Practitioner) @ 28 Apr 2015 0950**CHANGE HISTORY***The following Disposition Note Was Overwritten by PARSON, MARSHEA S @ 28 Apr 2015 0950 EDT:*

The Disposition section was last updated by PARSON, MARSHEA S @ 28 Apr 2015 0950 EDT - see above. Previous Version of Disposition section was entered/updated by POND, BRANDON J @ 28 Apr 2015 0921 EDT.

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following S/O Note Was Overwritten by PARSON, MARSHEA S @ 28 Apr 2015 0948 EDT:

S/O Note Written by POND, BRANDON J @ 28 Apr 2015 0926 EDT

History of present illness

The Patient is a 30 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Military service [] Y [X] N Deployed since previous PHA
 [] Y [X] N Post-Deployment Health Assessment completed
 [] Y [X] N Post-Deployment Health Reassessment completed
 [] Y [X] N Post-Deployment labs/tests completed
 [] Y [X] N Deployment/Shipboard limiting conditions identified

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [X] No. No chronic illness. An allergy SEE ABOVE.

Medications: Medication history SEE ABOVE. Not taking medication for high blood pressure.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [X] No.

SEE ABOVE.

Family history

No family history of cancer
 Mental illness (not retardation) MATERNAL
 Heart disease PATERNAL
 Diabetes mellitus PATERNAL.

Physical findings**Vital Signs:**

* Current vital signs reviewed.

Objective

Health Record [] Reviewed [X] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

* Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Therapy

* No electronic medical alert pendant in possession as indicated.

Plan

* Referred elsewhere for the options include referral

[] Physical Activity

[] Safety

[] Diabetes Counseling

[] Cholesterol

[X] Nutrition

[X] Sexuality

[] Other:

* Referred elsewhere for patient counseling

[] Tobacco Use

[] Alcohol Use

[] Weight Management

[] Dental Care

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 841

AR 0886

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

☐ Mental Health
☐ Hypertension
☒ Other: STRESS MANAGEMENT, SLEEP
Updated DD 2766 Sections: NO RECORD
Health counseling performed or scheduled documented on the DD 2766 and for additional topics below:

Notes

Follow-up in one year.

Practice Management

Risk factor counseling individual, 30 minutes.

The following A/P Note Was Overwritten by PARSON, MARSHEA S @ 28 Apr 2015 0943 EDT:

The A/P section was last updated by PARSON, MARSHEA S @ 28 Apr 2015 0943 EDT - see above. Previous Version of A/P section was entered/updated by POND, BRANDON J @ 28 Apr 2015 0921 EDT.

1. Visit for: military services physical (PERIODIC PREVENTION EXAMINATION)

Procedure(s):

-Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): POND, BRANDON J

Laboratory(ies):

-HEPATITIS C AB (Routine) Ordered By: POND, BRANDON J Ordering Provider: PARSON, MARSHEA S

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

27 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20600047 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS Date: 27 Apr 2015 0824 EDT Appt Type: GRP
 Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: REGIS, JAMES
 NAVY YARD
 Patient Status: Outpatient

AutoCites Refreshed by REGIS, JAMES @ 29 Apr 2015 0721 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 27 Apr 2015 0824 EDT
 OP GROUP

Screening Written by PATSOS, ASHLEY N @ 27 Apr 2015 0837 EDT
Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 27 Apr 2015 0824

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 27 Apr 2015 0837 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact # [REDACTED]

No vitals taken for SARP Treatment.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

S/O Note Written by PATSOS,ASHLEY N @ 27 Apr 2015 0840 EDTHistory of present illness

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 27 Apr 2015 0847 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 29 Apr 2015 0721 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 1, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's first day of treatment in group. Daniel did his introduction to the group which consisted of two other members present; as well as performed a check-in exercise and elaborated on his weekend.

During the introductions, Daniel stated that he had recently completed Level III Residential treatment at Fort Belvoir hospital and that he was encouraged by the knowledge and tools that he gained from his stay there. Daniel also stated that he is currently working on designing a video game which is taking up a lot of his time and that he wants to make sure he's addressing this need he has to please other people vs himself.

Daniel seemed determined and anxious to address his need to do things for himself and not others. He looked decisive prepared regarding him sharing the circumstances and events that got him here with the group. Daniel addressed Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level 1 on 29th of April 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 29 Apr 2015 0722Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 29 Apr 2015 1118

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

23 Apr 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-20572704 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: MERWIN, DANIEL DENNIS
 Treatment Facility: WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 Patient Status: Outpatient

Date: 23 Apr 2015 0900 EDT
 Clinic: PSYCHIATRY BE

Appt Type: SPEC
 Provider: ZEMBRZUSKA, HANNA
 DOMINIKA

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0853 EDT

Allergies

•OTHER: Unknown (SEE MED RECORD)

Labs

20 Apr 2015 0012
 ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative <0>

Units
 ng/mL

Ref Range
 Cutoff=500

20 Apr 2015 0012 <0>

Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result

not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range

(Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

13 Apr 2015 0548
 ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=500

13 Apr 2015 0548

Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result

not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range

(Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

06 Apr 2015 0722
 ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=500

06 Apr 2015 0722

Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result

not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range

(Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 845

AR 0890

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

30 Mar 2015 2236

Chlamydia+Gonococcus DNA Panel NAAT Site Specimen

	Site Specimen	Result	Units	Ref Range
Neisseria gonorrhoeae DNA	URINE	negative for n.gonorrhoeae <i>		
Chlamydia trachomatis DNA	URINE	negative for c.trachomatis <i>		(Negative)

30 Mar 2015 0805

ETG/ETS, UA (500 Cut-Off)

	Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	URINE	negative	ng/mL	Cutoff=500

30 Mar 2015 0805

Drug Abuse Screen

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	not detected <i>		(Not-detected)
Barbiturates	URINE	not detected <i>		(Not-detected)
Benzodiazepines	URINE	not detected <i>		(Not-detected)
Cocaine	URINE	not detected <i>		(Not-detected)
Opiates	URINE	not detected <i>		(Not-detected)
Phencyclidine, UA	URINE	not detected <i>		(Not-detected)
Cannabinoids	URINE	not detected <i>		(Not-detected)
Methadone	URINE	not detected <i>		(Not-detected)
Oxycodone	URINE	not detected <i>		(Not-detected)

27 Mar 2015 2159

Urinalysis Panel

	Site Specimen	Result	Units	Ref Range
Color	URINE	straw		(Yellow)
Ketones	URINE	neg	mg/dL	(neg)
Hemoglobin	URINE	neg		(neg)
Nitrite	URINE	neg		(neg)
pH	URINE	7.0		(5.0-9.0)
Protein	URINE	neg	mg/dL	(neg)
Appearance	URINE	clear		(Clear)
Leukocyte Esterase	URINE	neg		(neg)
Specific Gravity	URINE	1.006		(1.000-1.035)
Urobilinogen	URINE	normal	mg/dL	(norm 0.2-1)
Glucose	URINE	neg	mg/dL	(neg)
Bilirubin	URINE	neg		(neg)

27 Mar 2015 1630

Mephedrone, MDPV, Methyone

	Site Specimen	Result	Units	Ref Range
Mephedrone	URINE	negative		NEGATIVE
Methylenedioxypyrovalerone	URINE	negative		NEGATIVE
Methyone	URINE	negative <r>		NEGATIVE

27 Mar 2015 1630

Cannabinoids (THC), Synthetic

	Site Specimen	Result	Units	Ref Range
Cannabinoids, Synthetic	URINE	negative <r>		

27 Mar 2015 1630

Chlamydia+Gonococcus DNA Panel NAAT Site Specimen

	Site Specimen	Result	Units	Ref Range
Neisseria gonorrhoeae DNA	URINE	negative for n.gonorrhoeae <i>		
Chlamydia trachomatis DNA	URINE	negative for c.trachomatis <i>		(Negative)

27 Mar 2015 1630

ETG/ETS, UA (250 Cut-Off)

	Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	URINE	negative	ng/mL	Cutoff=250

27 Mar 2015 1630

Drug Abuse Screen

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	not detected <i>		(Not-detected)
Barbiturates	URINE	not detected <i>		(Not-detected)
Benzodiazepines	URINE	not detected <i>		(Not-detected)
Cocaine	URINE	not detected <i>		(Not-detected)
Opiates	URINE	not detected <i>		(Not-detected)
Phencyclidine, UA	URINE	not detected <i>		(Not-detected)
Cannabinoids	URINE	not detected <i>		(Not-detected)
Methadone	URINE	not detected <i>		(Not-detected)
Oxycodone	URINE	not detected <i>		(Not-detected)

27 Mar 2015 1630

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 846

AR 0891

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Urinalysis Panel	Site Specimen	Result	Units	Ref Range
Color	URINE	straw		(Yellow)
Ketones	URINE	neg	mg/dL	(neg)
Hemoglobin	URINE	neg		(neg)
Nitrite	URINE	neg		(neg)
pH	URINE	7.0		(5.0-9.0)
RBC	URINE	< 1	/HPF	(0-3)
Protein	URINE	neg	mg/dL	(neg)
Appearance	URINE	clear		(Clear)
Leukocyte Esterase	URINE	mod (H)		(neg)
Specific Gravity	URINE	1.008		(1.000-1.035)
Urobilinogen	URINE	normal	mg/dL	(norm 0.2-1)
WBC	URINE	3 (H)	/HPF	(0-2)
Glucose	URINE	neg	mg/dL	(neg)
Bilirubin	URINE	neg		(neg)
27 Mar 2015 1600				
Vitamin D, 1,25-Dihydroxy (Calcitriol) Panel	Site Specimen	Result	Units	Ref Range
Vitamin D, 1,25-Dihydroxy	SERUM	78 <I>	pg/mL	
Vitamin D2, 1,25-Dihydroxy	SERUM	<10	pg/mL	
Vitamin D3, 1,25-Dihydroxy	SERUM	76	pg/mL	
27 Mar 2015 1600				
Vitamin B1 (Thiamine)	Site Specimen	Result	Units	Ref Range
Vitamin B1 (Thiamine)	BLOOD	193.4	nmol/L	66.5-200.0
27 Mar 2015 1600				
HIV-1/O/2 Ab	Site Specimen	Result	Units	Ref Range
HIV-1/O/2 Ab	SERUM	*****		
27 Mar 2015 1600				
Rapid Plasma Reagin	Site Specimen	Result	Units	Ref Range
Reagin Ab	SERUM	nonreactive <I>		(Non-Reactive)
27 Mar 2015 1600				
Homocysteine	Site Specimen	Result	Units	Ref Range
Homocysteine	SERUM	9.1 <I> <I>	mcmol/L	(4.0-15.4)
27 Mar 2015 1600				
Vitamin B12 (Cyanocobalamin)+Folate Panel	Site Specimen	Result	Units	Ref Range
Vitamin B12 (Cobalamins)	SERUM	329 <I>	pg/mL	(211-946)
Folate	SERUM	>20.00 <I>	ng/mL	(4.6-34.8)
27 Mar 2015 1600				
Magnesium	Site Specimen	Result	Units	Ref Range
Magnesium	SERUM	2.2	mg/dL	(1.7-2.6)
27 Mar 2015 1600				
Thyroid Stimulating Hormone	Site Specimen	Result	Units	Ref Range
Thyrotropin	SERUM	0.757 <I>	mIU/mL	(0.27-4.20)
27 Mar 2015 1600				
Gamma Glutamyl Transferase	Site Specimen	Result	Units	Ref Range
Gamma-Glutamyl Transferase	SERUM	40	U/L	(10-71)
27 Mar 2015 1600				
Comprehensive Metabolic Panel	Site Specimen	Result	Units	Ref Range
Albumin	SERUM	4.9	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	71	U/L	(40-130)
Alanine Aminotransferase	SERUM	29 <I>	U/L	(0-41)
Bilirubin	SERUM	0.3	mg/dL	(0-1.0)
Urea Nitrogen	SERUM	14	mg/dL	(6-20)
Calcium	SERUM	10.0	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-31)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.9	mg/dL	(0.7-1.4)

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 847

AR 0892

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Glucose	SERUM	82	mg/dL	(74-106)
Potassium	SERUM	4.7	mmol/L	(3.5-5.1)
Protein	SERUM	7.9	g/dL	(6.4-8.3)
Sodium	SERUM	139	mmol/L	(135-145)
Anion Gap	SERUM	13	mmol/L	(8-18)
GFR Calculated Non-Black	SERUM	114.7	mL/min	(>=90)
GFR Calculated Black	SERUM	132.6 <i>	mL/min	(>=90)
Aspartate Aminotransferase	SERUM	<5	U/L	(0-40)

27 Mar 2015 1600

CBC W/Diff

	Site Specimen	Result	Units	Ref Range
WBC	BLOOD	6.8	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.65	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	14.5	g/dL	(12.8-17.7)
Hematocrit	BLOOD	43.1	%	(37.5-50.9)
MCV	BLOOD	92.6	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	33.6	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.0	%	(12.0-16.2)
Platelets	BLOOD	296	x10(3)/mcL	(162-427)
MPV	BLOOD	8.5	fL	(7.0-10.9)
Neutrophils	BLOOD	67.0	%	(40.7-76.4)
Lymphocytes	BLOOD	25.1	%	(15.9-47.8)
Monocytes	BLOOD	6.7	%	(4.5-11.8)
Eosinophils	BLOOD	0.9	%	(0.3-7.1)
Basophils	BLOOD	0.3	%	(0.2-1.2)
ABS Neutrophils	BLOOD	4.5	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	manual diff not performed		

27 Mar 2015 16

Coagulation Panel 1 (PT+APTT)

	Site Specimen	Result	Units	Ref Range
Protime	PLASMA	12.5	Sec	(12.4-14.4)
INR	PLASMA	1.0 <i>		
APTT	PLASMA	32.9 <i>	Sec	(23.4-36.2)

Microbiology Results

Urine Culture

Order #	150327-24502 (NNMC Bethesda)
Filler #	150327 DWB 64394 (NNMC Bethesda)
Status:	Final
Ordering Provider:	CEREMUGA, GEORGE J
Priority:	ROUTINE
Date Ordered:	27 Mar 2015 1557
Date Resulted:	29 Mar 2015 0651
COLLECT_SAMPLE:	URINE/CLEAN CATCH

BACTERIOLOGY RESULT:	03/28/15: LESS THAN 24 HOURS, FURTHER INCUBATION REQUIRED
BACTERIOLOGY RESULT:	03/29/15 URINE CULTURE NEGATIVE

Specimen:	Urine
Collected:	27 Mar 2015 1630

Results:	Final report
----------	--------------

Rads

No Rads Found.

Reason for Appointment:

Generalized Anxiety Disorder & Alcohol Use Disorder, Severe

Appointment Comments:

ddr

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Vitals**Vitals** Written by ERICKSON,NANCY A @ 23 Apr 2015 0855 EDTBP: 122/68, HR: 70, RR: 16, T: 96.0 °F, HT: 5' 9", WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters
Comments: PT weighed in uniform and boots.**S/O Note** Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1113 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder. Pt initially presented to Integrative Care on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged yesterday. SARP would like psychiatrist to evaluate pt for psychotropic medication for his depressed mood, anxiety, and sleep symptoms. Pt reports that every day he experiences either a depressed mood or apathy. He does have moments of happiness when he works on his computer game or cooks, but these moments don't last long. He often wonders what the point of life is and what his purpose in life is. He often worries about the future and tasks he has to complete. He feels that he is always planning and runs through scenarios (good version, bad version) of things in his head. He is frequently irritable, impatient, and judgmental of others. His anxious ruminations lead to initial insomnia. He did sleep well last night, but in rehab he was using Melatonin at bedtime. He has been started on Zoloft, but has not noticed a benefit yet. Denies side effects.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 ? 3 self-poured drinks, which has an estimated 4 ounces of alcohol per drink. He described the appeal in terms of the calming effect on his mind, specifically to dampen his anxious ruminations and ?obsessing.? He further reported that drinking helps prepare him for sleep onset (he has had problems with initial insomnia). Clinical interview further revealed evidence for marked tolerance, significant spending on alcohol (\$400 - \$500 per month), hangovers (every other week), being told that he drinks too much (past girlfriends), drinking despite the consistent worsening of his negative mood state, and unsuccessful efforts to reduce/quit drinking. In his personal reflection, he indicated that he does not like himself relative to his drinking and desires to stop. He recognizes that there are multiple triggers to his drinking and usually these involve longstanding feelings of disappointment, frustration, and loneliness. It should be noted that the SM indicated that he has been engaging in painful introspection, particularly regarding his childhood and family life.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 50mg daily started on 26MAR2015

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

- * THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

- * MEDS: Denies other medication trials

- * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 849

AR 0894

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself ?bored? with college. He enlisted in the Navy in October, 2005, after dropping out of college, working two jobs, and being on the verge of ?living on the street.? There were mounting debts (rent, college tuition, basic apartment furniture) also at the time. He started as an Aviation Boatswain's Mate, then cross-rated in 2009 to Cryptologic Technician ? Network. His duty stations have included USS ESSEX, Pensacola, and NIOC Maryland. He has been very successful in his enlisted service thus far, but has been disenchanted at his current Command because everyone is physically separated and it is not a tight knit command.

Pt was engaged to a Filipino girl he met while stationed overseas, but he ended the engagement in 2010 because she was 'crazy.'
No kids.

Behavioral: Caffeine use 16 oz tea/day and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Discharged yesterday from Ft. Belvoir 28 day Residential Alcohol Treatment.

Subjective**Additional Screening Questions:**

Are you having any thoughts about harming another person? Denies
Do you feel like you are at risk for workplace violence? Denies

PTSD CHECKLIST (PCL-C)

- [2] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- [0] Repeated, disturbing dreams of a stressful experience from the past?
- [0] Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- [2] Feeling very upset when something reminded you of a stressful experience from the past?
- [2] Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- [1] Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. Total Score = 13 DATE:

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? [] Not difficult [X] Somewhat difficult [] Very difficult [] Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? [] Yes [X] No

If 'Yes', how often? [] Several days [] More than half the days [] Almost everyday.

Depression Screening:

- [1] 1. Little Interest or pleasure in doing things
- [1] 2. Feeling down depressed or hopeless

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- [0] 3. Trouble sleeping or sleeping too much
 [1] 4. Feeling tired or little energy
 [0] 5. Poor appetite or overeating
 [0] 6. Feeling bad about self
 [0] 7. Trouble concentrating on things
 [1] 8. Moving or speaking slowly or being restless
 [0] 9. Thoughts that you would be better off dead
 Add point values from each response. Total (PHQ-9) Score = 4

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely.

Generalized Anxiety Disorder Screening:

- [1] 1. Feeling nervous, anxious, or on edge
 [1] 2. Not being able to stop or control worrying
 [1] 3. Worrying too much about different things
 [0] 4. Trouble relaxing
 [0] 5. Being so restless that it's hard to sit still
 [2] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 5

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely.

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms
 No current cognitive symptoms
 No current psychotic symptoms

Physical findings**Psychiatric:**

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide/Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 851

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Protective:

Strong Therapeutic Alliance:Y
 Positive Coping Skills:Y
 Responsible to/for Family:Y
 Responsible to/for Pet:N
 Frustration Tolerance:Y
 Resilience:Y
 Good Reality Testing:Y
 Amenable to Treatment:Y
 Social Support:Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: MELTON FOR CBT-I

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 23APR2015
 Reviewed with patient on: 23APR2015
 Does patient agree with plan? Yes
 If not, what part?
 Projected date of next treatment plan update: f/u in 3 weeks
 Discussion of assessment and intervention
 Tx Plan cont'd:

Diagnosis

Generalized Anxiety Disorder
 Alcohol Use Disorder, moderate to severe

Active Problem List:

1. Anxiety, worry, irritability
2. Depressed/apathetic mood
3. Insomnia

Long-Term Goals:

1. Improve relationship/increase social support from mother and sister
2. Improve financial knowledge/pay off debts

Discussion of risk of assessment and intervention
 Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 852

AR 0897

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

Interventions:

1. Pt to obtain Melatonin OTC to help with insomnia
2. Pt to download free CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts
3. Pt referred to CBT-I group with Ms. Melton at WRNMMC. First group starts Monday, 27 April 13-14:00 for 4 weeks

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

Lab Result Cited by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0856 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0855 EDT

Hemoglobin A1c	Site/Specimen	04 Jun 2013 0925
Hemoglobin A1c	BLOOD	5.4 <i>

Lab Result Cited by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0855 EDT

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 1026 EDT**1. GENERALIZED ANXIETY DISORDER 300.02**

Procedure(s): -(90792) Psychiatric Diagnostic Evaluation With Medical Evaluation And Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90**Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 1134 EDT****Released w/o Limitations**

Follow up: 3 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0852 EDT**Consult Order**

Referring Provider: EDWARDS, OLUSOLA O

Date of Request: 15 Apr 2015

Priority: Routine

Provisional Diagnosis:

Generalized Anxiety Disorder ~T~ Alcohol Use Disorder, Severe

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Reason for Request:

Patient will need follow-up appointment for inpatient discharge. Patient was diagnosed with generalized anxiety disorder. Patient reported history of physical and emotional abuse from his father.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 23 Apr 2015 1134

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

22 Apr 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20560323 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **22 Apr 2015 1019 EDT** Appt Type: **EST**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **GONZALEZZARAZUA, JORGE A**
NAVY YARD
 Patient Status: **Inpatient** Inpatient Location:

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 22 Apr 2015 1113 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 22 Apr 2015 1019 EDT
 OP INTAKE

Screening Written by PATSOS, ASHLEY N @ 22 Apr 2015 1031 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 22 Apr 2015 1019

OP INTAKE

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 22 Apr 2015 1031 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 22 Apr 2015 1033 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):
 -BEHAVAL HEALTH SCREEN DETERMINE ELIGIBLY, ADM TX PRGM x 1 - Met with patient one-on-one from 1030-1130 to discuss Individual Treatment Plan.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 23 Apr 2015 1333 EDT

Continued Stay

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his OP treatment intake. Treatment plan has been developed and Daniel has agreed to the terms and conditions of treatment, to include abstinence from alcohol and any other drugs starting 22 April 2015. Furthermore, he has agreed to complete the pre-confinement physical prior to his Tx start date or as soon as he can get an appointment with his PCM. CDP handout binder was provided to Daniel and he was also given instructions for completing his assignments.

P) Start working on treatment plan issues.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 23 Apr 2015 1333

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 23 Apr 2015 1341

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

23 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20234361 Primary Dx: ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Patient: MERWIN, DANIEL DENNIS Date: 23 Mar 2015 0909 EDT Appt Type: EST
 Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY Provider: REGIS, JAMES
 NAVY YARD
 Patient Status: Outpatient

AutoCites Refreshed by REGIS, JAMES @ 25 Mar 2015 1411 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 23 Mar 2015 0909 EDT
ESTScreening Written by PATSOS, ASHLEY N @ 23 Mar 2015 0909 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 23 Mar 2015 0909

EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 23 Mar 2015 0909 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

A/P Last Updated by PATSOS, ASHLEY N @ 23 Mar 2015 0910 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
 THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED. **Page 857**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

on-one from 0800-0900 to review Individual Treatment Plan.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS, JAMES @ 25 Mar 2015 1415 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his individual 1-on-1 session with his counselor on Monday 23rd of March 2015 at 08:00.

Daniel was told that his bed was confirmed for him to attend Level 3 Inpatient Treatment at Fort Belvoir Residential Treatment Center in VA. Daniel stated that he is ready to go to treatment; then mentioned that he was unable to reframe from abstaining from alcohol this weekend past weekend. Daniel stated that he had a date on Friday night that stood him up. While there waiting for her at the bar, he felt "upset" and decided to start drinking rum and cokes. After 6 rum and cokes, he decided to stop. Daniel mentioned that that was the 3rd time this week that he's been stood up. He further stated that he went home in a cab and passed out. He also mentioned that he stayed in his apartment the entire weekend and did nothing.

Daniel appeared miserable and fully aware of how different triggers can lead him to start drinking to mask his discontent. Realizing that Daniel does not have the necessary tools to handle these deterrence's, Daniel was asked to use a "feelings chart" to describe how he felt when he was at the bar. Daniel mentioned several to include, frustrated, disappointed, envious (of other couples), idiotic, enraged, jealous, hurt. This exercise made Daniel understand the importance of acknowledging all of the feelings he is going through and to understand that it's not just being "upset".

Daniel has not drunk since Friday night and states that he will abstain from alcohol throughout his treatment. He will check in to Fort Belvoir Level 3 Residential Treatment facilities in VA at 08:30 on Wednesday 25th of March 2015.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel is upon completion of Level 3 Residential Program at Ft Belvoir.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 25 Mar 2015 1415

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 25 Mar 2015 1441

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20216692 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS** Date: **20 Mar 2015 0737 EDT** Appt Type: **EST**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 20 Mar 2015 0806 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 20 Mar 2015 0737 EDT
EST**Screening** Written by PATSOS, ASHLEY N @ 20 Mar 2015 0737 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 20 Mar 2015 0737

EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 20 Mar 2015 0737 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

A/P Last Updated by PATSOS, ASHLEY N @ 20 Mar 2015 0739 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED. **Page 859**

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

on-one from 0800-0900 to review Individual Treatment Plan.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS, JAMES @ 20 Mar 2015 1448 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his individual 1-on-1 session with his counselor on Friday 20th of March 2015 at 07:30. Daniel was told that his LIP assessment confirmed the recommendation for him to attend Level 3 Inpatient Treatment. Daniel completed the package for admission to Fort Belvoir Residential Treatment Center. Daniel stated that he is ready to go next week. Daniel then mentioned that he's noticed that he is eating more now than when he was drinking and that he was stood up twice this week; both on Tuesday and on Thursday by the same girl which made him feel disappointed and lonely. Daniel also mentioned that he didn't know what he was doing this weekend but that he did have a date for tonight who already knows that he will not be drinking. Daniel appeared bashful and optimistic regarding his willingness to attend treatment next week. When communicating about being stood up this week, Daniel seemed hurt and perplexed. While expressing his disappointment about being stood up, he seemed in disbelief that this happened to him twice. Regarding his abstaining from alcohol, Daniel gives the impression of being very cautious. Daniel will continue to abstain from alcohol throughout his treatment. He was asked to make a weekend plan which included snowboarding and his 1st AA meeting on Saturday and then going to the gym and another AA meeting on Sunday. Daniel showed no evidence of SI/HI/ATV.
 Next scheduled appointment for Daniel is on the 23rd of March 2015 @ 07:30
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 20 Mar 2015 1448

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 20 Mar 2015 1514

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

19 Mar 2015 at WRNMMC, Substance Abuse NY by ARITA, ANTHONY AEncounter ID: BETH-20203468 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: MERWIN, DANIEL DENNIS Date: 19 Mar 2015 0755 EDT
Treatment Facility: NBHC WASHINGTON Clinic: SUBST ABUSE NY
NAVY YARD
Patient Status: OutpatientAppt Type: EST
Provider: ARITA, ANTHONY AKIOAutoCites Refreshed by ARITA, ANTHONY A @ 19 Mar 2015 1548 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDT
LIP APPOINTMENTScreening Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 19 Mar 2015 0755

LIP APPOINTMENT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

VitalsVitals Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

No vitals taken at SARP treatment.

A/P Written by ARITA, ANTHONY A @ 19 Mar 2015 1549 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Written by ARITA, ANTHONY A @ 19 Mar 2015 1743 EDT

Released w/o Limitations

Note Written by ARITA, ANTHONY A @ 19 Mar 2015 1743 EDT**Washington Navy Yard – Branch Health Clinic
Substance Abuse Rehabilitation Program (SARP)**

DEMOGRAPHIC/BACKGROUND SNAPSHOT	
Patient Name	Merwin, Daniel Dennis 20/[REDACTED]
Rank / Rate/MOS	E-6 / CTN1 (cryptologic technician – network), first class petty officer
Duty Station	Navy Information Operations Command (NIOC), Maryland
Branch of Service	USN
DoB / Age	[REDACTED] 1985 / 30 years old

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Marital Status	Single; no children
Current Duty Status	Fit for Full Duty
Notes	<ul style="list-style-type: none"> • Primary Language: English • Education: 13 • TBI/Concussive Events: <ul style="list-style-type: none"> • denied • Medical: <ul style="list-style-type: none"> • Recurrent abdominal pains • Psych Health: <ul style="list-style-type: none"> • History of intermittent SI • History of SA (in 10th or 11th grade) • Alcohol Dependence (documented this visit) • Anxiety Disorder, NOS (documented 04 AUG 2014)

19 MAR 2015**Psychological Health Evaluation**

IDENTIFYING DATA AND REASON FOR REFERRAL: The Service Member (SM) is a 30-year old, single, Caucasian male, E-6/AD/USN, with approximately 9 ½ years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland. The SM was seen as a self-referral, based on his concern about his drinking.

CONSENT/PRIVACY: The SM was given an explanation of the nature and purpose of the present evaluation, as well as the limits of confidentiality and he consented to the procedures. He signed the Privacy Act statement on 17 MAR 2015 – a copy is in his secondary (clinic) file.

HISTORY OF PRESENT CONCERNS: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 – 3 self-poured drinks, which has an estimated 4 ounces of alcohol per drink. He described the appeal in terms of the calming effect on his mind, specifically to dampen his anxious ruminations and “obsessing.” He further reported that drinking helps prepare him for sleep onset (he has had problems with initial insomnia). Clinical interview further revealed evidence for marked tolerance, significant spending on alcohol (\$400 - \$500 per month), hangovers (every other week), being told that he drinks too much (past girlfriends), drinking despite the consistent worsening of his negative mood state, and unsuccessful efforts to reduce/quit drinking. In his personal reflection, he indicated that he does not like himself relative to his drinking and desires to stop. He recognizes that there are multiple triggers to his drinking and usually these involve longstanding feelings of disappointment, frustration, and loneliness. It should be noted that the SM indicated that he has been engaging in painful introspection, particularly regarding his childhood and family life. Over the past couple of years, he has been frustrated in his job (is preparing to leave the Navy at his EAOS in OCT 2015) and disappointed in his romantic life. He reported a longstanding history of intermittent suicidal ideation. He reported a couple of instances of suicide attempts in adolescence. In his adult life, his suicidal ideations, which occur about once per month, might include consideration of various methods, but without intense distress or intent to follow through. He further revealed that the thought of pain associated with any act of self-harm discourages serious consideration of suicide. Additionally, the SM reported that he tends to pick at the hair in particular places on his scalp – he pointed to some visible bald patches at the crown of his head that has become a source of embarrassment to him.

REVIEW OF RECORDS: the SM's AHLTA records were reviewed. SM's record was notable for multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

HISTORY OF HEAD INJURIES AND BLAST EXPOSURE: The SM denied any history of head or concussive injuries.

PSYCHIATRIC HISTORY: Much of his history is reported in sections above. Family history was significant for depression (mother, sister) and Bipolar Disorder (sister, maternal grandmother). SM denied past and present use of illicit substances. He reported abusing his albuterol inhaler during his childhood/adolescence. With regard to conduct problems, the SM described himself as a "good kid," however noted school suspensions due to computer hacking, fighting, and being connected with the presence of stink bombs at school. He denied any past legal problems or history of arrests.

MEDICAL HISTORY: The SM reported a history of asthma during childhood, but also that he had an allergic response to pets, which were kept in the home. He used an inhaler throughout his childhood. At times, he had to be hospitalized due to his asthma response and he estimates that, summed together, he spent a total of about 30 days hospitalized. He reported a problem with recurrent intestinal pain that has not yet been definitively diagnosed. This has been a problem since about age 15 and is tied to having to go to the bathroom. He had PRK performed in 2011. He was not taking any prescription or OTC medications at the time of the evaluation. There were no known drug allergies. He denied use of tobacco products. He reported his consumption of caffeinated beverages in terms of 14 oz. of coffee daily, more on weekends.

PAIN: The SM reported mild dental pain associated with his orthodontic braces. He reported his pain as a 2 on a scale from 0 – 10 (10 = most excruciating; 0 = none).

SOCIAL AND FAMILY HISTORY: The SM was the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler. He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. The SM indicated that he had few friends. He was often by himself; he was absorbed playing with Legos and watching Star Trek. He left his family abruptly, upon graduation from high school, in 2003. He enlisted in the Navy in October, 2005, after dropping out of college, working two jobs, and being on the verge of "living on the street." There were mounting debts also at the time. He started as an Aviation Boatswain's Mate, then cross-rated in 2009 to Cryptologic Technician – Network. His duty stations have included USS ESSEX, Pensacola, and NIOC Maryland. He has been very successful in his enlisted service thus far, but has been disenchanted at his current Command. He expressed an interest in getting out of the Navy and continuing his current line of work as a civilian contractor.

MENTAL STATUS AND BEHAVIORAL OBSERVATIONS: SM was an adequately groomed and dressed, Caucasian male with red hair. He appeared younger than his age of 30. SM was alert and fully oriented. Eye contact was good. He was cooperative with the interview and answered all questions. Behavior and conduct were appropriate to the interview. Affect was subdued, but responsive. He reported his mood as "mixed...crappy...anxious...frustrated." Immediate and remote memory appeared good. Thought processes were clear, coherent, linear, logical, and goal-directed. Speech was of normal rate, rhythm, and volume. There was no evidence for psychosis as indicated by hallucinations, delusions, and bizarre thinking. Intelligence, based on verbal skills and vocabulary, was estimated to be average. Judgment and impulse control appeared intact, without evidence for gross impairment. Treatment motivation was viewed to be good.

PRIMARY FINDINGS: The SM's pattern of drinking meets the criteria for Alcohol Dependence. He is unable to manage or control his drinking and has little confidence that he can discontinue on his own. He appreciates the multiple triggers, usually mood related, that make him vulnerable to resumption of drinking. He will require the high structure and controlled environment of a residential setting. Level III care is therefore indicated. He also presents with prominent psychological concerns – persistent dysphoria with intermittent, mild suicidal ideation. There is an anxiety component, obsessive/ruminative

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

thinking, and compulsions. Trichotillomania may explain his compulsion to pick at his hair (leaving bald patches). A repeat mental health evaluation to specifically address his mood/anxiety symptoms and possible Axis II contributions to his recurrent dysphoria is also appropriate.

SAFETY ISSUES: The Service Member is not currently reporting suicidal or homicidal ideation, intentions, or plans. At present, the Service Member has sufficient ego strength and functional capacity to alert others should he experience a crisis. There are no acute signs of distress presently requiring more extensive suicide risk assessment at this time. Neither is there a need to increase his level of care or restrict autonomy.

FITNESS FOR DUTY AND DISPOSITION: The Service Member is currently psychologically fit for full duty. There is no psychological condition at present that warrants medical board action. The impact of his psychological symptoms described above have largely been associated with distress, to a lesser degree decrements in functioning

DIAGNOSIS:

AXIS I: Alcohol Use Disorder, Moderate – Severe
History of Anxiety Disorder, NOS
R/O Trichotillomania
AXIS II: Cluster C traits
AXIS III: No known contributory physical illnesses
AXIS IV: multiple sources of dissatisfaction
AXIS V: Current GAF: 51

SUMMARY OF FINDINGS AND RECOMMENDATIONS:

1. Based on the available data, the Service Member meets the criteria for Alcohol Dependence.
2. The Service Member is recommended to attend Level III (Residential) treatment, which will afford him the high structure, monitoring, and support required to sustain his abstinence over the course of treatment. His risk of drinking resumption is unacceptably high on an outpatient basis. Level III care will help equip him with the tools/skills he will need to maintain his sobriety and participate meaningfully in his recovery trajectory following completion of residential care.
3. He is to remain abstinent throughout the period of treatment and continuing care.
4. The Service Member is to attend AA meetings at the frequency recommended by the SARP counselor.
5. The Service Member is recommended to resume mental health care at Walter Reed – Bethesda. He will benefit most from a re-evaluation, particularly for psychotropic medication consultation with regard to his mood, anxiety, and sleep symptoms. Cognitive behavioral therapy for insomnia might also be helpful, given his ruminative style.
6. These findings and recommendations were discussed with the SM, who expressed understanding and willingness to comply.

Anthony A. Arita, PhD
CAPT, MSC, USN
Clinical Psychologist / Neuropsychologist

Signed By ARITA, ANTHONY A (Clinical Psychologist/Neuropsychologist) @ 19 Mar 2015 1744

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

17 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20171109 Primary Dx: Visit for: screening exam alcoholism

Patient: **MERWIN, DANIEL DENNIS** Date: **17 Mar 2015 0725 EDT** Appt Type: **SPEC**
 Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **REGIS, JAMES**
NAVY YARD
 Patient Status: **Outpatient**

AutoCites Refreshed by REGIS, JAMES @ 18 Mar 2015 1505 EDT**Problems**

- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 17 Mar 2015 0725 EDT
 ASSESSMENT

Screening Written by PATSOS, ASHLEY N @ 17 Mar 2015 0730 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 17 Mar 2015 0725

ASSESSMENT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (New) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 17 Mar 2015 0730 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

No vitals taken at SARP treatment.

S/O Note Written by REGIS, JAMES @ 18 Mar 2015 1506 EDT

History of present illness

The Patient is a 30 year old male.

He reported: Encounter Background Information: This 30 year old, Single, Male, AD, E-6, USN, NIOC, Fort Meade, MD service member with 9 years active service, was command self-referred for substance abuse evaluation due to: Pt states that he has concerns about his inability to resist drinking; which he feels contributes to his growing lack of motivation.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by PATSOS,ASHLEY N @ 17 Mar 2015 0731 EDT

1. Visit for: screening exam alcoholism

Procedure(s): -ALCOHOL AND/OR DRUG ASSESSMENT x 1 - The patient arrived at 0730 and was provided a screening assessment questionnaire, which he completed at 0830. The questionnaire was reviewed and a face to face conducted from 0845-1030.

Disposition Last Updated by REGIS,JAMES @ 18 Mar 2015 1506 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: The patient was briefed on the screening process with Privacy Act and

Informed Consent reviewed and discussed. The patient was also briefed on DSM-IV and ASAM/PPC indicating his understanding.

No evidence of HI/SI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 18 Mar 2015 1509

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 18 Mar 2015 1524

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

30 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18858979 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 04 Nov 2014 1356 EST**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 04 Nov 2014 1357 EST**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 867

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10-30-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient stated that his sleep is not good. He wakes up in the middle of the night and sometimes has a hard time going back to sleep. Over the weekend, he had a date with a woman who lives in Harrisburg, PA. While he was in the area, he also tried to look up a woman he dated several years ago. He is trying to accept other's points of view. He did not find the one, and the other didn't turn out. One of his main concerns with women he dates, is he needs alone time to do his own thing (computer programming mainly).

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL. Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lots, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day: Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
☐ Repeated, disturbing dreams of a stressful experience from the past?
☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
☐ Feeling very upset when something reminded you of a stressful experience from the past?
☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
☐ Avoid activities or situations because they remind you of a stressful experience from the past?
☐ Trouble remembering important parts of a stressful experience from the past?
☐ Loss of interest in things that you used to enjoy?
☐ Feeling distant or cut off from other people?
☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
☐ Feeling as if your future will somehow be cut short?
☐ Trouble falling or staying asleep?
☐ Feeling irritable or having angry outbursts?
☐ Having difficulty concentrating?
☐ Being
'super alert
'or watchful on guard?
☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little interest or pleasure in doing things
☐ 2. Feeling down depressed or hopeless
☐ 3. Trouble sleeping or sleeping too much
☐ 4. Feeling tired or little energy
☐ 5. Poor appetite or overeating
☐ 6. Feeling bad about self
☐ 7. Trouble concentrating on things
☐ 8. Moving or speaking slowly or being restless
☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
☐ 2. Not being able to stop or control worrying
☐ 3. Worrying too much about different things
☐ 4. Trouble relaxing
☐ 5. Being so restless that it
's hard to sit still
☐ 6. Becoming easily annoyed or irritable
☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 869

AR 0914

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.
 Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 870

AR 0915

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Organized Plan:
 Chronic Psychiatric Disorder:
 Recent Psychiatric Hospitalization:
 x H/O Abuse or Trauma:
 Chronic Physical Illness:
 x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:
 x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
 x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
 x Impulsivity:
 Substance Abuse:
 x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

Strong Therapeutic Alliance:
 Positive Coping Skills:
 Responsible to/for Family:
 Responsible to/for Pet:
 Frustration Tolerance: likes to hid his feelings
 x Resilience:
 Good Reality Testing: can add details that are not true
 x Amenable to Treatment:
 Social Support: just his girl friend, no one to talk to
 Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 871

AR 0916

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont--"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety

2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.

2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 04 Nov 2014 1359 EST

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 04 Nov 2014 1359 EST

Released w/o Limitations**Follow up:** for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Nov 2014 1400

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

23 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18795728 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **23 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 24 Oct 2014 0906 EDT**Family History**

- *fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- *family medical history (General FHx)
- *paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- *paternal history of preliminary background HPI [use for free text] (Father)
- *paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- *family history of supplemental HPI [use for free text] (General FHx)
- *no family history of malignant neoplasm of the large intestine (General FHx)
- *no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- *no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 24 Oct 2014 0907 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

10-23-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient is re-enlisting for another 4 years. His family (Mom, sister, sister's child and brother) are coming to the event on Dec 12. They are staying at his house. He is not close to his family, but is working on getting closer. Patient is also going home for Christmas. He feels guilty and anxious about them. He feels guilty because if other people knew how little he sees them, they would think less of him. After his parents divorced, he rarely saw his Mom. He says he has probably seen her in total about a year since the divorce. His mother is bi-polar. She has been in therapy in the past. Her mother is also bi-polar and takes meds. Patient likes his mom's side of the family. They were nice to him when he was a child. His grandfather taught him Doss, other computer stuff, and played video games with him. He has not seen his dad for 5 years. Dad now has another family and lives in Cal. Dad's brother was in jail for having sex with an under-aged girlfriend. He was about 20 years older than her and was married at the time. His other brother is disabled and lives with their mom. He is mean. The grandmother is mean too. When he was a child, he stayed with them for several weeks at a time. (He visited his mom for about 2 weeks a summer.) Patient states that his sister seems to have inherited the worst parts of both families-she is bi-polar and is the same kind of mean as his father's mother.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rent a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lots, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 876

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people
 Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very []
 Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.
 Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of aspirin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of aspirin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 878

AR 0923

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:
 Behavioral Health Advanced directives completed? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Do you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:
 Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Written by NILSEN, LINDA M @ 24 Oct 2014 0912 EDT

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN, LINDA M @ 24 Oct 2014 0912 EDT

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 24 Oct 2014 0912

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Oct 2014 at WRNMMC, FLU CI Ki by JORDAN, TIMOTHY W

Encounter ID: BETH-18765071 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
Patient Status: **Outpatient**Date: **22 Oct 2014 0935 EDT**
Clinic: **SRP CL KI**Appt Type: **PROC**
Provider: **JORDAN, TIMOTHY W****AutoCites Refreshed by JORDAN, TIMOTHY W @ 22 Oct 2014 0936 EDT****Problems**

No Problems Found.

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Social History

No Social History Found.

Reason for Appointment: Written by JORDAN, TIMOTHY W @ 22 Oct 2014 0935 EDT
flu vaccine**Questionnaire AutoCites Refreshed by JORDAN, TIMOTHY W @ 22 Oct 2014 0936 EDT**
Questionnaires**S/O Note Written by JORDAN, TIMOTHY W @ 22 Oct 2014 0936 EDT****Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

Vaccinations

- Received dose of influenza live virus vaccine, for intranasal use MEDIMMUNE 'FLUMIST'
- Lot#: CK2008 Expiration Date: 8 Dec2014
- 0.2 ML PRE-FILLED, SINGLE-USE, INTRANASAL SPRAY;
- FOR IMMUNIZING PERSONS 2 TO 49 YRS. OF AGE;
- PRESERVATIVE-FREE, NOT FOR USE DURING PREGNANCY
- Information Sheet: 19August 2014
- Manufacturer by: MedImmune Biologics
- Date vaccinated: 14 OCT 2014
- Vaccination/injection Site: IN

Past medical/surgical history**Reported:**

Recent Events: No active illness.

Medical: Reviewed no allergies. No allergy to certain foods; and not to eggs. No known drug allergies.

Review of systems**Systemic:** No fever.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 881

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by JORDAN, TIMOTHY W @ 22 Oct 2014 0937 EDT

1. Vaccines Prophylactic Need Against Influenza

Procedure(s):
-Immunization Admin By Intranasal / Oral Route One Vaccine x 1
-Influenza Virus Vaccine Live Intranasal Quadrivalent x 1

Disposition Last Updated by JORDAN, TIMOTHY W @ 22 Oct 2014 0937 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the SRP CL KI clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By JORDAN, TIMOTHY W (Health Care Specialist) @ 22 Oct 2014 0951

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18694226 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN,LINDA M**

AutoCites Refreshed by NILSEN,LINDA M @ 16 Oct 2014 0946 EDT**Family History**

- family medical history (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN,LINDA M @ 16 Oct 2014 0958 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10-16-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Pt saw his PCM who excused his PTR, but did not fill out the paper for his regular PT. His ankle is still giving him trouble. He said that she was rude. When asked if he told her, he said no, he does not confront people. He learned as a child to just deal with whatever is going on. He was at sea the first 3 years in the Navy, stationed by Japan. They were on 12 hr shifts, not much down time. He tried to be the "perfect" worker-did his job the best that he could. He does believe this is where some of his anxiety came from. He started pulling his hair out during this time. So he has continued to put up with bad behavior. I encouraged him to tell the providers he finds them rude. He talked about his problems with reading and writing. In the past he has not been able to do well in school. He can handle books on tape and videos. It sounds like he might have a learning disability. We discussed ways he could work around this and on it. Patient stated he is going home to his mom's for X-mas. He said that he jokingly said that they needed to find some girlfriend possibilities for him. He said he was joking, but they have already found someone for him to meet.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL. Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective**Additional Screening Questions:**

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being
'super alert
' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficultDuring the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.**Depression Screening:**

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.**Generalized Anxiety Disorder Screening:**

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

[0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of asprin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of asprin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment**History ANNUAL SCREENING DATE:**

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 887

AR 0932

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Behavioral Health Advanced directives completed? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Do you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:
 Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14
 Reviewed with patient on: 9-11-14
 Does patient agree with plan? yes
 If not, what part?
 Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention
 Tx Plan cont~"d:

Diagnosis

- I. 300.00 Anxiety D/O NOS
- II. 799.9 deferred
- III. none
- IV. Limited support system, few friends
- V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Last Updated by NILSEN, LINDA M @ 16 Oct 2014 1001 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Last Updated by NILSEN, LINDA M @ 16 Oct 2014 1002 EDT

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 16 Oct 2014 1054

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by RINIS, DONNA L

Encounter ID: BETH-18590652 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **07 Oct 2014 0938 EDT**
Clinic: **INT MED MEDICAL HOME CL C**
BEAppt Type: **T-CON***
Provider: **RINIS, DONNA L**

Call Back Phone: [REDACTED]

AutoCites Refreshed by RINIS, DONNA L @ 07 Oct 2014 0938 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by RINIS, DONNA L @ 07 Oct 2014 0938 EDT
MRI resultsQuestionnaire AutoCites Refreshed by RINIS, DONNA L @ 07 Oct 2014 0938 EDT
QuestionnairesA/P Written by RINIS, DONNA L @ 07 Oct 2014 0947 EDT

1. Visit for: administrative purpose
2. ANKLE SPRAIN LEFT

Disposition Written by RINIS, DONNA L @ 07 Oct 2014 0947 EDTNote Written by RINIS, DONNA L @ 07 Oct 2014 0946 EDT

PCM _ NP Austin, out of office this week.

RelayHealth sent to patient -

NP Austin is out of the office this week, so I am looking at her lab & xray results.

Below are copies of your recent MRI's, showing evidence of a prior lateral (the outside of the ankle) ankle sprain and, also, mild degenerative changes over the "bunion" area of your foot.

This is just a "FYI". Please keep your pending appointments with NP Austin 10/20/14 and with Physical Therapy 11/4/14, at which times you can review the results again, if needed.

v/r
Dr. Rinis

MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M

***** MRI, ANKLE LT W OR W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC
Status: Complete (Amended)Procedure: MRI, ANKLE LT W OR W/O CON
Event Date: 26-Sep-2014 13:28:00
Exam #: 14327823
Exam Date/Time: 05-Oct-2014 14:43:00
Transcription Date/Time: 06-Oct-2014 15:51:00
Provider: AUSTIN, MARIE
Requesting Location:
INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
Status: COMPLETE (Amended)Amended Result Code: SEE RADIOLOGIST'S REPORT
Interpreted By: LUTYNSKI, MATTHEW LEO
Supervised By: FRANK E. MULLENS, LCDR, MC, USNAnderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Approved By: LUTYNSKI, MATTHEW LEO
 Approved Date: 06-Oct-2014 15:52:00
 Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN
 Supervised By Date: 06-Oct-2014 15:52:00
 Amended Report Text:

HISTORY: Continuous pain following injury

COMPARISONS:
 Left foot and ankle radiographs dated 5/6/14

TECHNIQUE:
 WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:
 ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons:
 Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments:
 Syndesmotc ankle ligaments: within normal limits.

Low lateral ankle ligaments:
 The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT:
 Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments:
 Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae:

No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity:

Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION:

Findings suggestive of prior lateral ankle sprain.

Electronically signed by resident:

Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time: 14:23

Electronically signed by:

FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military Medical Center

Date: 10/06/14 Time: 15:52

MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M

***** MRI, FOOT LT W OR W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, FOOT LT W OR W/O CON
 Event Date: 26-Sep-2014 13:27:00
 Exam #: 14327819
 Exam Date/Time: 05-Oct-2014 14:43:00
 Transcription Date/Time: 06-Oct-2014 15:51:00
 Provider: AUSTIN, MARIE
 Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT
 Interpreted By: LUTYNSKI, MATTHEW LEO
 Supervised By: FRANK E. MULLENS, LCDR, MC, USN
 Approved By: LUTYNSKI, MATTHEW LEO
 Approved Date: 06-Oct-2014 15:52:00
 Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN
 Supervised By Date: 06-Oct-2014 15:52:00
 Amended Report Text:

HISTORY: Continuous pain following injury

COMPARISONS:

Left foot and ankle radiographs dated 5/6/14

TECHNIQUE:

WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat,

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:

ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons:

Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments:

Syndesmotic ankle ligaments: within normal limits.

Low lateral ankle ligaments:

The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT:

Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments:

Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae:

No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity:

Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Findings suggestive of prior lateral ankle sprain.

Electronically signed by resident:

Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time:14:23

Electronically signed by:

FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military
Medical Center

Date: 10/06/14 Time:15:52

Signed By **RINIS, DONNA L** (Physician/Workstation) @ 07 Oct 2014 0948

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-18536263 Primary Dx: Foot pain (soft tissue)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **01 Oct 2014 1834 EDT**
Clinic: **INT MED MEDICAL HOME CL C**
BEAppt Type: **T-CON***
Provider: **AUSTIN, MARIE**

Call Back Phone: [REDACTED]

AutoCites Refreshed by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	SWISH AND SPIT 15 ML TWICE A DAY FOR 2 WEEKS STARTING TOMORROW #0 RF0	NR	18 Sep 2014
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Telephone Consult: Written by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT
Really health messageQuestionnaire AutoCites Refreshed by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT
QuestionnairesS/O Note Written by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT**Subjective**

From Daniel Merwin To Ms. Marie Austin, NPP Provider Ms. Marie Austin NPP Patient Daniel Merwin Sent Date Sep 30, 2014 8:53 AM Subject Medical Waiver - Foot Details Message I was in to have my ankle looked at and medical waiver signed. Two signatures were missed. I will be at Walter Reed in the morning on 02 October 2014 for another appointment. I will stop by with the paper work. The MRI is scheduled for Sunday October 5th, 2014 and the follow up with Austin, Marie is set for 20 October 2014. A note on my foot. It was definitely swollen yesterday around the area of pain. I was actually able to purposely hurt it along with making a popping/grinding sound when I rotated my ankle within its normal range of motion. I discovered it when I accidentally stretched my ankle when lying in bed. So I decided to test it by pointing my toe forward and then rotating it in 360 degrees, each revolution made a sound or two and increased the pain. The pain lasted through the night and still exists this morning at a level of about 3.

A/P Last Updated by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT1. **Foot pain (soft tissue)** 729.5Disposition Last Updated by AUSTIN, MARIE @ 01 Oct 2014 1835 EDTNote Written by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT

Closed a relay health message if he stops by I will see

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 01 Oct 2014 1835

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

26 Sep 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-18481751 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS** Date: **26 Sep 2014 1330 EDT** Appt Type: **EST**
 Treatment Facility: **WALTER REED** Clinic: **INT MED MEDICAL HOME CL C** Provider: **AUSTIN, MARIE**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient**

Reason for Appointment:
 Left knee pain/ paper work

Vitals**Vitals Written by NEWMAN, BRENDA W @ 26 Sep 2014 1249 EDT**

BP: 118/76 Left Arm, Adult Cuff, HR: 84, RR: 16, T: 97.8 °F, HT: 69 in, WT: 158.4 lbs, SpO₂: 98%,
 BMI: 23.39, BSA: 1.871 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 2/10 Mild, Pain Scale
 Comments: Left ankle

Questionnaire AutoCites Refreshed by NEWMAN, BRENDA W @ 26 Sep 2014 1306 EDT**Questionnaires**

Copy of Anxiety & Depression Screening Taken On: 26 Sep 2014

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Nearly every day
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN, MARIE @ 02 Oct 2014 0801 EDT**Chief complaint**

The Chief Complaint is: Scalp issues, PT referral for left ankle and PRT waiver.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

PO1 needed a PARFQ and PRT waiver as a result of injured he sustained in April of 2014. Initial injury occurred while he was running and stepped into a hole hyperextending his foot. He was seen in the ER with a negative xray r/o a fx. He continued to have increased swelling and pain and was seen and x rayed again no fx seen. He then was sent for traing and has returned to WR and underwent PT. There is some improvement in pain. However he continues to have pain and swelling over the medial malleolus and is unable to run or walk fast.

PMH is positive for several stress fx in the foot in his young adult years.

Patient is compliant with medications.

Current medication

Motrin but no OTC meds, vitamins, herbals, etc.

Past medical/surgical history**Reported:**

Medical: Reported medical history Ankl pain

Surgical / Procedural: Surgical / procedural history
 none.

Personal history

Social history reviewed No tob no etoh.

Family history

Family medical history
 Noncontributory.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 896

AR 0941

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pulmonary: No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Neurological:

• Oriented to time, place, and person.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Practice Management

Preventive medicine services Pt is active duty and up to date in all immunization and vaccines.

Note Written by AUSTIN, MARIE @ 02 Oct 2014 0805 EDT

pt is back to clinic on 10/2 to get weight and the rest of the paperwork complete . we do not do that part and I directed them to paul cachon. Command is insiting it be completed

Rad Result Cited by AUSTIN, MARIE @ 26 Sep 2014 1320 EDT**MERWIN, DANIEL DENNIS** 20/[REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M

***** FOOT, LT WT BEARING 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete

Procedure: FOOT, LT WT BEARING 3 VIEWS**Event Date:** 06-May-2014 14:46:00**Order Comment:** NO BRIEF COMMENT**Reason for Order:**

left foot pain x 2 weeks following a recent injury, re-evaluate for fracture

Exam #: 14151531**Exam Date/Time:** 06-May-2014 15:03:00**Transcription Date/Time:** 06-May-2014 16:04:00**Provider:** UDE, ASSUMPTA O**Requesting Location:** AMHM01AREDKI KIMBROUGH ACC**Status:** COMPLETE**Result Code:** SEE RADIOLOGIST'S REPORT**Interpreted By:** MUNTER, FLETCHER M**Approved By:** MUNTER, FLETCHER M**Approved Date:** 06-May-2014 15:57:00**Report Text:**

CHCS 14151531

History: Left foot pain for 2 weeks.**Technique:** AP and lateral weight-bearing images of the left foot were performed.**FINDINGS:** No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. No soft tissue abnormality is identified.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 897

AR 0942

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

IMPRESSION: Normal left foot.

Rad Result Cited by AUSTIN, MARIE @ 26 Sep 2014 1320 EDT**MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M**

***** ANKLE, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete

Procedure: ANKLE, LT 3 VIEWS
 Event Date: 06-May-2014 14:45:00
 Order Comment: with weight bearing
 Reason for Order:
 left lateral ankle pain and swelling 2 weeks following a sprained ankle,
 re-evaluate for fracture
 Exam #: 14151527
 Exam Date/Time: 06-May-2014 15:03:00
 Transcription Date/Time: 06-May-2014 16:05:00
 Provider: UDE, ASSUMPTA O
 Requesting Location: AMHM01AREDKI KIMBROUGH ACC
 Status: COMPLETE
 Result Code: SEE RADIOLOGIST'S REPORT
 Interpreted By: MUNTER, FLETCHER M
 Approved By: MUNTER, FLETCHER M
 Approved Date: 06-May-2014 15:58:00
 Report Text:
 CHCS 14151527

History: Ankle sprain 2 weeks ago.

Technique: 3 images of the left ankle were performed.

FINDINGS: No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. There is mild lateral swelling.

IMPRESSION: No fractures demonstrated.

A/P Last Updated by AUSTIN, MARIE @ 26 Sep 2014 1342 EDT**1. Left ankle joint pain 719.47**

Laboratory(ies): -COMPREHENSIVE METABOLIC PANEL (Routine)
 Radiology(ies): -MRI, FOOT LT W OR W/O CON (Routine) Impression: Pt had and ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment
 -MRI, ANKLE LT W OR W/O CON (Routine) Impression: Pt had a L ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment. r/o stress fx

Disposition Written by AUSTIN, MARIE @ 02 Oct 2014 0805 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: parq and waiver completed

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 02 Oct 2014 0806**CHANGE HISTORY**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 898

AR 0943

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The following S/O Note Was Overwritten by AUSTIN, MARIE @ 26 Sep 2014 1320 EDT:
S/O Note Written by NEWMAN, BRENDA W @ 26 Sep 2014 1306 EDT

Chief complaint

The Chief Complaint is: Scalp issues, PT referral for left ankle and PRT waiver.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 899

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

25 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18459536 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **25 Sep 2014 0730 EDT**
 Clinic: **Psychiatry Be**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 25 Sep 2014 0936 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 16 Oct 2014 0822 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

9-25-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient saw a physical therapist yesterday. He has been having problems with his left ankle since April 2014. He wanted to get light limited duty. He found out after he got there that only his PCM can issue light limited duty. They did give him a brace to help immobilize the ankle. He is working on his list of serious dating potentials. So far he has decided he does not want kids and does want someone who is OK with he doing things he likes to do (like computer work for long periods of time). Focus on sleep problems - mainly getting to sleep. It takes him 1 - 2 hours to get to sleep each night. His mind is very active. He thinks about problems he wants to solve, etc. If he stops thinking about one problem, he starts thinking about another problem. This writer suggested he write down the problem so he can let it go for the night. He said he could then have to keep rereading what he wrote to make sure he got it right. During the next week, he is going to think about how to set things aside for the night without forgetting them and not getting them quite right when he starts thinking about them the next day.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 901

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective**Additional Screening Questions:**

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert
- ☐ or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficultDuring the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.**Depression Screening:**

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.**Generalized Anxiety Disorder Screening:**

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

[0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of asprin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of asprin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment**• History ANNUAL SCREENING DATE:**

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 904

AR 0949

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Behavioral Health Advanced directives completed? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Do you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:
 Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont--"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Last Updated by NILSEN, LINDA M @ 25 Sep 2014 0939 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Last Updated by NILSEN, LINDA M @ 25 Sep 2014 0940 EDT**Released w/o Limitations****Follow up:** for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 16 Oct 2014 0832**CHANGE HISTORY***The following S/O Note Was Overwritten by NILSEN, LINDA M @ 16 Oct 2014 0824 EDT:**S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0936 EDT***History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade, 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

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Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

- THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

- MEDS: none

- INPATIENT/RESIDENTIAL CARE: denied

- SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

- FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 28, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 906

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:
Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert'
- ☐ or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable
- ☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Physical findings

General Appearance:

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed, oriented x3, oriented x3. * No hallucinations. * Memory was unimpaired. * Remote memory was not impaired. * Recent memory was not impaired. * Judgement was not impaired.

Speech: * Normal, regular rate, non-pressured. , regular rate, non-pressured. * Rate was not slowed. * Not pressured. * Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: * Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. * No psychomotor retardation.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 907

AR 0952

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

* Behavior demonstrated no psychomotor agitation. * No decreased eye-to-eye contact was observed.
 Mood: * Euthymic. * Not depressed. * Not anxious.
 Affect: * Normal. * Not labile. * Not flat. * Not constricted. * Showed no irritability.
 Thought Processes: * Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed. * Attention demonstrated no abnormalities.
 * Attention span was not decreased.
 Thought Content: * Insight was intact. * No delusions. * No suicidal ideation. * No suicidal plans. * No suicidal intent. * No homicidal ideations. * No homicidal plans.
 * No homicidal intent.
 Neurovegetative Assessment: * Dangerousness assessment; suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
 Organized Plan:
 Chronic Psychiatric Disorder:
 Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
 Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
- x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
- x Impulsivity:
 Substance Abuse:
- x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- [x] Released without limitations. Advised of emergency procedures.
- [] SM released to Chain of Command with the following limitations:
- [] SM sent to ER for evaluation for admission to inpatient psychiatry
- [] Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
 Organized Plan:
 Chronic Psychiatric Disorder:
 Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
 Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
- x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
- x Impulsivity:
 Substance Abuse:
- x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
- ☐ SM released to Chain of Command with the following limitations:
- ☐ SM sent to ER for evaluation for admission to inpatient psychiatry
- ☐ Other:

Assessment

* History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

* Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.

2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by NILSEN, LINDA M @ 16 Oct 2014 0822 EDT:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 909

AR 0954

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0940

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

24 Sep 2014 at WRNMMC, Orthotics & Prosthetics Srv Be by ANDERSON, PETER P

Encounter ID: BETH-18452120 Primary Dx: Brace

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **24 Sep 2014 1201 EDT**
 Clinic: **ORTHOTICS & PROSTHETICS**
SRV BE

Appt Type: **EST**
 Provider: **ANDERSON, PETER P**

Reason for Appointment: Written by TIVEY-ANDERSON, MILAN D @ 24 Sep 2014 1201 EDT
 ASO ankle brace

A/P Written by ANDERSON, PETER P @ 25 Sep 2014 0834 EDT

1. **Brace:** Pt fit with aso brace.

Procedure(s):
 -Phys Ther Ed Checkout For Ortho/Prosth Use Estab Patient x 1
 -ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFAB, OTS x 1

Disposition Written by ANDERSON, PETER P @ 25 Sep 2014 0835 EDT

Released w/o Limitations

Follow up: as needed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by ANDERSON, PETER P @ 25 Sep 2014 0835 EDT

Pt received device.

Signed By ANDERSON, PETER P (Physician) @ 25 Sep 2014 0835

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

24 Sep 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-18457059 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **24 Sep 2014 1100 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **EST**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 24 Sep 2014 1506 EDT**Problems**

- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OXYCODONE HCL/ACETAMINOPHEN, 5MG-325MG, TABLET, ORAL	Active	TAKE ONE TABLET EVERY 4-6 HOURS AS NEEDED FOR PAIN #0 RF0	NR	18 Sep 2014
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	SWISH AND SPIT 15 ML TWICE A DAY FOR 2 WEEKS STARTING TOMORROW #0 RF0	NR	18 Sep 2014
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	18 Sep 2014
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Appointment Comments:

tan

Note Written by LAI, PHILOMENA C @ 24 Sep 2014 1547 EDT**Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation
 (9/24/2014)

Subjective: Patient presents to clinic reporting continue L ankle pain since his return doing PT as he has been walking, running, jumping a lot, L ankle swelling resurface, now pain on L ankle even walking for long distance. Patient states he will be doing his PFT in 2 weeks but will not be able to do the running portion of PT.

(8/8/2014)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: Improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment, mild swelling L lateral malleolus area

palpation: TTP lateral L ankle anterior to lateral malleolus

flexibility: mod tightness hamstrings, calf

Joint Mobility: normal L ankle joint mobility

Sensation/Reflex: intact

ROM: ankle: DF L 15 deg R 13 deg, PF L 44 deg R 50 deg, IV L 35 deg R 35 deg, EV L 12 deg R 15 deg, 1st ray ext L 50 deg R 70 deg, flex L 12 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 5/5 R 5/5, EV L 5/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted but fatigue quickly L with pain

Tests

Re-evaluation (9/24/2014): Patient with recurrent ankle pain, most likely repeated strain from excessive impact activities.

Recommend patient hold off from jumping, squatting and running activities at this time to allow sufficient time for healing. Patient will need to continue strengthening and stretching program. Provided prescription for ankle brace to provide support.

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP- met

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg - met

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5 - met

Improve function to: tolerate long distance walking without increased in symptoms

running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (8/8/2014): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Continue HEP for stretching and strengthening. Follow up in 5-6 weeks for re-evaluation.

A/P Written by LAI, PHILOMENA C @ 24 Sep 2014 1509 EDT

1. Left ankle joint pain

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI.PHILOMENA C @ 24 Sep 2014 1547 EDT

Released w/o Limitations

Follow up: 5 to 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 24 Sep 2014 1548

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 914

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

18 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18463167 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 Sep 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 25 Sep 2014 0929 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0930 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

9-18-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Focus on relationships. He has turned match.com back on. He did this before his girlfriend moved out. Realized he should have talked to her about ending their relationship first. Pt stated he has had numerous sexual encounters. He needs to slow down how quickly he gets very involved in a relationship. Patient is going to work on making a list of the top 10 things he wants in a potential partner.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't

want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current

smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 916

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Additional Screening Questions:

Are you having any thoughts about harming another person? denied
 Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable
- ☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other: Suicide Risk and Protective Factors Review:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- [x] Released without limitations. Advised of emergency procedures.
- [] SM released to Chain of Command with the following limitations:
- [] SM sent to ER for evaluation for admission to inpatient psychiatry
- [] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 919

AR 0964

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN, LINDA M @ 25 Sep 2014 0934 EDT

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN, LINDA M @ 25 Sep 2014 0935 EDT

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 920

AR 0965

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0935

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

11 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18447431 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Sep 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 24 Sep 2014 0918 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0909 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

9-11-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient trying to decide whether to reenlist or not. He thinks he might be better off owning his own business. If he stays in the military and he advances, he will end up supervising more which he does not like as much. He is more than qualified for his job now. He gets bored easily. His girlfriend moved out. She had been talking to her X. She is not as neat as the SM, he likes to have everything clean again.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

- * THERAPY: Fleet and Family Aug 2012 for 4 or 5 months
- * MEDS: none
- * INPATIENT/RESIDENTIAL CARE: denied
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone
- * FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead
- Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable
- ☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 924

AR 0969

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of asprin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 925

AR 0970

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
- ☐ SM released to Chain of Command with the following limitations:
- ☐ SM sent to ER for evaluation for admission to inpatient psychiatry
- ☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Behavioral Health Advanced directives completed? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoDo you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Behavioral Health Advanced directives completed? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoDo you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 926

AR 0971

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont--"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 25 Sep 2014 0927 EDT**1. ANXIETY DISORDER NOS**

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 25 Sep 2014 0928 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) .

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0928

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18110266 Primary Dx: MAJOR DEPRESSION RECURRENT MODERATE

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 21 Aug 2014 0757 EDT
Clinic: PSYCHIATRY BEAppt Type: T-CON*
Provider: NILSEN, LINDA M

Call Back Phone: [REDACTED]

AutoCites Refreshed by NILSEN, LINDA M @ 21 Aug 2014 0914 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Telephone Consult: Written by AZARRAGA, ANN B @ 21 Aug 2014 0757 EDT

Pt wanted clarification if he is being seen weekly starting on the 28th at 0730.

Telephone Consult Comments: Written by AZARRAGA, ANN B @ 21 Aug 2014 0757 EDT

Pt was confused whether he was supposed to see you today or next week. Please phone pt back to clear the confusion.

Note Written by NILSEN, LINDA M @ 21 Aug 2014 1407 EDT**Returned phone call**

This writer called patient back to let him know he missed his appointment this morning, and that he has appointments on Thursdays through the end of September at 7:30.

A/P Written by NILSEN, LINDA M @ 21 Aug 2014 1411 EDT**1. MAJOR DEPRESSION RECURRENT MODERATE**Disposition Last Updated by NILSEN, LINDA M @ 21 Aug 2014 1411 EDTSigned By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 21 Aug 2014 1412

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18110190 Primary Dx: MAJOR DEPRESSION RECURRENT MODERATE

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 21 Aug 2014 0756 EDT
Clinic: PSYCHIATRY BEAppt Type: T-CON*
Provider: NILSEN, LINDA M

Call Back Phone: [REDACTED]

AutoCites Refreshed by NILSEN, LINDA M @ 21 Aug 2014 0756 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Telephone Consult: Written by NILSEN, LINDA M @ 21 Aug 2014 0756 EDT
N/S This writer called and left a message for patient at 7:45A/P Last Updated by NILSEN, LINDA M @ 21 Aug 2014 0758 EDT**1. MAJOR DEPRESSION RECURRENT MODERATE**Disposition Last Updated by NILSEN, LINDA M @ 21 Aug 2014 0758 EDTSigned By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 21 Aug 2014 0758

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

08 Aug 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-17983790 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Aug 2014 0700 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **EST**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 08 Aug 2014 0649 EDT**Problems**

- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

est

Appointment Comments:

tan

S/O Note Written by LAI, PHILOMENA C. @ 08 Aug 2014 0735 EDT**Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout. Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10

best 0/10 worst 3/10

Description of pain: comes and goes

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 931

AR 0976

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Aggravating factors: motion
 Mitigating factors: rest, elevation, ice
 Day pattern: episodic
 Recent/previous treatment: none
 Functional limitations: no running at this time, increased throbbing sensation after prolonged walking
 Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none
 Diagnostics: x-ray L ankle in AHLTA
 Medical precautions: none
 Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment
 palpation: no TTP
 flexibility: mod tightness hamstrings, calf
 Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob
 Sensation/Reflex: intact
 ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg, EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg
 Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5
 Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg
 function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted.

Tests

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.
 Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks
 Patient to be independent with HEP
 Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks
 Decrease pain to: 0/10
 Increase MMT to: 5/5
 Improve function to: tolerate long distance walking without increased in symptoms
 running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.
 HEP instructions and performance (15 min): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..

A/P Written by LAI, PHILOMENA C @ 08 Aug 2014 0653 EDT

1. Left ankle joint pain

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI, PHILOMENA C @ 08 Aug 2014 0750 EDT

Released w/o Limitations

Follow up: 4 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 08 Aug 2014 0751

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 932

AR 0977

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-17934643 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **04 Aug 2014 1300 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **ROUT**
Provider: **NILSEN, LINDA M**AutoCites Refreshed by NILSEN, LINDA M @ 04 Aug 2014 1054 EDT**Family History**

- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

Rout

Appointment Comments:

Jnb

S/O Note Written by NILSEN, LINDA M @ 04 Aug 2014 1525 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 933

AR 0978

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing.

Personal history

Social history Born and raised in Riverside, CAL. Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more. Current smoker Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective**Generalized Anxiety Disorder Screening:**

- [3] 1. Feeling nervous, anxious, or on edge
 [1] 2. Not being able to stop or control worrying
 [2] 3. Worrying too much about different things
 [2] 4. Trouble relaxing
 [1] 5. Being so restless that it's hard to sit still
 [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

PTSD CHECKLIST (PCL-C)

- [] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
 [] Repeated, disturbing dreams of a stressful experience from the past?
 [] Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
 [] Feeling very upset when something reminded you of a stressful experience from the past?

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being
'super alert
' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes
' how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Additional Screening Questions:

Are you having any thoughts about harming another person? denied
Do you feel like you are at risk for workplace violence? denied

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: ° Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of aspirin

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 935

AR 0980

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Organized Plan:
 Chronic Psychiatric Disorder:
 Recent Psychiatric Hospitalization:
 x H/O Abuse or Trauma:
 Chronic Physical Illness:
 x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:
 x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
 x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
 x Impulsivity:
 Substance Abuse:
 x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

Strong Therapeutic Alliance:
 Positive Coping Skills:
 Responsible to/for Family:
 Responsible to/for Pet:
 Frustration Tolerance: likes to hid his feelings
 x Resilience:
 Good Reality Testing: can add details that are not true
 x Amenable to Treatment:
 Social Support: just his girl friend, no one to talk to
 Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 90 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated:

Reviewed with patient on:

Does patient agree with plan?

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 936

AR 0981

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

If not, what part?

Projected date of next treatment plan update:

THIS WAS THE FIRST SESSION. WE SPENT THE TIME FILLING OUT THE ASSESSMENT. NEXT SESSION THE ITP WILL BE FINISHED Discussion of assessment and intervention

Tx Plan cont

'd:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

- 1.
- 2.
- 3.

Long-Term Goals:

- 1.
- 2.
- 3 Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Objective 2 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Objective 3 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN, LINDA M @ 04 Aug 2014 1424 EDT**1. ANXIETY DISORDER NOS**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Written by NILSEN, LINDA M @ 04 Aug 2014 1536 EDT**Released w/o Limitations****Follow up:** for therapy 1 to week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

90 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Aug 2014 1537**CHANGE HISTORY**The following S/O Note Was Overwritten by NILSEN, LINDA M @ 04 Aug 2014 1530 EDT:S/O Note Written by NILSEN, LINDA M @ 04 Aug 2014 1055 EDT

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 937

AR 0982

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade, 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient 'picks' at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10.

Current medication

See ALTHA

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing.

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more. Current smoker Used to smoke hooka when overseas - Amt per Day: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied
Do you feel like you are at risk for workplace violence? denied

Physical findings**General Appearance:**

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed, oriented x3. * No hallucinations. * Memory was unimpaired. * Remote memory was not impaired. * Recent memory was not impaired. * Judgement was not impaired.

Speech: * Normal, regular rate, non-pressured. * Rate was not slowed. * Not pressured. * Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: * Behavior demonstrated no abnormalities - appropriate and cooperative. * No psychomotor retardation. * Behavior demonstrated no psychomotor agitation. * No decreased eye-to-eye contact was observed.

Mood: * Euthymic. * Not depressed. * Not anxious.

Affect: * Normal. * Not labile. * Not flat. * Not constricted. * Showed no irritability.

Thought Processes: * Not impaired, they were linear, logical, and goal directed. * Attention demonstrated no abnormalities. * Attention span was not decreased.

Thought Content: * Insight was intact. * No delusions. * No suicidal ideation. * No suicidal plans. * No suicidal intent. * No homicidal ideations. * No homicidal plans.

* No homicidal intent.

Neurovegetative Assessment: * Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 938

AR 0983

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal Ideation/plans/intent:
 x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
 x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
 x Impulsivity:
 Substance Abuse:
 x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

Strong Therapeutic Alliance:
 Positive Coping Skills:
 Responsible to/for Family:
 Responsible to/for Pet:
 Frustration Tolerance: likes to hid his feelings
 x Resilience:
 Good Reality Testing: can add details that are not true
 x Amenable to Treatment:
 Social Support: just his girl friend, no one to talk to
 Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.
 [] SM released to Chain of Command with the following limitations:
 [] SM sent to ER for evaluation for admission to inpatient psychiatry
 [] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 90 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated:

Reviewed with patient on:

Does patient agree with plan?

If not, what part?

Projected date of next treatment plan update:

THIS WAS THE FIRST SESSION. WE SPENT THE TIME FILLING OUT THE ASSESSMENT. NEXT SESSION THE ITP WILL BE FINISHED Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #):

Interventions:

1.

2.

Objective 2 (Corresponds to Goal #):

-

Interventions:

1.

2.

Objective 3 (Corresponds to Goal #):

-

Interventions:

1.

2.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop Discussion of assessment and intervention

Tx Plan cont

d:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1.

2.

3.

Long-Term Goals:

1.

2.

3.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by NILSEN, LINDA M @ 04 Aug 2014 1431 EDT:

Signed NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Aug 2014 1424

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 940

AR 0985

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

27 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by YORK, CARLA M

Encounter ID: BETH-17580231 Primary Dx: Anxiety

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 27 Jun 2014 1000 EDT
Clinic: HEALTH PROMOTION CL BEAppt Type: EST
Provider: YORK, CARLA M.AutoCites Refreshed by YORK, CARLA M. @ 27 Jun 2014 0829 EDT**Allergies**

-OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

F/u

Appointment Comments:

anb

S/O Note Written by YORK, CARLA M. @ 27 Jun 2014 1007 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

Referred here

By PCM, Thomas S. Clark, FNP.

History of present illness

The Patient is a 29 year old male.

This is the patient's second visit to the IBHC clinic.

Source of information was self.

Feedback was provided to the PCM.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Previous history of visit is not deployment-related. No decrease in concentrating ability.

Pain Severity 0 / 10.

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Progress and barriers in adhering to behavior change plan: work-related stress, on a 30 day assignment to 'fix

' a systems problem; feels that his symptoms have been evident since he was a child and therefore not likely to change with brief intervention

Changes in symptoms and/or functioning: reports some improvement in mood, anxious thoughts; however, that he continues to constantly think about getting tasks done, believes it traces back to his childhood and father's authoritarian parenting style

....

Anxiety Intervention:☐ Trained in relaxation strategies☒ Trained in improving communication skills☒ Discussed potential treatments for anxiety (i.e. PE, CPT, CBT)☒ Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).☐ Developed Crisis Response plan.☒ Trained in strategies for increasing balanced thinking.Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

[] Other:

....

Personal history

Behavioral: Caffeine use 16 oz. Coffee per day; up to 32 oz. On weekend. No tobacco use in the last 10 years.

Alcohol: Alcohol use Occasional-approximately 3-5 drinks a week or less.

Review of systems**Systemic:** Feeling tired (fatigue).**Gastrointestinal:** Normal appetite.**Neurological:** No disorientation.**Psychological:** No sleep disturbances. Normal enjoyment of activities, a desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No frequent thoughts of death /morbid ideation and no impulsive behavior.**Physical findings****General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results:

Value

PHQ-9 Score

4

Tests:

Value

GAD-7 Score

15

*** DEPRESSION SCREENING / MONITORING (PHQ-9)**

[0] Little Interest or pleasure in doing things

[1] Feeling down depressed or hopeless

[2] Trouble sleeping or sleeping too much

[0] Feeling tired or little energy

[0] Poor appetite or overeating

[0] Feeling bad about self

[1] Trouble concentrating on things

[0] Moving or speaking slowly or being restless

[0] Thoughts that you would be better off dead

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Thoughts that you would be better off dead: [] Yes [x] No

....

Generalized Anxiety Disorder Screening:

[3] 1. Feeling nervous, anxious, or on edge

[2] 2. Not being able to stop or control worrying

[3] 3. Worrying too much about different things

[2] 4. Trouble relaxing

[2] 5. Being so restless that its hard to sit still

[2] 6. Becoming easily annoyed or irritable

[1] 7. Feeling afraid as if something awful might happen

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 942

AR 0987

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-2[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Counseling/Education

Anxiety Recommendations for patient:

Continue with relaxation exercises as previously trained in initial session

Follow through with BH specialty care referral-appointment 4 AUG 14 at 1300-Psychology

F/U IBHC as needed

Anxiety Recommendations for PCM Team:

Encourage attendance at scheduled BH visit

Practice Management

Patient exercises-has started with physical therapy; previously was running 5+ miles per day, now starting physical therapy due to ankle sprain.

A/P Written by YORK, CARLA M @ 27 Jun 2014 1028 EDT**1. Anxiety 300.00:** Pt. Presenting with longstanding symptoms of anxiety; he has completed 2 sessions with the IBHC program.

Due to duration of symptoms, patient in agreement with recommendation at this time to participate in specialty BH treatment.

Referral placed and appointment made during session for 4 AUG 14.

Consult(s): -Referred To: TBI/DEPLOYMENT BEH HLTH MTF BE (Routine) Specialty: PSYCHOLOGY Clinic:
NEUROPSYCHOL HLTH SVC BE Provisional Diagnosis: Anxiety**Disposition Written by YORK, CARLA M @ 27 Jun 2014 1029 EDT****Released w/o Limitations****Follow up:** in the PSYCHOLOGY HEALTH BE clinic. - Comments: 4 AUG 14**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: Availability of BH services, including emergency services, was discussed with SM

Administrative Options: Consultation requested**Signed By YORK, CARLA M** (Clinical Health Psychologist, Walter Reed National Military Medical Center-Bethesda) @ 27 Jun 2014 1029

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

27 Jun 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-17579298 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Jun 2014 0700 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **SPEC**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT**Problems**

- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

ANKLE SPRAIN LEFT

Appointment Comments:

snf

Vitals**Vitals** Written by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT**Comments:** Patient has falls in the past 6 months, minor injury to L ankle. Patient is not a fall risk.**S/O Note Written by LAI, PHILOMENA C. @ 27 Jun 2014 1034 EDT****Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Initial Evaluation

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 times per week).

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 944

AR 0989

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none
 Diagnostics: x-ray L ankle in AHLTA
 Medical precautions: none
 Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment
 palpation: no TTP
 flexibility: mod tightness hamstrings, calf
 Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob
 Sensation/Reflex: intact
 ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg, EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg
 Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5
 Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg
 function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted.

Tests

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.
 Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks
 Patient to be independent with HEP
 Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5

Improve function to: tolerate long distance walking without increased in symptoms
 running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (15 min): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..

A/P Written by LAI.PHILOMENA C @ 27 Jun 2014 1043 EDT

1. Left ankle joint pain

Procedure(s): -Physical Therapy Service Evaluation x 1
 -Physical Therapy: ___ Session Segments, 15 Minutes Each x 1

Disposition Written by LAI.PHILOMENA C @ 27 Jun 2014 1043 EDT

Released w/o Limitations

Follow up: 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by LAI.PHILOMENA C @ 27 Jun 2014 0753 EDT

Consult Order

Referring Provider: DOUGHERTY, DIANA L

Date of Request: 04 Jun 2014

Priority: Routine

Provisional Diagnosis:

ANKLE SPRAIN LEFT

Reason for Request:

29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM. Please eval and provide exercises to improve strength, ROM. Please consider soft brace for stability while recovering.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 27 Jun 2014 1043

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-17458952 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **16 Jun 2014 1300 EDT**
Clinic: **HEALTH PROMOTION CL BE**Appt Type: **EST**
Provider: **JARRETT, ERICA M.**AutoCites Refreshed by TURNER, RHONDA S @ 16 Jun 2014 1241 EDT**Allergies**

-OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

anxiety

Appointment Comments:

snf

S/O Note Written by O'SULLIVAN, ROBIN R @ 16 Jun 2014 1505 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

Referred here

By PCM, Thomas S. Clark, FNP.

History of present illness

The Patient is a 29 year old male.

This is the initial visit to the IBHC clinic.

Source of information was self.

Feedback was provided to the PCM.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Normal appetite.

Sleep disturbances.

Previous history of visit is not deployment-related. No decrease in concentrating ability.

Pain Severity 3 / 10 (dental and ankle).

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Description of Symptoms:

Anxiety symptoms include irritable bowel, anxious mood, biting nails, picking hair, attentional difficulties, irritable, insomnia. No issue with sleep onset, but difficulty with sleep maintenance (averaging 5 - 8 hours in bed, but awake much of that time; Pt estimated 3 - 4 hrs sleeping).

Duration of Problem:

Since age 14 has experienced most of symptoms of anxiety listed above, with exception of hair difficulty (began August 2011).

Factors correlated with onset: Pt described difficult childhood and home environment (father alcoholic & harsh disciplinarian, mother bipolar). More recently, Pt spent 850 days at sea over 3 years & had mersa 3xs during this, contributing to scalp/hair picking. Currently, Pt was selected for new job which is high stress, with increased responsibility, leadership and management duties (would prefer to do computer work in isolation). Pt is considering separation (eligible in 2 years) due to dissatisfaction with Navy, but anxious about alternative future options;

Frequency of symptoms: daily and pervasive throughout the day.

Severity of symptoms: Very difficult - able to perform well at work but is uncomfortable by feeling anxious and inability to relax.

Course of problem: slightly worse lately, which Pt attributed to recent dispute with girlfriend and increasing work-related stress.

Psychosocial factors: Stress from work enhances a preexisting anxious tendency; Pt described his relationship with his girlfriend as conflict avoidant and desires it to have more honest communication.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 947

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Aggravating factors: over-planning, anxious ruminating thoughts; obsessively planning procedures to optimize efficiency; rigid with cleaning at home.

Alleviating factors: Drinking coffee is reported to be helpful; Reading technical material and computer programming; alone time and spending time with his girlfriend.

Current tx: Pt stated has he has avoided seeking help for fear of impacting career.

Past tx: Pt received therapy for about 18 months at Ft Meade and found this helpful.

Functional impact: Pt stated it is hard to enjoy free time and is constantly stressed at work.

....
Anxiety Intervention:

☐ Trained in relaxation strategies

☒ Trained in improving communication skills

☒ Discussed potential treatments for anxiety (i.e. PE, CPT, CBT)

☒ Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).

☐ Developed Crisis Response plan.

☒ Trained in strategies for increasing balanced thinking.

☐ Other:

Personal history

Behavioral: Caffeine use 2 - 4 cups / coffee daily, rare energy drinks. No tobacco use in the last 10 years.

Alcohol: Alcohol use 2-3 drinks / week.

Review of systems

Systemic: Not feeling tired (fatigue).

Neurological: No disorientation.

Psychological: Normal enjoyment of activities, a desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No frequent thoughts of death / morbid ideation and no impulsive behavior.

Physical findings**General Appearance:**

° Alert ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Anxious. ° Euthymic. ° Not depressed.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results:	Value	
PHQ-9 Score	5	
Test Results:	Value	
Duke Health Profile Physical Health Score:	80	
Test Results:	Value	
GAD-7 Score	15	
Test Results:	Value	
Duke Health Profile Mental Health Score:	40	
Test Results:	Value	
DUKE HEALTH PROFILE TOTAL GENERAL HEALTH SCORE:		43
Tests:	Value	
Duke Health Profile Social Health Score:	10	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The patient completed the DUKE Health Profile, a 17-item measure of health-related quality of life. On this measure, scores range from 0 to 100, with higher scores indicating better health status.

Mental Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

Social Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

General Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

• DEPRESSION SCREENING / MONITORING (PHQ-9)

- [0] Little Interest or pleasure in doing things
 [1] Feeling down depressed or hopeless
 [2] Trouble sleeping or sleeping too much
 [0] Feeling tired or little energy
 [0] Poor appetite or overeating
 [0] Feeling bad about self
 [0] Trouble concentrating on things
 [2] Moving or speaking slowly or being restless (circled fidgety & restless)
 [0] Thoughts that you would be better off dead

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Thoughts that you would be better off dead: [] Yes [x] No

....

Generalized Anxiety Disorder Screening:

- [3] 1. Feeling nervous, anxious, or on edge
 [2] 2. Not being able to stop or control worrying
 [3] 3. Worrying too much about different things
 [3] 4. Trouble relaxing
 [1] 5. Being so restless that its hard to sit still
 [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response and document in the box below. 15

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

....

Assessment

• Depression

PHQ-9 Score: 5 Date: 16 June 2014 Comments: Mild

....

• Anxiety disorder NOS

GAD-7 Score: 15 Date: 16 June 2014 Comments: Severe

....

Counseling/Education

Anxiety Recommendations for patient:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 949

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

Anxiety Recommendations for PCM Team: Support Pt in implementing above recommendations

....

A/P Last updated by JARRETT, ERICA M @ 20 Jun 2014 1414 EDT

1. GENERALIZED ANXIETY DISORDER: Pt was seen for a 30 minute initial consultation to address symptoms of anxiety. Pt meets diagnostic criteria for Generalized Anxiety Disorder: (inability to control excessive worry with restlessness, fatigue, difficulty concentrating, irritability, and sleep disturbance more days than not for longer than the past 6 months). Pt recalls times in his past that he self-isolated and avoided social encounters due to anxiety and feels his chronic worry negatively impacts his functioning. Pt is in the preparation stage of change in managing his anxiety, to include attending initial consultation with psychiatric and behavioral health providers for further treatment. In the meantime, Pt received education on relaxation techniques and agreed to implement the following interventions:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.
5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

2. NEUROTIC EXCORIATION: Per DSM-V, excoriation disorder is a separate diagnosis. Pt routinely picks his skin on the back of his scalp and has created a bald spot larger than the size of a quarter. Pt reported this behavior initially began with Folliculitis a few years ago, but has persisted and occurs whenever he feels anxious.

Disposition Last Updated by JARRETT, ERICA M @ 20 Jun 2014 1415 EDT

Released w/o Limitations

Follow up: as needed in 2 week(s) with PCM and/or in the HEALTH PROMOTION CL BE clinic or sooner if there are problems. -

Comments: Follow up scheduled for 27 June 2014 at 1000 with Dr. York.

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By JARRETT, ERICA M (Clinical Health Psychologist, NNMC Bethesda, MD) @ 23 Jun 2014 0715

CHANGE HISTORY

The following Disposition Note Was Overwritten by JARRETT, ERICA M @ 20 Jun 2014 1415 EDT:

The Disposition section was last updated by JARRETT, ERICA M @ 20 Jun 2014 1415 EDT - see above. Previous Version of Disposition section was entered/updated by O'SULLIVAN, ROBIN R @ 17 Jun 2014 1320 EDT.

Released w/o Limitations

Follow up: as needed in 2 week(s) with PCM and/or in the HEALTH PROMOTION CL BE clinic or sooner if there are problems. - **Comments:** Follow up scheduled for 27 June 2014 at 1000 with Dr. York.

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following A/P Note Was Overwritten by JARRETT, ERICA M @ 20 Jun 2014 1413 EDT:

The A/P section was last updated by JARRETT, ERICA M @ 20 Jun 2014 1413 EDT - see above. Previous Version of A/P section was entered/updated by O'SULLIVAN, ROBIN R @ 19 Jun 2014 1212 EDT.

1. GENERALIZED ANXIETY DISORDER 300.02: Pt was seen for a 30 minute initial consultation to address symptoms of anxiety. Pt meets diagnostic criteria for Generalized Anxiety Disorder: (inability to control excessive worry with restlessness, fatigue, difficulty concentrating, irritability, and sleep disturbance more days than not for longer than the past 6 months). Pt recalls times in his past that he self-isolated and avoided social encounters due to anxiety and feels his chronic worry negatively impacts his functioning. Pt is in the preparation stage of change in managing his anxiety, to include attending initial consultation with psychiatric and behavioral health providers for further treatment. In the meantime, Pt received education on relaxation techniques and agreed to implement the following interventions:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 950

AR 0995

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

Procedure(s):

-(90791) Psychiatric Diagnostic Evaluation Initial x 1 ADDITIONAL PROVIDER(S): O'SULLIVAN,ROBIN R

2. NEUROTIC EXCORIATION 698.4: Per DSM-V, excoriation disorder is a separate diagnosis. Pt routinely picks his skin on the back of his scalp and has created a bald spot larger than the size of a quarter. Pt reported this behavior initially began with Folliculitis a few years ago, but has persisted and occurs whenever he feels anxious.

Procedure(s):

-(90791) Psychiatric Diagnostic Evaluation Initial x 1 ADDITIONAL PROVIDER(S): O'SULLIVAN,ROBIN R

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 951

AR 0996

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Jun 2014 at WRNMMC, Int Med CL A Medical Home BE by CLARK, THOMAS S

Encounter ID: BETH-17454981 Primary Dx: ANKLE SPRAIN LEFT

Patient: **MERWIN, DANIEL DENNIS** Date: **16 Jun 2014 0930 EDT** Appt Type: **EST**
 Treatment Facility: **WALTER REED** Clinic: **INT MED MEDICAL HOME CL A** Provider: **CLARK, THOMAS STEPHEN**
NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: **Outpatient**

AutoCites Refreshed by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1003 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

f/u after sprained ankle

Appointment Comments:

kcm

VitalsVitals Written by OWENS, ANGELA M @ 16 Jun 2014 0955 EDT

BP: 137/84, HR: 80, RR: 18, T: 98.2 °F, HT: 69 in, WT: 155 lbs, SpO2: 98%, BMI: 22.89,
 BSA: 1.854 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: socially, Pain Scale: 2/10 Mild, Pain Scale Comments: left ankle

S/O Note Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1003 EDT**Chief complaint**

The Chief Complaint is: Limited Duty Chit.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 yo active duty male with 6 week old ankle sprain, consult to PT 12 days ago, he hasn't made appt. needs limited duty chit.

Redirecting to make PT appt. 30d limited duty chit provided.

Pain localized to one or more joints L ankle pain.

allergy to HPI [use for free text].

Pain Severity 2 / 10.

Review of systems

Systemic: No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.

Head: No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 952

AR 0997

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pulmonary: No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Eyes:

General/bilateral:

Pupils: ° PERRL.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

A/P Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1013 EDT**1. ANKLE SPRAIN LEFT**Medication(s): -DOXYCYCLINE-PO 100MG TAB - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS
#60 RF1Disposition Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1014 EDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the INT MED MEDICAL HOME CL A BE clinic. - Comments: f/u with PT**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.Signed By CLARK, THOMAS STEPHEN (Family Nurse Practitioner) @ 16 Jun 2014 1014

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

04 Jun 2014 at WRNMMC, Int Med Cons/Spec Care Cl Be by DOUGHERTY, DIANA L

Encounter ID: BETH-17336631 Primary Dx: ANKLE SPRAIN LEFT

Patient: MERWIN, DANIEL DENNIS Date: 04 Jun 2014 0632 EDT Appt Type: ACUT
 Treatment Facility: WALTER REED Clinic: INT MED CONS/SPEC CARE CL Provider: DOUGHERTY, DIANA L
 NATIONAL MILITARY MEDICAL CNTR BE
 Patient Status: Outpatient

Reason for Appointment: Written by PEREZ, DULCE C @ 04 Jun 2014 0632 EDT
 left ankle swelling

Vitals**Vitals** Written by PEREZ, DULCE C @ 04 Jun 2014 0633 EDT

BP: 119/82, HR: 81, T: 97.9 °F, HT: 69 in, WT: 155 lbs, SpO₂: 97%, BMI: 22.89, BSA: 1.854 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: occasional, Pain Scale: 4/10 Moderate, Pain Scale Comments:
 left ankle

SO Note Written by DOUGHERTY, DIANA L @ 04 Jun 2014 0855 EDT**Chief complaint**

The Chief Complaint is: L ankle swelling.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

Pt is 24 yo AD navy who presents with c/o L ankle swelling/pain that has persisted since injury 15 April 2014. He reports that while playing softball, he sustained injury that involved forward force of the foot into a hole while playing softball. At that time, he was evaluated in the ER, found to have no e/o fracture on XR, and given a brace and crutches. He used the brace for approx 2 weeks, and the crutches for approx 4 at which point he was able to bear weight with minimal pain. Repeat XR obtained by his PCM in early May continued to demonstrate no e/o fracture.

Today, he presents because of ongoing aching pain at the ankle joint and forefoot, associated with swelling localized to the ankle. He denies sharp pain or point tenderness, and is able to bear weight. However ROM is limited, and pain exacerbated particularly with dorsiflexion. He has been unable to obtain a timely appointment with his primary provider, and needs exemption from PT.

No localized joint pain and no localized joint swelling. No sensory disturbances.

Current medication

Ibuprofen prn

Past medical/surgical history**Reported:**

Medical: Reported medical history
 reviewed, noncontributory.

Review of systems**Musculoskeletal:** No knee symptoms.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Injuries: • No evidence of a head injury.
 Appearance: • Head normocephalic.

Cardiovascular:

Arterial Pulses: • Dorsalis pedis pulses were normal and PT pulses intact.

Musculoskeletal System:**Knee:**

Right Knee: • No effusion. • No tenderness on palpation.
 Left Knee: • No effusion. • No tenderness on palpation.

Lower Leg:

Right Leg: • Calf was not swollen. • Leg exhibited no warmth. • No erythema. • No tenderness on palpation.
 Left Leg: • Calf was not swollen. • Leg exhibited no warmth. • No erythema. • No tenderness on palpation.

Ankle:

Right Ankle: • No swelling. • No erythema. • Ankle was not warm. • No misalignment. • No tenderness on palpation.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 954

AR 0999

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

° Motion was normal. ° No pain was elicited by motion. ° Ankle was not tender on ambulation.

Left Ankle: • Swelling localized to ankle, both medial and lateral aspects. • Tenderness on palpation aching tenderness at both lateral and medial malleoli. No point tenderness. • Motion was abnormal decreased ROM with dorsiflexion, inversion, eversion. • Pain was elicited by motion. • Ankle was tender on ambulation. ° No erythema. ° Ankle was not warm. ° No misalignment.

Foot:

Right Foot: • Pes planus. ° No erythema. ° No tenderness on palpation.

Left Foot: • Examined resolving ecchymosis. Foot warm, well perfused with 2+ distal pulses. • Pes planus. • Tenderness on palpation aching tenderness of forefoot. No point tenderness. ° No erythema. ° No abnormal warmth. ° No deformity.

Functional Exam:

General/bilateral: • Mobility was limited.

Neurological:

Motor (Strength): ° No weakness of the right ankle was observed. ° No weakness of the left ankle was observed.

A/P Last Updated by DOUGHERTY, DIANA L @ 04 Jun 2014 0939 EDT

1. **ANKLE SPRAIN LEFT:** Residual ankle swelling and limited ROM 6 weeks s/p injury resulting in ankle sprain. It is not unexpected to have these residual symptoms, and XR imaging on 2 occasions has failed to demonstrate fracture. No e/o neurovascular compromise. Patient improving, but not yet back to baseline.

* chit provided for light duty/no PT/no running or prolonged standing walking x7 days

* pt instructed to follow-up with his primary for ongoing treatment and profile, if needed

* physical therapy consult for assistance with re-gaining ROM

* patient counseled to avoid activities which cause pain, and to elevate/ice ankle as needed

Consult(s): -Referred To: PHYSICAL THERAPY MTF BE (Routine) Specialty: THERAPY, PHYSICAL Clinic: PHYS THERAPY CL BE Provisional Diagnosis: ANKLE SPRAIN LEFT

Disposition Last Updated by DOUGHERTY, DIANA L @ 04 Jun 2014 0941 EDT**Released w/ Work/Duty Limitations**

Follow up: 1 week(s) with PCM or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DOUGHERTY, DIANA L (Physician) @ 04 Jun 2014 0941Co-Signed By SALUJA, SHUCHI M (Physician, General Internal Medicine, WRAMC) @ 10 Jun 2014 1826Note Written by SALUJA, SHUCHI M @ 10 Jun 2014 1826 EDT

(Added after encounter was signed.)

discussed pt with Dr Daugherty, agree with above

CHANGE HISTORYThe following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by SALUJA, SHUCHI M @ 10 Jun 2014 1825 EDT:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 955

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

30 May 2014 at WRNMMC, AMH M01A Red Ki by COLEMAN, AUDREY G

Encounter ID: BETH-17298002 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **30 May 2014 1141 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **T-CON***
 Provider: **COLEMAN, AUDREY G**

Call Back Phone: [REDACTED]

AutoCites Refreshed by COLEMAN, AUDREY G @ 30 May 2014 1410 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by ELLIS, KEISHA @ 30 May 2014 1141 EDT
 REFERRAL

Questionnaire AutoCites Refreshed by COLEMAN, AUDREY G @ 30 May 2014 1410 EDT
 Questionnaires

Note Written by ELLIS, KEISHA @ 30 May 2014 1142 EDT

PATIENT STATES THAT HE WAS INSTRUCTED CALL BACK IN REGARDS TO HIS LEFT ANKLE HE IS STILL HAVING THE SAME PROBLEM.

PCM: UDE

CB#: (850)696-7239 (CELL)

Note Written by COLEMAN, AUDREY G @ 30 May 2014 1416 EDT

SPOKE WITH PT NAME AND DOB VERIFIED, PT STATES THAT LEFT FOOT SWOLLEN TODAY. HE HAS BEEN USING CRUTCHES OFF ON FOR WEIGHT BEARING. HAVE NOT BEEN ABLE TO ELEVATE FOOT AT WORK SITTING AT DESK. WILL DISCUSS WITH PROVIDER AND CALL THE PT BACK.

Note Written by COLEMAN, AUDREY G @ 30 May 2014 1458 EDT

SPOKE WITH PT NAME AND DOB VERIFIED, INFORMED PT THAT HE NEED TO MAKE A F/U APPT FOR LEFT ANKLE PER PROVIDER. PT STATED THAT HE WOULD RATHER CALL BACK TO SCHEDULE APPT. HE DON'T HAVE HIS SCHEDULE IN FRONT OF HIM.

A/P Last Updated by COLEMAN, AUDREY G @ 30 May 2014 1501 EDT

1. Left ankle joint pain

Disposition Last Updated by ELLIS, KEISHA @ 30 May 2014 1142 EDT

Signed By COLEMAN, AUDREY G (LPN, Family Practice Red Team, KACC, Ft. Meade Md) @ 30 May 2014 1502

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page 956

AR 1001

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

19 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O

Encounter ID: BETH-17164995 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **19 May 2014 1150 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **EST**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by COLEMAN,AUDREY G @ 16 May 2014 0945 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- IMPAIRED FASTING GLUCOSE
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- Other: OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

PHA/NAVY/NIOC

Appointment Comments:

eed [REDACTED]

Screening Written by SNOWDEN,HEATHER @ 19 May 2014 1142 EDT**Reason For Appointment:** PHA/NAVY/NIOC

Allergen information verified by SNOWDEN, HEATHER @ 19 May 2014 1142 EDT

VitalsVitals Written by SNOWDEN,HEATHER @ 19 May 2014 1149 EDT

BP: 127/68 Right Arm, Adult Cuff, HR: 66, RR: 16, T: 98.3 °F, HT: 69 in Stated, Without Shoes, WT: 153.6 lbs Upright Scale, Actual, Without Shoes, Uncorr OD: 20/30, Uncorr OS: 20/50, Uncorr OU: 20/50, BMI: 22.68, BSA: 1.846 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No, Have people Annoyed you by criticizing or complaining about your drinking? No, Have you ever felt bad or Guilty about your drinking? No, Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No, Alcohol Comments: 2-3 month, Pain Scale: 0 Pain Free

S/O Note Written by UDE,ASSUMPTA O @ 19 May 2014 1331 EDT**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O AD SM HERE FOR PHA-NO HEALTH CONCERNS EXCEPT FOR RESOVLING LT ANKLE SPRAIN

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Pain localized to one or more joints.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 958

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Visit is not deployment-related.
 Pain Severity 0 / 10.
 PHQ-2 Depression Screen Negative.
 Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.
 Patient is compliant with medications.
 Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 19 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Annual Questions Date: 19 MAY 2014.

Social history reviewed single, no children

AD Navy

Non smoker

Occasional drinker.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 19MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info: [REDACTED]

PCM: UDE.

Family history

Family medical history

Father with DM, CAD.

Review of systems**Systemic:** No systemic symptoms, no fever, no chills, and no recent weight loss.**Head:** No head symptoms and no headache.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Otolaryngeal:** No otolaryngeal symptoms, no earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms and no chest pain or discomfort.**Pulmonary:** No pulmonary symptoms, no dyspnea, and no cough.**Gastrointestinal:** No gastrointestinal symptoms, no nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No genitourinary symptoms, no change in urinary frequency, and no feelings of urinary urgency. No dysuria.**Endocrine:** No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Musculoskeletal:** No musculoskeletal symptoms and no back pain.**Neurological:** No neurological symptoms and no lightheadedness.**Psychological:** No psychological symptoms.**Skin:** No skin symptoms.**Physical findings**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 959

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Head:

Appearance: • Head normocephalic.

Neck:

Appearance: • Of the neck was normal.

Eyes:

General/bilateral:

Pupils: • PERRL.

External: • Eyelids showed no abnormalities.

Ears:

General/bilateral:

Outer Ear: • Normal.

External Auditory Canal: • External auditory meatus normal.

Nose:

General/bilateral:

External Deformities: • No external nose deformities.

Sinus Tenderness: • No sinus tenderness.

Oral Cavity:

Lips: • Showed no abnormalities.

Lungs:

• Respiration rhythm and depth was normal. • Clear to auscultation.

Musculoskeletal System:

Other:

General/bilateral: • No muscle tenderness.

Neurological:

• Oriented to time, place, and person. • Remote memory was not impaired. • Recent memory was not impaired. • Judgement was not impaired.

Balance: • Normal.

Gait And Stance: • Normal.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Skin:

• No skin lesions.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[X] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

.....

Tests: Value

AUDIT-C Score 2

Practice Management

Patient's BMI < 30. Date: 19 MAY 2014.

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis - No

HIV Screen - APR 2014

Colonoscopy - 2012

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 960

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Tetanus (Td/Tdap) - MAR 2013
 Influenza - NOV 2013
 Zoster - No record of titer or vaccine
 Pneumococcal -
 HPV -

Men:
 Aortic Aneurysm Screen -
 G6pd- Nov 2005
 Sickie cell- nov 2005
 blood tye- O +
 hearing exam- march 2013
 vision exam - no record

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1210 EDT

Basic Metabolic Panel	Site/Specimen	04 Jun 2013 0925
Urea Nitrogen	SERUM	12
Carbon Dioxide	SERUM	30
Chloride	SERUM	102
Creatinine	SERUM	1.0
Glucose	SERUM	94 <i>
Potassium	SERUM	4.3
Sodium	SERUM	140
Calcium	SERUM	9.7
Anion Gap	SERUM	8
GFR Calculated Non-Black	SERUM	102.0
GFR Calculated Black	SERUM	117.9 <i>

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1208 EDT

HIV-1/O/2 Ab	Site/Specimen	10 Apr 2014 0951
HIV-1/O/2 Ab	SERUM	Negative <r>

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1208 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by COLEMAN,AUDREY G @ 16 May 2014 0944 EDT

HIV-1/O/2 Ab	Site/Specimen	10 Apr 2014 0951	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Lipid Panel	Site/Specimen	10 Apr 2014 0951	Units	Ref Rng
Cholesterol	SERUM	208 (H) <i>	mg/dL	(50-200)
Triglyceride	SERUM	158 (H) <i>	mg/dL	(40-150)
HDL Cholesterol	SERUM	64.0 (H)	mg/dL	(40-60)
LDL Cholesterol	SERUM	112 <i>	mg/dL	(0-129)
VLDL Cholesterol	SERUM	32	mg/dL	(2-49)
Cholesterol/HDL Cholesterol	SERUM	3.25		

A/P Last updated by UDE,ASSUMPTA O @ 19 May 2014 1334 EDT

1. Visit for: military services physical(PERIODIC PREVENTION EXAMINATION): AGE AND GENDER APPROPRIATE PREVENTIVE TASK FORCE REQUIRED COUNSELLING GIVEN, SEE MRRS AND NAVMED 6120/4 FOR READINESS AND VACCINE UPDATES

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 961

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

2. ESSENTIAL HYPERTRIGLYCERIDEMIA: SIG REDUCTION OF TRIG-CONTINUE lifestyle mod
Laboratory(ies): -GLUCOSE FASTING (Routine) Start Date: 06/01/2014**Disposition** Written by UDE, ASSUMPTA O @ 19 May 2014 1334 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: MEDICATIONS RECONCILED, LIST GIVEN TO PATIENT, MASTER PROBLEM LIST REVIEWED AND RECONCILED WITH PATIENT.**Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 19 May 2014 1334****CHANGE HISTORY***The following A/P Note Was Overwritten by UDE, ASSUMPTA O @ 19 May 2014 1316 EDT:*

The A/P section was last updated by UDE, ASSUMPTA O @ 19 May 2014 1316 EDT - see above. Previous Version of A/P section was entered/updated by COLEMAN, AUDREY G @ 16 May 2014 0942 EDT.

*The following S/O Note Was Overwritten by UDE, ASSUMPTA O @ 19 May 2014 1212 EDT:**S/O Note Written by SNOWDEN, HEATHER @ 19 May 2014 1144 EDT***Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O AD SM HERE FOR PHA

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Visit is not deployment-related.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Patient is compliant with medications.

Allergies

Current Allergies: Cats updated 19 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

Tonsillectomy - 2004

Colonoscopy 2012.

Personal history

Annual Questions Date: 19 MAY 2014.

Social history reviewed single, no children

AD Navy

Non smoker

Occasional drinker.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 19MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☒ No

Contact info: 850-696-7239

PCM: UDE.

Family history

Family medical history

Father with DM, CAD.

Tests

ALCOHOL SCREENING

How often did you have a -

drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 962

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[X] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

AUDIT-C Score

2

Practice Management

Patient's BMI < 30. Date: 19 MAY 2014.

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis - No

HIV Screen - APR 2014

Colonoscopy - 2012

Tetanus (Td/Tdap) - MAR 2013

Influenza - NOV 2013

Zoster - No record of titer or vaccine

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

G6pd- Nov 2005

Sickle cell- nov 2005

blood type- O +

hearing exam- march 2013

vision exam - no record

Patient exercises for at least 30 minutes a day.

*The following SO Note Was Overwritten by SNOWDEN, HEATHER @ 19 May 2014 1149 EDT:**SO Note Written by COLEMAN, AUDREY G @ 16 May 2014 0942 EDT***Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O ASDM HERE FOR PHA

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Visit is not deployment-related.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 15 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? [X] Verbal [X] Written [X] Visual [] Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? [] Yes [X] No Specify:

Advance directives completed? [] Yes [X] No

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 963

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[X] Negative AUDIT-C

[] Positive AUDIT-C >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Tests:

Value

AUDIT-C Score

2

Practice Management

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - APR 2014

Colonoscopy -

Tetanus (Td/Tdap) - MAR 2013

Influenza - NOV 2013

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Patient's BMI < 30. Date: 6 MAY 2014.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 964

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O

Encounter ID: BETH-17036973 Primary Dx: ANKLE SPRAIN LEFT

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
Patient Status: **Outpatient**Date: **06 May 2014 1430 EDT**
Clinic: **AMHM01AREDKI**Appt Type: **EST**
Provider: **UDE,ASSUMPTA O**AutoCites Refreshed by SMITH,PRISCILLA E @ 05 May 2014 1133 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- IMPAIRED FASTING GLUCOSE
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS
- Visit for: military services physical

Family History

- family medical history (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

UDE-F/U FROM ER

Appointment Comments:

KLS/KACC

Screening Written by COLEMAN,AUDREY G @ 06 May 2014 1419 EDT**Reason For Appointment:** UDE-F/U FROM ER

Allergen information verified by COLEMAN, AUDREY G @ 06 May 2014 1419 EDT

VitalsVitals Written by COLEMAN,AUDREY G @ 06 May 2014 1409 EDTBP: 130/82 Left Arm, HR: 79, RR: 18, T: 97.5 °F, HT: 69 in Stated, WT: 153 lbs Upright Scale, Actual, With Shoes, SpO₂: 97%, BMI: 22.59, BSA: 1.843 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 3/10 Mild, Pain Scale Comments: LEFT ANKLE**Comments:** UNIFORMS/O Note Written by UDE,ASSUMPTA O @ 06 May 2014 1426 EDT**Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADSDM FOR F/U ER VISIT while he was sprinting during softball game, and his foot went into the hole while he was running-2 weeks ago, Reports not using crutches currently. On morin pen, pain is 3/10.

Good general overall feeling /health.

Pain localized to one or more joints and joint swelling localized to one or more joints.

Visit is not deployment-related.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 965

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pain assessment
 Location: LEFT ANKLE
 Duration:
 Quality: AHARP/THROBBING
 Factors that correlate with onset:
 Frequency: CONSTANT
 Average level: 3
 Worst level: 7-8
 Least level: 3
 What makes it better: ELEVATION
 What makes it worse: PRESSURE, STANDING, FULL EXTENSION

Pain Severity 3 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic 19 APR 2014 BETHESDA.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Review of systems**Systemic:** No systemic symptoms.**Musculoskeletal:** No muscle aches and no limb pain.**Neurological:** No neurological symptoms.**Psychological:** No psychological symptoms.**Skin:** No skin symptoms.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 966

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Musculoskeletal System:**Ankle:**

Left Ankle: • Swelling. • Tenderness on palpation. • Pain was elicited by motion. • Ankle was tender on ambulation. • No erythema. • Ankle was not warm. • Motion was normal. • No crepitus on motion was noted.

Foot:

Left Foot: • Tenderness on palpation. • No erythema. • No pain was elicited by motion.

Functional Exam:

General/bilateral: • Mobility was limited.

Other:

General/bilateral: • Muscle tenderness.

Neurological:

• Oriented to time, place, and person. • Remote memory was not impaired. • Recent memory was not impaired. • Judgement was not impaired.

Motor (Strength): • No weakness of the left ankle was observed.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SXSCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Tests:

Value

AUDIT-C Score

2

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Patient's BMI < 30. Date: 6 MAY 2014.

Rad Result Cited by UDE ASSUMPTA O @ 06 May 2014 1443 EDT**MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M**
***** ANKLE, LT 3 VIEWS *****Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

POC Enc: #E4520771 POC Fac: WRNMMC
Status: Complete (Amended)

Procedure: ANKLE, LT 3 VIEWS
 Event Date: 19-Apr-2014 15:38:00
 Exam #: 14130312
 Exam Date/Time: 19-Apr-2014 15:42:00
 Transcription Date/Time: 20-Apr-2014 19:41:00
 Provider: PIRRI, MICHAEL P
 Requesting Location:
 EMERGENCY RM BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: NIELSEN, NATHAN S
 Supervised By: KENRIC T. ABAN, MD. LCDR, MC, USN.
 Approved By: ABAN, KENRIC T
 Approved Date: 20-Apr-2014 19:40:00
 Supervised By:
 122645 KENRIC T. ABAN, MD. LCDR, MC, USN.
 Supervised By Date: 20-Apr-2014 19:40:00
 Amended Report Text:

History:

Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique:

Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident:

Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Electronically signed by:

Dr. Kenric T Aban Date: 04/20/14 Time:19:40

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Rad Result Cited by UDE ASSUMPTA O @ 06 May 2014 1443 EDT**MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M**

***** FOOT, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: FOOT, LT 3 VIEWS
 Event Date: 19-Apr-2014 15:38:00
 Exam #: 14130311
 Exam Date/Time: 19-Apr-2014 15:42:00
 Transcription Date/Time: 20-Apr-2014 19:41:00
 Provider: PIRRI, MICHAEL P
 Requesting Location:
 EMERGENCY RM BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: NIELSEN, NATHAN S
 Supervised By: KENRIC T. ABAN, MD. LCDR, MC, USN.
 Approved By: ABAN, KENRIC T
 Approved Date: 20-Apr-2014 19:40:00
 Supervised By:
 122645 KENRIC T. ABAN, MD. LCDR, MC, USN.
 Supervised By Date: 20-Apr-2014 19:40:00
 Amended Report Text:

History:

Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique:

Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available**Findings:**

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Electronically signed by:

Dr. Kenric T Aban Date: 04/20/14 Time:19:40

A/P Written by UDE,ASSUMPTA O @ 06 May 2014 1448 EDT**1. ANKLE SPRAIN LEFT:** CONTINUE REST, ICE, MOIST HEAT, NSAID AND ELEVATE, USE CRUTCHES FOR LONG DISTANCE WALK PRNRadiology(ies): -ANKLE, LT 3 VIEWS (Routine) Impression: left lateral ankle pain and swelling 2 weeks following a sprain
Comment: with weight bearing**2. Visit for: exam following treatment**

Radiology(ies): -FOOT, LT WT BEARING 3 VIEWS (Routine) Impression: left foot pain x 2 weeks following a recent injury, re-eval

3. ARMED FORCES FITNESS FOR DUTY EXAM(FITNESS FOR DUTY EXAMINATION): NO JUMPING/RUNNING/CARDIO X 30DAYS-RECENT SPRAINED ANKLE-SEE DD689Disposition Written by UDE,ASSUMPTA O @ 06 May 2014 1448 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -**Comments:** MEDICATIONS RECONCILED, LIST GIVEN TO PATIENT, MASTER PROBLEM LIST REVIEWED AND RECONCILED WITH PATIENT.Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 06 May 2014 1449**CHANGE HISTORY**The following S/O Note Was Overwritten by UDE,ASSUMPTA O @ 06 May 2014 1442 EDT:S/O Note Written by COLEMAN,AUDREY G @ 06 May 2014 1422 EDT**Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADPM FOR F/U ER VISIT.
Good general overall feeling /health.
Visit is not deployment-related.**Pain assessment**

Location: LEFT ANKLE

Duration:

Quality: AHARP/THROBBING

Factors that correlate with onset:

Frequency: CONSTANT

Average level: 3

Worst level: 7-8

Least level: 3

What makes it better: ELEVATION

What makes it worse: PRESSURE,STANDING,FULL EXTENSION

Pain Severity 3 / 10.

PHQ-2 Depression Screen Negative.

Patient is NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic 19 APR 2014 BETHESDA.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 970

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history
PRK eyes - 2011
tonsillectomy - 2004
colonoscopy 2012.

Personal history

Social history reviewed single, no children.
Behavioral: No tobacco use in the last 10 years.
Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Tests**ALCOHOL SCREENING**

How often did you have a -
drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SXSCREENING for Alcohol Use (AUDIT-C)☐ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

AUDIT-C Score

2

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Patient's BMI < 30. Date: 6 MAY 2014.

*The following SO Note Was Overwritten by COLEMAN,AUDREY G @ 06 May 2014 1422 EDT:**SO Note Written by SMITH,PRISCILLA E @ 05 May 2014 1129 EDT***Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADSM FOR F/U ER VISIT.

Good general overall feeling /health.

Visit is not deployment-related.

PHQ-2 Depression Screen Negative.

Patient is NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 971

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

NONE

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient's BMI < 30. Date: 6 MAY 2014.

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 972

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

30 Dec 2013 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-15820677 Primary Dx: Visit for: administrative purpose

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 30 Dec 2013 0802 EST
Clinic: GI CL BEAppt Type: T-CON*
Provider: COPSEY, HELEN C

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 30 Dec 2013 0802 EST
Called pt**SO Note** Written by COPSEY, HELEN C @ 30 Dec 2013 0803 EST**Subjective**

Called patient this morning- no answer. LM that if he has new issues, he should make a follow-up appointment in the GI clinic, as he was last seen by me well over a year ago. If he has any trouble getting an appointment or needs immediate attention he was given my direct phone number. From: Burleson, Ronald A CIV US WRNMMC Sent: Friday, December 27, 2013 12:14 PM To: Hopkins, Ida E CIV US WRNMMC Subject: RE: vmail msgs for your action Pls call mr merwin, [REDACTED] dob [REDACTED] 85, [REDACTED] f-up. Has some medical issues now.

A/P Last Updated by COPSEY, HELEN C @ 30 Dec 2013 0803 EST

1. visit for: administrative purpose

Disposition Last Updated by COPSEY, HELEN C @ 30 Dec 2013 0803 EST**Signed By** COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 30 Dec 2013 0803

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 Aug 2013 at WRNMMC, AMH M01A Red Ki by SLOAN, DAWN M

Encounter ID: BETH-14393823 Primary Dx: Visit for: military services physical

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: KIMBROUGH
AMBULATORY CARE CENTER
Patient Status: OutpatientDate: 07 Aug 2013 1450 EDT
Clinic: AMHM01AREDKIAppt Type: EST
Provider: SLOAN,DAWN MReason for Appointment:
TIO HIGH RISK MEDICAL SCREENING
Appointment Comments:
rar [REDACTED]Screening Written by SMITH,PRISCILLA E @ 07 Aug 2013 1454 EDT
Reason For Appointment: TIO HIGH RISK MEDICAL SCREENING

Allergen information verified by SMITH, PRISCILLA E @ 07 Aug 2013 1454 EDT

VitalsVitals Written by SMITH,PRISCILLA E @ 07 Aug 2013 1449 EDT
BP: 106/60 Left Arm, Adult Cuff, HR: 88 Regular, Radial Artery, RR: 14, T: 98.1 °F Oral, HT: 69 in Stated,
WT: 149 lbs Upright Scale, Actual, With Shoes, SpO₂: 96%, BMI: 22, BSA: 1.823 square metersQuestionnaire AutoCites Refreshed by SLOAN,DAWN M @ 07 Aug 2013 1539 EDT
Questionnaires

MEADE MEDCOM E774-I Version: 2 Completed On: 07 Aug 2013

1. SECTION I Feeling down, depressed, or hopeless.: No
2. Little interest or pleasure in doing things.: No
3. SECTION II Had any nightmares about it or thought about it when you did not want to?: No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?: No
5. Were constantly on guard, watchful, or easily startled?: No
6. Felt numb or detached from others, activities, or your surroundings?: No
7. PHQ-9 Severity Score or click Not Administered: NOT ADMINISTERED PHQ-9
8. Suicide Risk Score Item 1i or click Not Administered: NOT ADMINISTERED PHQ-9
9. PCL Severity Score or click Not Administered: Not Administered (PCL)
10. Risk Score Item #19 of PCL or click Not Administered.: Not Administered PCL
11. MEDCOM 774 Results: SELECT ALL THAT APPLY——IF NEGATIVE FOR BOTH ——STOP/DONE unless otherwise indicated. (CLICK DONE AND AUTOCITE): Negative for Both;

SO Note Written by SLOAN,DAWN M @ 11 Aug 2013 2245 EDT**Chief complaint**

The Chief Complaint is: High Risk Medical Screening.

History of present illness

The Patient is a 28 year old male.

<<Note accomplished in TSWF-CORE>>

28yo Male presented for TIO High risk medical screening. Has form for review.

Does have hx of asthma as child, last episode in 2005 requiring albuterol. No episodes despite exposure to cats and dogs since, which were his trigger in the past. Notes hospitalization for 'bowel obstruction' last Oct with neg colonoscopy. No abdominal issues since stopping coffee and watching dairy.

Medication list reviewed, reconciled and list given to patient.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain assessment: denies.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: Cats updated 7 Aug 2013.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Current medication

NONE.

Past medical/surgical history**Reported:**

Medical: Reported medical history
 Asthma - last affected in 2005.
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease
 .
 Surgical / Procedural: Surgical / procedural history
 PRK eyes - 2011
 tonsillectomy - 2004
 colonoscopy 2012.
 Medications: No medication noncompliance.

Personal history

Social history reviewed single, no children.
 Behavioral: No tobacco use in the last 10 years.
 Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.
 History
 ANNUAL SCREENING DATE: 18 JAN 2013
 What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):
 Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:
 Advance directives completed? ☐ Yes ☒ No
 Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact info:
 PCM:

Family history

Family medical history
 Father with DM, CAD.

Review of systems

Systemic: No fever, no chills, and no recent weight loss.
Head: No headache.
Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage, and no sore throat.
Cardiovascular: No chest pain or discomfort.
Pulmonary: No dyspnea and no cough.
Gastrointestinal: No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.
Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.
Musculoskeletal: No back pain.
Neurological: No lightheadedness.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Oriented to time, place, and person. • Well developed. • Well nourished. • In no acute distress.

Eyes:

General/bilateral:
 External: • Conjunctiva exhibited no abnormalities.
 Sclera: • Normal.

Lungs:

• Respiration rhythm and depth was normal. • Clear to auscultation. • No wheezing was heard. • No rhonchi were heard.
 • No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.
 Heart Sounds: • Normal S1 and S2. • No S3 heard. • No gallop was heard. • No pericardial friction rub heard.
 Murmurs: • No murmurs were heard.
 Edema: • Not present.

Neurological:

Balance: • Normal.
 Gait And Stance: • Normal.

Psychiatric:

Mood: • Euthymic.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 975

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Affect: ° Normal.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

A/P Written by SLOAN,DAWN M @ 11 Aug 2013 2253 EDT

1. visit for: military services physical(OCCUPATIONAL EXAMINATION): Pt in good condition currently. Has had health issues in the past which he seems to be managing well with diet changes and exercise. Signed off on form noting previous health issues and discussed with pt.

Disposition Written by SLOAN,DAWN M @ 11 Aug 2013 2254 EDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: No medication reconciliation needed. Master problem List reconciled

Note Written by JORDAN,TIMOTHY W @ 07 Aug 2013 1616 EDT

TIO High Risk Screening Form

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

For Official Use ONLY - Privacy Act Information

TIO PROGRAM HIGH RISK MEDICAL SCREENING FORM			
Name: (Last, First Middle Initial)		Rate/Rank:	
MERWIN, DANIEL D		CTN1/E-6	
Date:	Age:	Weight:	Unit:
07 AUG 13	28	150	NIOC MARYLAND
Rate your current health? (circle)			
Poor Good Excellent <u>Outstanding</u>			
List current medications:			
NONE			
PLEASE ANSWER THE FOLLOWING QUESTIONS (circle one answer)			
1. Do you have any fractures, sprains, strains or casts?	Yes	No	
2. Do you have a hernia?	Yes	No	
3. Do you have pneumonia, bronchitis, or asthma?	Yes	No	
4. Do you have nasal congestion or an ear/nose/throat condition?	Yes	No	
5. Do you have any allergies?	Yes	No	
6. Have you had high blood pressure, heart disease, stress related chest pains, or are you currently being treated or monitored for any of these?	Yes	No	
7. Have you had any surgery or post-operative procedure within the past 10 years?	Yes	No	
8. Do you have hypertension (low blood pressure) or hypoglycemia (low blood sugar)?	Yes	No	
9. Do you have a history of heat related illnesses/injuries?	Yes	No	
10. Have you had any cold weather related injuries?	Yes	No	
11. Have you tested positive for Sickie Call or G4PD?	Yes	No	
12. Are you claustrophobic?	Yes	No	
13. Have you seen a Mental Health Professional for any reason?	Yes	No	
14. Do you have a history of heat related illnesses/injuries?	Yes	No	
15. Do you have any existing condition or injury that might preclude you from participating in high risk training that may include temperature extremes, emotional and physical stress, or risk of death?	Yes	No	
Please explain any "YES" answers above in the space provided below.			
SCATS Injury 7- PRK eyes... acute 14/10 2 1/2" 10- + NO SICKIE... 2 1/2 4			
I have completed this form to the best of my ability. I will notify the Detainer and TIO Recruiter of any changes in my medical standing.			
SIGNATURE		DATE	
		07 AUG 13	
MEDICAL OFFICER			
Comments			
HE OF ASTHMA AS CHILD IS THE LAST REPRESENTATION OF SURVIVAL OF BURNING IN 2005 NO RESPIRATORY ISSUES SINCE HYPERTENSIVE DIET DAWN SLOAN, MD MAL MC USA			
I have reviewed the medical record of individual and am capable of entering the Tactical Information Operations (TIO) program.			
SIGNATURE		DATE	
		07 AUG 13	

Signed By SLOAN, DAWN M (Family Medicine Physician) @ 11 Aug 2013 2254

CHANGE HISTORY

The following SO Note Was Overwritten by SLOAN, DAWN M @ 07 Aug 2013 1545 EDT:

SO Note Written by SMITH, PRISCILLA E @ 07 Aug 2013 1454 EDT:

Chief complaint

The Chief Complaint is: High Risk Medical Screening.

History of present illness

The Patient is a 28 year old male.

<<Note accomplished in TSWF-CORE>>

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 977

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

28yo Male presented for High risk medical screening

Medication list reviewed, reconciled and list given to patient.
 Currently on active duty. Visit is not deployment-related.
 Good general overall feeling.

Pain Severity 0 / 10.

Pain assessment: denies.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: Cats updated 7 Aug 2013.

Current medication

NONE.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.
 Medical: Reported medical history Asthma
 Dyspnea
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history
 PRK eyes - 2011
 tonsillectomy - 2004.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services
 Lipid Screening - 19 MAR 2013
 Blood Sugar Screening - 5.4 June 2013
 Aspirin Prophylaxis -
 HIV Screen - 19 MAR 2013.
 Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005
 Influenza -
 Zoster -
 Pneumococcal -
 HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 978

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

05 Aug 2013 at WRNMMC, Immunization Kimbrough by WRAY, KIM D

Encounter ID: BETH-14383762 Primary Dx: Vaccines Prophylactic Need Against Bacterial Diseases

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: KIMBROUGH
AMBULATORY CARE CENTER
Patient Status: OutpatientDate: 05 Aug 2013 0903 EDT
Clinic: IMMUNIZATION KIAppt Type: PROC
Provider: WRAY, KIM DReason for Appointment: Written by RYAN, LINDSEY O @ 05 Aug 2013 0903 EDT
update immSO Note Written by WRAY, KIM D @ 05 Aug 2013 0917 EDT**Vaccinations**

- Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Therapy

- Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record.

Practice ManagementPatient information sheet: Given to x Patient Parent Guardian on Vaccination Information Statement(s)A/P Last Updated by WRAY, KIM D @ 05 Aug 2013 0931 EDT**1. Vaccines Prophylactic Need Against Bacterial Diseases**

Procedure(s): -Meningococcal Oligosaccharide Diphtheria Toxoid Conjugate Vaccine x 1 - Meningococcal A,C,Y,W-135 Diphtheria Conj; Series #: 1; .5 mL; IM; Right Arm; Mfg: Sanofi Pasteur; Lot: U4575BA; VIS given (Ver: 10/14/11).
-Immunization Administration One Vaccine x 1

Disposition Last Updated by WRAY, KIM D @ 05 Aug 2013 0931 EDT**Released w/o Limitations****Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By WRAY, KIM D (LPN, Kimbrough Ambulatory Care Center, Ft Meade, MD) @ 05 Aug 2013 0932

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10 Apr 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-13259945 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
Patient Status: **Outpatient**Date: **10 Apr 2013 1130 EDT**
Clinic: **AMHM01BBLUEKI**Appt Type: **WELL**
Provider: **UDE,ASSUMPTA O**AutoCites Refreshed by OLAWUMI, OMOWUMI D @ 09 Apr 2013 1620 EDT**Problems****Chronic:**

- Visit for: ears/hearing exam
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Visit for: follow-up exam
- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

navy pha

Appointment Comments:

rks 8506028501

Screening Written by OLAWUMI, OMOWUMI D @ 09 Apr 2013 1620 EDT**Reason For Appointment:** navy pha

Allergen information verified by OLAWUMI, OMOWUMI D @ 09 Apr 2013 1620 EDT

VitalsVitals Written by OLAWUMI, OMOWUMI D @ 10 Apr 2013 1131 EDTBP: 110/72 Left Arm, Adult Cuff, HR: 77 Regular, Radial Artery, RR: 16, T: 98.7 °F Oral, HT: 69 in Stated, WT: 153.4 lbs Upright Scale, Actual, With Shoes, SpO₂: 98%, BMI: 22.65, BSA: 1.845 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain FreeSO Note Written by UDE, ASSUMPTA O @ 10 Apr 2013 1413 EDT**Chief complaint**

The Chief Complaint is: NAVY PHA.

History of present illness

The Patient is a 28 year old male.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 980

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

A PHA has been completed in past year. Date: 10 APR 2013.

<<Note accomplished in TSWF-CORE>> PRESENTS FOR ANNUAL PHA, NO HEALTH CONCERNS TODAY, FLAKINESS OF SCALP AND SOLE OF FEET, NON ITCHY BUT COMES AND GOES, HE HAS TRIED ANTIFUNGAL TOPICAL WITH NO IMPROVEMNT

In the Navy and currently on active duty. Visit is not deployment-related.
Good general overall feeling.
Skin lesion:

Pain Severity 0 / 10.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma
Dyspnea
Skin neoplasm of uncertain behavior
Rosacea
Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems

Systemic: No systemic symptoms, no fever, no chills, and no recent weight loss.

Head: No head symptoms and no headache.

Neck: No neck symptoms.

Eyes: No eye symptoms.

Otolaryngeal: No otolaryngeal symptoms, no earache, no nasal discharge, no nasal passage blockage, and no sore throat.

Breasts: No breast symptoms.

Cardiovascular: No cardiovascular symptoms and no chest pain or discomfort.

Pulmonary: No pulmonary symptoms, no dyspnea, and no cough.

Gastrointestinal: No gastrointestinal symptoms, no nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No genitourinary symptoms, no change in urinary frequency, and no feelings of urinary urgency. No dysuria.

Endocrine: No endocrine symptoms.

Hematologic: No hematologic symptoms.

Musculoskeletal: No musculoskeletal symptoms and no back pain.

Neurological: No neurological symptoms and no lightheadedness.

Psychological: No psychological symptoms.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Oriented to time, place, and person. • Well developed. • Well nourished. • In no acute distress.

Neck:

Appearance: • Of the neck was normal.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 981

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Palpation: ° No tenderness of the neck.
 Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:
 Pupils: ° PERRL.
 Sclera: ° Normal.

Ears:

General/bilateral:
 Outer Ear: ° Normal.
 Right Ear:
 Tympanic Membrane: ° No bulging tympanic membrane.
 Left Ear:
 Tympanic Membrane: ° No bulging tympanic membrane.

Nose:

General/bilateral:
 Cavity: ° Nasal mucosa normal.
 Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: ° Normal.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Breasts:

General/bilateral:
 ° Appearance of the breast was normal. ° Palpation of the breast revealed no abnormalities.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.
 ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.
 Heart Sounds: ° Normal S1 and S2. ° No S3 heard.
 Murmurs: ° No murmurs were heard.
 Edema: ° Not present.

Abdomen:

Visual Inspection: ° Abdomen was not distended.
 Auscultation: ° Bowel sounds were not diminished or absent.
 Palpation: ° No abdominal tenderness. ° No mass was palpated in the abdomen.
 Liver: ° Normal to palpation.
 Spleen: ° Normal to palpation.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.
 Other:
 General/bilateral: ° No muscle tenderness.

Neurological:

Sensation: ° No sensory exam abnormalities were noted. ° Monofilament wire test of the foot did not show decreased sensation.
 Motor: ° Strength was normal.
 Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.
 Balance: ° Normal.
 Gait And Stance: ° Normal.
 Reflexes: ° Deep tendon reflexes were normal.

Psychiatric:

Mood: ° Euthymic.
 Affect: ° Normal.

Skin:

° Skin: MILD SCALY REDNESS, SOLE OF FEET AND ONE SPOT ON THE SCALP, ° Lesions. ° Showed no ecchymosis.
 ° Temperature was normal.

Practice Management

Preventive medicine services
 Lipid Screening - 19 MAR 2013
 Blood Sugar Screening -
 Aspirin Prophylaxis -
 HIV Screen - 19 MAR 2013.
 Colonoscopy -

 Tetanus (Td/Tdap) - 08 NOV 2005
 Influenza -
 Zoster -

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page 982

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Pneumococcal -
HPV -Men:
Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE ASSUMPTA O @ 10 Apr 2013 1213 EDT

Lipid Panel	Site/Specimen	22 Feb 2012 1006 <o>
Cholesterol	PLASMA	207 (H) <i>
HDL Cholesterol	PLASMA	60 <i>
Triglyceride	PLASMA	183 (H) <i>
LDL Cholesterol	PLASMA	110 (H) <i>

Lab Result Cited by UDE ASSUMPTA O @ 10 Apr 2013 1209 EDT

Basic Metabolic Panel	Site/Specimen	12 Oct 2012 0434
Urea Nitrogen	SERUM	5 (L)
Carbon Dioxide	SERUM	27
Chloride	SERUM	107
Creatinine	SERUM	0.80
Glucose	SERUM	113 (H)
Potassium	SERUM	4.0
Sodium	SERUM	141
Calcium	SERUM	9.2
Anion Gap	SERUM	8
GFR	SERUM	>60 <i>

Lab Result Cited by UDE ASSUMPTA O @ 10 Apr 2013 1208 EDT

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Written by UDE ASSUMPTA O @ 10 Apr 2013 1223 EDT

1. visit for: military services physical(PERIODIC PREVENTION EXAMINATION): I have reviewed all formatted and free text responses on the DD Form 2766. A review of age and gender appropriate preventive medicine task force items were discussed with SM. Included are cancer screening/prevention, CAD, and injury prevention. IN order to reduce TRIGLYCERIDE AND FBS in prediabetes, It was recommended to exercise 160 minutes per week at 80% of the Max heart rate minimum, this does not count warm up and cool down.

2. ANOMALIES OF SKIN: REFERRAL TO DERM

Consult(s): -Referred To: DERMATOLOGY MTF KI (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL
KI Primary Diagnosis: visit for: military services physical

3. IMPAIRED FASTING GLUCOSE: PER 10/12, SIG FAM HX OF T2DM, A1C AND FBG RECHECK

Laboratory(ies): -BASIC METABOLIC PANEL (Routine); HEMOGLOBIN A1C (Routine)

4. ESSENTIAL HYPERTRIGLYCERIDEMIA**Disposition Written by UDE ASSUMPTA O @ 10 Apr 2013 1416 EDT****Released w/o Limitations**

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: MED REC NOT INDICATED

Administrative Options: Consultation requested

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 10 Apr 2013 1416**CHANGE HISTORY***The following SO Note Was Overwritten by UDE, ASSUMPTA O @ 10 Apr 2013 1214 EDT:**SO Note Written by OLAWUMI, OMOWUMI D @ 10 Apr 2013 1134 EDT***Chief complaint**

The Chief Complaint is: NAVY PHA.

History of present illness

The Patient is a 28 year old male.

A PHA has been completed in past year. Date: 10 APR 2013.

In the Navy and currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma

Dyspnea

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 984

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

21 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13070095 Primary Dx: Visit for: follow-up exam

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH
AMBULATORY CARE CENTER**
Patient Status: **Inpatient**Date: **21 Mar 2013 0914 EDT**
Clinic: **IMMUNIZATION KI**
Inpatient Location: **ABAA**Appt Type: **PROC**
Provider: **MASON,HAZEL J**AutoCites Refreshed by MASON,HAZEL J @ 21 Mar 2013 1042 EDT**Problems****Chronic:**

- Visit for: ears/hearing exam
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Allergies

•OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment: Written by RYAN,LINDSEY O @ 21 Mar 2013 0914 EDT
ppd checkA/P Written by MASON,HAZEL J @ 21 Mar 2013 1157 EDT

1. visit for: follow-up exam: PPD check today, noted to be negative 0mm, reinforce to patient on the negative reaction versus the positive, verbalize understanding

Disposition Written by MASON,HAZEL J @ 21 Mar 2013 1201 EDT**Continued Stay****Follow up:** as needed with PCM. - Comments: PPD check today, noted to be negative 0mm, reinforce to patient on the negative reaction versus the positive, verbalize understanding**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By MASON, HAZEL J (LPN, NNMC Bethesda, MD) @ 21 Mar 2013 1201

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13045263 Primary Dx: Visit for: occupational health / fitness exam

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: KIMBROUGH
AMBULATORY CARE CENTER
Patient Status: InpatientDate: 19 Mar 2013 1225 EDT
Clinic: HEARING CONS KI
Inpatient Location: ABAAAppt Type: SPEC
Provider: PERRY, CHARLESAutoCites Refreshed by PERRY, CHARLES @ 19 Mar 2013 1357 EDT**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment: Written by PERRY, CHARLES @ 19 Mar 2013 1225 EDT
ANNAUL HEARING EXAMSO Note Written by PERRY, CHARLES @ 19 Mar 2013 1357 EDT**Reason for Visit**

Visit for: occupational health/fitness exam

- ☐ New Hire
- ☐ Periodic Medical Surveillance
- ☒ Military hearing
- ☐ Deployment

Following tests were ordered:

- ☒ Audio exam
- ☐ DD 2215
- ☒ DD 2216
- ☐ 4700
- ☐ Termination

Results:

- ☒ No STS noted
- ☐ STS noted. Scheduled for a follow-up exam.
- ☐ Referred to audiologist.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 986

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

- ☐ New Hire
- ☐ Periodic Medical Surveillance
- ☒ Military hearing
- ☐ Deployment
- ☐ Post Deployment

Results:

- ☒ No STS noted
- ☐ STS noted. Scheduled for a follow-up exam- #1 [] ; #2 []
- ☐ Referred to audiologist

☐ Ear wax noted. Moderate amount of wax does not preclude testing. Patient advised to talk with his physician/pharmacist about cleaning of ear/s.

To continue annual job related medical surveillance.

DISCUSSED THE FOLLOWING:

- ☒ Counseled on symptoms of occupational illnesses, wearing of protective equipment and need for medical surveillance.
- ☒ Discussed effects of noise on hearing; hearing protection - its purpose, advantages, and disadvantages; various types of ear protection, sizes, uses, and care, testing and today's testing results, and hearing conservation.
- ☒ Employee verbalized understanding of above counseling.

A/P Written by PERRY, CHARLES @ 19 Mar 2013 1358 EDT

1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION)
 2. visit for: ears / hearing exam (OTHER EXAMINATION OF EARS AND HEARING, OTOSCOPIC EXAM DONE)
- Procedure(s): -Threshold Audiogram (Pure Tone) x 1

Disposition Written by PERRY, CHARLES @ 19 Mar 2013 1358 EDT
Continued Stay

Signed By PERRY, CHARLES (Physician/Workstation) @ 19 Mar 2013 1358

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

19 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13039226 Primary Dx: Need For Vaccination Typhoid

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH
 AMBULATORY CARE CENTER**
 Patient Status: **Inpatient**

Date: **19 Mar 2013 0852 EDT**
 Clinic: **IMMUNIZATION KI**
 Inpatient Location: **ABAA**

Appt Type: **PROC**
 Provider: **WRAY,KIM D**

AutoCites Refreshed by WRAY,KIM D @ 19 Mar 2013 0853 EDT**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Procedures

- CASE MANAGEMENT, EACH 15 MINUTES (12 Oct 2012)
- COORDINATED CARE FEE, MAINTENANCE RATE (12 Oct 2012)
- Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral (29 Mar 2011)
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) (24 Mar 2011)

Active Medications

No Active Medications Found.

Reason for Appointment: Written by WRAY,KIM D @ 19 Mar 2013 0852 EDT
 imm update

Questionnaire AutoCites Refreshed by WRAY,KIM D @ 19 Mar 2013 0853 EDT
Questionnaires

SO Note Written by WRAY,KIM D @ 19 Mar 2013 0855 EDT

Vaccinations

- Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Therapy

- Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record.

Practice Management

Patient information sheet: Given to _x_Patient__ Parent__ Guardian on Vaccination Information Statement(s)

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 988

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

A/P Last Updated by WRAY, KIM D @ 19 Mar 2013 0856 EDT

1. Need For Vaccination Typhoid

Procedure(s): -Typhoid Vaccine Vi Capsular Polysaccharide, For Intramus Use x 1 - Typhoid, ViCPs; Series #: 1; .5 mL; IM; Right Arm; Mfg: Sanofi Pasteur; Lot: H1481; VIS given (Ver: 05/29/12).
-Immunization Administration One Vaccine x 1

2. Need For Vaccination DTP + TAB

Procedure(s): -Tdap Vaccine x 1 - Tdap; Series #: 1; .5 mL; IM; Left Arm; Mfg: Sanofi Pasteur; Lot: U4422AA; VIS given (Ver: 01/24/12).
-Immunization Administration Each Additional Vaccine x 1

3. visit for: screening exam pulmonary tuberculosis

Procedure(s): -Skin Test Anergy Tuberculin Intradermal x 1 - IPPD; Series #: 1; .1 mL; ID; Left Arm; Mfg: Other; Lot: 293239; VIS given.

Disposition Last Updated by WRAY, KIM D @ 19 Mar 2013 0856 EDT

Continued Stay

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By WRAY, KIM D (LPN, Kimbrough Ambulatory Care Center, Ft Meade, MD) @ 19 Mar 2013 0908

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

28 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-12473998 Primary Dx: Visit for: screening exam STD

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
Patient Status: **Outpatient**Date: **28 Jan 2013 1020 EST**
Clinic: **FAM PRACTICE KI**Appt Type: **ROUT**
Provider: **UDE,ASSUMPTA O**AutoCites Refreshed by OLAWUMI, OMOWUMI D @ 23 Jan 2013 0904 EST**Problems**

- Chronic:
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

Ude Personal

Appointment Comments:

agm/kacc

Screening Written by OLAWUMI, OMOWUMI D @ 23 Jan 2013 0905 EST**Reason For Appointment:** Ude Personal

Allergen information verified by OLAWUMI, OMOWUMI D @ 23 Jan 2013 0905 EST

VitalsVitals Written by OLAWUMI, OMOWUMI D @ 28 Jan 2013 1019 ESTBP: 124/72 Right Arm, Adult Cuff, HR: 73 Radial Artery, RR: 18, T: 97.3 °F Oral, HT: 69 in Stated, WT: 156.4 lbs Upright Scale, Actual, With Shoes, SpO₂: 97%, BMI: 23.1, BSA: 1.861 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain FreeSO Note Written by UDE, ASSUMPTA O @ 28 Jan 2013 1049 EST**Chief complaint**

The Chief Complaint is: STD SCREENING.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF-CORE>> PRESENTS FOR STD SCREENING, POSSIBLE EXPOSURE TO HERPES, 15 PARTNERS IN PAST 1 YR

Currently on active duty. Visit is not deployment-related.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 990

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

General overall feeling - Very Good.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma

Dyspnea

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems**Systemic:** No generalized pain and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Neck:** No neck pain and no swollen glands in the neck.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage, and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea, no cough, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No hematuria, no change in urinary frequency, and no feelings of urinary urgency. No urinary loss of control, no dysuria, and no pain in the flank. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Skin:** No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Oriented to time, place, and person. • Well developed. • Well nourished. • In no acute distress.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Auscultation: • Bowel sounds were diminished or absent.

Palpation: • No abdominal tenderness. • No mass was palpated in the abdomen.

Liver: • Normal to palpation.

Spleen: • Normal to palpation.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Skin:

• Showed no ecchymosis. • Temperature was normal. • No skin lesions.

Practice Management

Preventive medicine services

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Lipid Screening - 22 FEB 2012.
 Blood Sugar Screening -
 Aspirin Prophylaxis -
 HIV Screen - 22 FEB 2012.
 Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005
 Influenza -
 Zoster -
 Pneumococcal -
 HPV -

Men:
 Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE ASSUMPTA O @ 28 Jan 2013 1037 EST

HIV-1/O/2 Ab	Site/Specimen	22 Feb 2012 1006
HIV-1/O/2 Ab	SERUM	Negative <0>

A/P Written by UDE ASSUMPTA O @ 28 Jan 2013 1049 EST**1. visit for: screening exam venereal disease**

Laboratory(ies): -HIV-1/O/2 (Routine); URINALYSIS PANEL (Routine); RAPID PLASMA REAGIN (Routine);
 GC/CHLAMYDIA NAAT (Routine); HERPES SIMPLEX VIRUS IGG 1+2 (Routine)

2. Anticipatory Guidance: Unsafe Sexual Practices: MULTIPLE SEX PARTNERS IN 1 YR, INC RISK FOR STD, 100PERCENT USE OF CONDOM ADVISED**Disposition Written by UDE ASSUMPTA O @ 28 Jan 2013 1104 EST****Released w/o Limitations**

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: MED REC NOT INDICATED

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 28 Jan 2013 1104**CHANGE HISTORY**

The following SO Note Was Overwritten by UDE ASSUMPTA O @ 28 Jan 2013 1034 EST:

SO Note Written by OLAWUMI, OMOWUMI D @ 28 Jan 2013 1026 EST

Chief complaint

The Chief Complaint is: STD SCREENING.

History of present illness

The Patient is a 27 year old male.
 He reported: Currently on active duty. Visit is not deployment-related.
 General overall feeling - Very Good.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma
 Dyspnea
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services

Lipid Screening - 22 FEB 2012.

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 22 FEB 2012.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 993

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

30 Nov 2012 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-11987536 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH
 AMBULATORY CARE CENTER**
 Patient Status: **Outpatient**

Date: **30 Nov 2012 0840 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **ACUT**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI, OMOWUMI D @ 29 Nov 2012 1403 EST**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Need for prophylactic measure

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

Reason for Appointment:

UDE: ACNE

Appointment Comments:

TCB

Screening Written by OLAWUMI, OMOWUMI D @ 29 Nov 2012 1353 EST**Reason For Appointment:** UDE: ACNE

Allergen information verified by OLAWUMI, OMOWUMI D @ 29 Nov 2012 1353 EST

Vitals**Vitals** Written by OLAWUMI, OMOWUMI D @ 30 Nov 2012 0830 EST

BP: 120/76 Left Arm, Adult Cuff, HR: 66 Radial Artery, RR: 18, T: 97.5 °F Oral, HT: 69 in Stated, WT: 145 lbs Stated,
 SpO₂: 100%, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 0 Pain Free

SO Note Written by UDE, ASSUMPTA O @ 30 Nov 2012 0845 EST**Chief complaint**

The Chief Complaint is: RASH.

History of present illness

The Patient is a 27 year old male.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 994

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

<<Note accomplished in TSWF-CORE>> ACTIVE DUTY PRESENTS FOR 2 WEEKS OF INFLAMED PUSTULAR FLUCTUANT RASHES ALONG THE BEARD THAT POPS OUT WITH HAIR FOLLICULES AND PUSSY DRAINAGE, HE SHAVES WITH SHAVING CREAM AND BLADE, NO OTHER AREA OF SKIN AFFECTED.

Currently on active duty. Visit is not deployment-related.
Good general overall feeling.
Rash:

Pain Severity 0 / 10.
PHQ-2 Depression Screen Negative.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Asthma
Dyspnea
Skin neoplasm of uncertain behavior
Rosacea
Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/29/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, no night sweats, and no recent weight gain.

Endocrine: No flushing.

Skin: No pruritus. No skin lesions.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Well developed. • Well nourished. • In no acute distress.

Musculoskeletal System:

Other:

General/bilateral: • Muscle tenderness.

Skin:

• Skin: TENDER INFLAMED BUMP AND MULTIPLE OPEN SCARS FROM OLD PUSTULAR RASH ALONG THE BEARD.
• Showed ecchymosis. • Lesions. • Temperature was normal.

Practice Management

Preventive medicine services

Lipid Screening - 22 FEB 2012.

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 22 FEB 2012.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Influenza -
 Zoster -
 Pneumococcal -
 HPV -

Men:
 Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

A/P Written by UDE, ASSUMPTA O @ 30 Nov 2012 1434 EST

1. FOLLICULITIS: Afebrile, PUSTULAR PER SELF REPORT, on exam non pustular nodular tender lesion- TOPICAL AND ORAL ANTIBIOTIC

Medication(s): -SKIN CLEANSING LOTION-TOP LOTN - USE INSTEAD OF SOAP UD #1 RF0 Qt: 1 Rf: 0
 -CLINDAMYCIN-TOP 1% GEL - APPLY TO RASH AREA ALONG THE BEARD BID X 7DAYS #1 RF0
 Qt: 1 Rf: 0
 -TRIMETHOPRIM/SULFAM--PO 160/800MG TAB - 1 TAB PO BID #20 RF0 Qt: 20 Rf: 0

Disposition Written by UDE, ASSUMPTA O @ 30 Nov 2012 1434 EST

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: MED REC DONE AND LIST GIVEN TO PT

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 30 Nov 2012 1434

CHANGE HISTORY

The following SO Note Was Overwritten by UDE, ASSUMPTA O @ 30 Nov 2012 0848 EST:

SO Note Written by OLAWUMI, OMOWUMI D @ 30 Nov 2012 0837 EST

Chief complaint

The Chief Complaint is: RASH/ ACNE.

History of present illness

The Patient is a 27 year old male.

He reported: Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Asthma
 Dyspnea
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/29/2012

What is your preferred method of learning? ☐ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:**PCM:****Practice Management**

Preventive medicine services
 Lipid Screening - 22 FEB 2012.
 Blood Sugar Screening -
 Aspirin Prophylaxis -
 HIV Screen - 22 FEB 2012.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page 996

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 30 Oct 2017

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 997

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

05 Nov 2012 at WRNMMC, AMH M01B Blue Ki by DING, YIMING

Encounter ID: BETH-11743237 Primary Dx: Need For Prophylactic Measure

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **05 Nov 2012 0820 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **EST**
 Provider: **DING, YIMING**

AutoCites Refreshed by SPINKS, JEAN M @ 05 Nov 2012 0845 EST**Problems**

- Chronic:**
- Abdominal pain
 - Conditions influencing health status
 - Asthma
 - Postsurgical state of eye and adnexa
 - Dyspnea
 - Skin neoplasm of uncertain behavior
 - Removal of sutures
 - Extrinsic asthma
 - Rosacea
 - Lattice peripheral retinal degeneration
 - Myopia
 - Allergic rhinitis
 - Visit for: occupational health/fitness exam
 - Parent education about immunizations
 - Visit for: military services physical
 - Exposure to venereal disease
 - Inquiry and counseling about contraceptive practices
 - Visit for: administrative purposes

Acute:

- Nonspecific abnormal imaging findings

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

Reason for Appointment:

Ude Discuss Vasectomy

Appointment Comments:

agm/kacc

Screening Written by SPINKS, JEAN M @ 05 Nov 2012 0838 EST**Reason For Appointment:** Ude Discuss Vasectomy

Allergen information verified by SPINKS, JEAN M @ 05 Nov 2012 0838 EST

Vitals**Vitals Written by SPINKS, JEAN M @ 05 Nov 2012 0842 EST**BP: 122/84 Right Arm, Adult Cuff, HR: 65, RR: 18, T: 97.7 °F, SpO₂: 97%**Vitals Written by SPINKS, JEAN M @ 05 Nov 2012 0841 EST**

HT: 69 in Stated, Without Shoes, WT: 152 lbs Upright Scale, Actual, With Shoes, BMI: 22.45, BSA: 1.838 square meters, Tobacco Use: No,

Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 1 DRINK A DAY, Pain Scale: 0 Pain Free

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page 998

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

SO Note Written by DING.YIMING @ 05 Nov 2012 1131 EST**Chief complaint**

The Chief Complaint is: DISCUSS VASECTOMY.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF-CORE>> 27 Y/O MALE IS HERE FOR REFERRAL. FOR VASECTOMY.

A PHA has been completed in past year. Date: FEB 2012.

Medication list reviewed with patient, reconciliation completed.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Current medication

NO CURRENT MEDS.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/05/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems**Systemic:** No fever and no chills.**Neck:** No neck pain and no swollen glands in the neck.**Cardiovascular:** No palpitations.**Pulmonary:** No paroxysmal nocturnal dyspnea, no orthopnea, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, and no abdominal pain.**Musculoskeletal:** No limb swelling.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Oriented to time, place, and person.

Lungs:

• Clear to auscultation.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Auscultation: • Bowel sounds were not diminished or absent.

Palpation: • No abdominal tenderness. • No mass was palpated in the abdomen.

Liver: • Normal to palpation.

Spleen: • Normal to palpation.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[4] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page 999

AR 1044

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

How often did you have six or more drinks on one occasion in the past year?
(0) 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

AUDIT-C Score= 4 DATE ACCOMPLISHED: 11/05/2012

☒ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)**Practice Management**

Patient exercises for at least 30 minutes a day.

A/P Written by DING, YIMING @ 05 Nov 2012 0853 EST**1. Need For Prophylactic Measure**

Consult(s):

-Referred To: UROLOGY MTF KI (Routine) Specialty: UROLOGY Clinic: UROLOGY CL KI Primary
Diagnosis: Need For Prophylactic MeasureDisposition Written by DING, YIMING @ 05 Nov 2012 1134 EST**Released w/o Limitations**

Follow up: as needed with PCM and/or in the FAM PRACTICE KI clinic. - Comments: Med rec not indicated, Master Problem list reconciliation completed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

Signed By DING, YIMING (MD, KACC) @ 05 Nov 2012 1134

CHANGE HISTORY*The following SO Note Was Overwritten by DING, YIMING @ 05 Nov 2012 1031 EST.**SO Note Written by SPINKS, JEAN M @ 05 Nov 2012 0838 EST***Chief complaint**

The Chief Complaint is: DISCUSS VASECTOMY.

History of present illness

The Patient is a 27 year old male.

A PHA has been completed in past year. Date: FEB 2012.

Medication list reviewed with patient, reconciliation completed.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Patient feels safe at home.

Current medication

NO CURRENT MEDS.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/05/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

(4) 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

(0) 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1000

AR 1045

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

AUDIT-C Score= 4 DATE ACCOMPLISHED: 11/05/2012

[X] Negative AUDIT-C

[] Positive AUDIT-C >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Practice Management

Patient exercises for at least 30 minutes a day.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

24 Oct 2012 at WRNMMC, FLU CI Ki by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-11655430 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: HQS IMCOM G1
ARMY SUBSTANCE ABUSE PROGRAM
Patient Status: InpatientDate: 24 Oct 2012 0848 EDT
Clinic: SRP CL KI
Inpatient Location: ABAAAppt Type: PROC
Provider: JACOBS, MILLASENT J

Reason for Appointment: FLU MIST

AutoCites Refreshed by JACOBS, MILLASENT J @ 26 Oct 2012 1135 EDT**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Nonspecific abnormal imaging findings

Family History

- No Family History of malignant neoplasm of the large intestine (General FHx)
- No Family History of malignant neoplasm of the gastrointestinal tract (General FHx)
- No Family History of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

SO Note Written by RIKAS, MEGAN M @ 24 Oct 2012 0849 EDT**Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 27 year old male. Source of patient information was patient. Past medical history reviewed.

Allergies

Reviewed no allergies. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

- Received dose of influenza live virus vaccine, for intranasal use .FLUMIST
MANUFACTURED BY: MEDIMMUNE LLC
LOT #: AH2139 EXPIRATION DT: 3DEC2012
DOSE GIVEN: 0.2ML (0.1ML PER NOSTRIL)
INJECTION GIVEN INTRANASAL

Past medical/surgical history

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Reported History:

Recent events: No active illness.

Review of systems

Systemic symptoms: No fever.

Counseling/Education

- Patient education about adverse reactions to medication Patient instructed to remain in clinic for 20 minutes post vaccination.
- Patient educated regarding possible side effects: soreness\ redness\ or swelling at the site of injection\ Fever\

A/P Written by RIKAS,MEGAN M @ 24 Oct 2012 0850 EDT

1. Vaccines Prophylactic Need Against Influenza

Procedure(s):
-Influenza Virus Vaccine Live Intranasal x 1
-Immunization Administration One Vaccine x 1
-Immunization Admin By Intranasal / Oral Route One Vaccine x 1

Disposition Last updated by JACOBS,MILLASENT J @ 26 Oct 2012 1138 EDT

Continued Stay

Follow up: as needed .

Discussed: Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding.

Signed By JACOBS, MILLASENT J (Physician/Workstation) @ 26 Oct 2012 1138

CHANGE HISTORY

The following Disposition Note Was Overwritten by JACOBS,MILLASENT J @ 26 Oct 2012 1137 EDT:

The Disposition section was last updated by JACOBS,MILLASENT J @ 26 Oct 2012 1137 EDT - see above.Previous Version of Disposition section was entered/updated by RIKAS,MEGAN M @ 24 Oct 2012 0850 EDT.

Continued Stay

Follow up: as needed with PCM.

Discussed: Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

23 Oct 2012 at WRNMMC, GI Inflamm Bowel Dis Be by COPSEY, HELEN C

Encounter ID: BETH-11637615 Primary Dx: Imaging Studies Nonspecific Abnormal Findings

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: OutpatientDate: 23 Oct 2012 0800 EST
Clinic: GI Inflamm Bowel Dis BeAppt Type: SPEC
Provider: COPSEY, HELEN CAutoCites Refreshed by COPSEY, HELEN C @ 23 Oct 2012 0756 EST**Problems****Chronic:**

- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by FARRINGTON, SHAUN C @ 23 Oct 2012 0739 EDT

BP: 114/66, HR: 79, T: 95.4 °F, HT: 5' 9", WT: 147 lbs, SpO₂: 97%, BMI: 21.71, BSA: 1.812 square meters,
Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,
Have people Annoyed you by criticizing or complaining about your drinking? No,
Have you ever felt bad or Guilty about your drinking? No,
Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
Alcohol Comments: COUPLE DRINKS/WEEK, Pain Scale: 0 Pain Free

SO Note Written by COPSEY, HELEN C @ 24 Oct 2012 0936 EST**Reason for Visit**

Visit for: R/O of IBD.

History of present illness

The Patient is a 27 year old male.

This is a WM, AD PO2, who presents for R/O of IBD. He reports a long history of presumed IBS presenting with intermittent lower abdominal cramping that occurs several times per week, and is triggered by dairy intake, anxiety, and physical activity. This can be associated with looser stool and mild urgency, although in general he reports a soft stool each day. An evaluation for these symptoms along with isolated BRBPR in 2005 (IL) includes a CT scan showing moderate stool retention in the colon, and a flex sig that was reportedly limited d/t patient discomfort. He denies any rectal bleeding since that time. He does endorse occasional oral aphthi but otherwise denies any additional complaints. His weight has been stable.

Earlier this month he experienced worsening of his baseline abdominal pain, possibly precipitated by consuming a milk-shake. A CT in the ER showed focal colitis at the right colon (hepatic flexure) with fecalization of the small bowel, concerning for IBD. CRP was 1.2, labs otherwise nl. A follow-up colonoscopy with Dr. McNally showed cogested appearing mucosa in the left colon. Images of the right colon/ cecum are limited due to liquid stool, and the TI was not intubated per report. Biopsies are pending. The patient reports self-resolution of the pain, and has since been feeling back to baseline.

Allergies

ASA- (nausea).

Past medical/surgical history

Reported:

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1004

AR 1049

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Past medical history

- Allergic asthma (cats); Headache, NOS

Surgical / Procedural: Prior surgery

- PRK, Tonsillectomy

Medications: Medication history

- Albuterol, Aleve prn (less than once per week)

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

Pre-op ASA class 1

Previous therapy

History of possible limitations and risks do not include complications from anesthesia

Personal history

Tob: (-)

Etoh: (2 drinks every other day)

Drug use: (-)

Family history

No chronic liver disease

No malignant neoplasm of the large intestine

No malignant neoplasm of the gastrointestinal tract

No known FH of IBD, autoimmune diseases.

Review of systems

Systemic: Not feeling tired (fatigue). No fever, no chills, no night sweats, and no recent weight loss.

Head: No headache.

Eyes: No vision problems.

Otolaryngeal: No hoarseness, no lump in the throat, and no mouth sores.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: No dyspnea and no cough.

Gastrointestinal: No dysphagia, no pain on swallowing, no heartburn, no regurgitation, no early satiety, no nausea, no vomiting, no hematemesis, no hematemesis ('coffee grounds'), no abdominal swelling, no jaundice, no recent increase in bowel frequency, and not decrease. No tenesmus, no melena, no hematochezia, no acholic stools, no steatorrhea, and stool diameter is not smaller. No change in consistency of stool and no nocturnal diarrhea. No rectal pain.

Genitourinary: No urinary symptoms.

Endocrine: No endocrine symptoms.

Hematologic: No tendency for easy bruising.

Musculoskeletal: No arthralgias, new. No nonspecific pain, swelling, and stiffness.

Neurological: No confusion and no memory lapses or loss.

Psychological: Mood was euthymic and no sleep complaints.

Skin: No pruritus, no change in skin texture, new, and no rash, new.

Physical findings**Vital Signs:**

° Current vital signs reviewed.

Standard Measurements:

° Patient was not observed to be obese.

General Appearance:

° Awake. ° Alert. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress. ° Patient did not appear uncomfortable. ° Not acutely ill. ° Not chronically ill.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Sclera: ° Showed no icterus.

Oral Cavity:

° Normal OP clear, Mallampati score = 1.

Chest:

° Visual inspection revealed no abnormalities.

Lungs:

° Normal CTA B.

Cardiovascular:

° System: normal RRR, no M or G.

Abdomen:

° Normal soft, NT/ND, +BS.

Neurological:

° Level of consciousness was normal.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Speech: ° Normal.
Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.

Skin:

° General appearance was normal. ° No jaundice. ° No skin lesions.

Therapy

• Medical regimen review – medication reconciliation performed.

Lab Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EST

ESR	Site/Specimen	12 Oct 2012 1209
ESR	BLOOD	10
C-Reactive Protein	Site/Specimen	12 Oct 2012 1209
C-Reactive Protein	SERUM	1.206 (H)
Magnesium	Site/Specimen	12 Oct 2012 0434
Magnesium	SERUM	2.1
Phosphorus	Site/Specimen	12 Oct 2012 0434
Phosphate	SERUM	3.5
Basic Metabolic Panel	Site/Specimen	12 Oct 2012 0434
Urea Nitrogen	SERUM	5 (L)
Carbon Dioxide	SERUM	27
Chloride	SERUM	107
Creatinine	SERUM	0.80
Glucose	SERUM	113 (H)
Potassium	SERUM	4.0
Sodium	SERUM	141
Calcium	SERUM	9.2
Anion Gap	SERUM	8
GFR	SERUM	>60 <i>
CBC W/o Diff	Site/Specimen	12 Oct 2012 0434
WBC	BLOOD	5.5
RBC	BLOOD	4.02 (L)
Hemoglobin	BLOOD	13.1
Hematocrit	BLOOD	38.1
MCV	BLOOD	94.9
MCH	BLOOD	32.6
MCHC	BLOOD	34.3
Platelets	BLOOD	264
RDW CV	BLOOD	13.1
MPV	BLOOD	7.8
Neutrophil Cytoplasmic Ab (ANCA)	Site/Specimen	11 Oct 2012 1147
Myeloperoxidase Ab	SERUM	<0.2 <i>
Proteinase 3 Ab	SERUM	<0.2 <i>
Neutrophil Cytoplasmic Ab (ANCA) Screen W/Reflex Titer	Site/Specimen	11 Oct 2012 1147
Neutrophil Cytoplasmic Ab Cytoplasmic	SERUM	Titer not indicated-ANCA screen Negative
Neutrophil Cytoplasmic Ab Perinuclear	SERUM	Titer not indicated-ANCA screen Negative
Neutrophil Cytoplasmic Ab	SERUM	Negative
Neutrophil Cytoplasmic Ab Perinuclear Atypical	SERUM	Titer not indicated-ANCA screen
Negative <r> <i>		
Carcinoembryonic Ag	Site/Specimen	11 Oct 2012 1147
Carcinoembryonic Ag	SERUM	0.9 <i>
Magnesium	Site/Specimen	11 Oct 2012 1147
Magnesium	SERUM	2.3
Amylase	Site/Specimen	11 Oct 2012 1147

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Amylase	SERUM	49
Comprehensive Metabolic Panel	Site/Specimen	11 Oct 2012 1147
Albumin	SERUM	4.7
Alkaline Phosphatase	SERUM	56
Alanine Aminotransferase	SERUM	33
Aspartate Aminotransferase	SERUM	29
Bilirubin	SERUM	0.5
Urea Nitrogen	SERUM	9
Calcium	SERUM	9.5
Carbon Dioxide	SERUM	29
Chloride	SERUM	101
Creatinine	SERUM	0.85
Glucose	SERUM	82
Potassium	SERUM	4.0
Protein	SERUM	7.3
Sodium	SERUM	139
Anion Gap	SERUM	9
GFR	SERUM	>60 <i>

Lipase	Site/Specimen	11 Oct 2012 1147
Triacylglycerol Lipase	SERUM	19

Phosphorus	Site/Specimen	11 Oct 2012 1147
Phosphate	SERUM	3.5

CBC W/Diff	Site/Specimen	11 Oct 2012 1147
WBC	BLOOD	6.4
RBC	BLOOD	4.30
Hemoglobin	BLOOD	14.1
Hematocrit	BLOOD	41.0
MCV	BLOOD	95.4
MCH	BLOOD	32.6
MCHC	BLOOD	34.2
RDW CV	BLOOD	13.1
Platelets	BLOOD	268
MPV	BLOOD	8.3
Neutrophils	BLOOD	72.7
Lymphocytes	BLOOD	18.1
Monocytes	BLOOD	7.1
Eosinophils	BLOOD	1.8
Basophils	BLOOD	0.3
Neutrophils	BLOOD	4.6
Lymphocytes	BLOOD	1.2
Monocytes	BLOOD	0.5
Eosinophils	BLOOD	0.1
Basophils	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED

Rad Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EST

MERWIN, DANIEL DENNIS 20 [REDACTED] 27yo [REDACTED] 1985 M

***** CT, ABD/PELVIS W/ CONTRAST *****

POC Enc: #E923164 POC Fac: NH Great Lakes IL

Status: Complete

Procedure: CT, ABD/PELVIS W/ CONTRAST

Event Date: 22-Nov-2005 10:48:00

Order Comment: NO BRIEF COMMENT

Reason for Order:

20y/o male dot 2-5 with intermittent abdominal pain x 4-5 years with rectal bleeding on 19th of NOV.Had normal sigmoidoscopy to proximal transverse colon

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-2[REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page

1007

AR 1052

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

and mild int hemorrhoids done on Nov 21.

Exam #: 05050343

Exam Date/Time: 23-Nov-2005 09:26:00

Transcription Date/Time: 29-Nov-2005 10:02:00

Provider: ARTATES, NEMESIA F

Requesting Location:

COURAGE (WHITE) 1007 NBHC 1007/1017

Status: COMPLETE

Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MARINBERG, BORIS V

Approved By: MARINBERG, BORIS V

Approved Date: 29-Nov-2005 12:25:00

Report Text:

ba/DICTATION DATE: 23 November 2005

CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST:

Technique: 7.5 mm cross-sectional images of the abdomen and pelvis were obtained following oral and intravenous introduction of contrast.

Findings: There is a normal appearance of the liver, spleen, and pancreas. There is no gallstones. No dilatation of biliary ducts or pancreatic duct identified. There is no enlargement of the adrenal glands. There is no hydronephrosis. No renal stones are seen. There is no lymphadenopathy. No abnormal collection of fluid in the abdomen or pelvis identified. Moderate amount of fecal material noted throughout the colon. There is no changes of appendicitis. No aneurysmal dilatation of the abdominal aorta noted. There is no signs of bowel obstruction.

IMPRESSION: NORMAL COMPUTED TOMOGRAPHY OF THE ABDOMEN AND PELVIS.**MODERATE AMOUNT OF FECAL MATERIAL THROUGHOUT THE COLON.**Rad Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0956 EST**MERWIN, DANIEL DENNIS 20 [REDACTED] 27yo [REDACTED] 1985 M**

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)

Event Date: 11-Oct-2012 01:30:00

Exam #: 12343907

Exam Date/Time: 11-Oct-2012 00:30:00

Transcription Date/Time: 12-Oct-2012 07:00:00

Provider: HARDWARE, LESLIE

Requesting Location:

EMERGENCY RM BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN
Approved By: BERNARD, JACQUELINE M
Approved Date: 11-Oct-2012 08:16:00
Supervised By: BERNARD, JACQUELINE, MD, CDR, USN
Supervised By Date: 11-Oct-2012 08:16:00
Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12 Time:08:16

A/P Last Updated by COPSEY, HELEN C @ 24 Oct 2012 1002 EST

1. Imaging Studies Nonspecific Abnormal Findings: CT concerning for colitis and fecalization of SB ? radiographic artifact, constipation, acute vs. chronic inflammation, stenosis. Colonoscopy with limited evaluation of right colon, ICD, distal ileum.

Recommend MRE for further evaluation of small bowel as d/w Dr. Kikendall. He may ultimately require repeat colonoscopy, however will await biopsy results prior to determining next steps. Patient voices understanding/ agreement.

2. abdominal pain: Patient with long history of intermittent abdominal pain ? due to IBS vs. dietary intolerance vs. inflammatory. Will proceed with evaluation to r/o IBD, however if negative encouraged patient to continue f/u with GI for management of chronic symptoms.

Disposition Last Updated by COPSEY, HELEN C @ 24 Oct 2012 1003 EST

Released w/o Limitations

Follow up: in the GI INFLAM BOWEL DIS BE clinic. - Comments: Will call pt 850-602-8501 after obtaining pathology and discussing need for repeat colonoscopy with IBD staff.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments:

45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BROWN, CANDICE C @ 23 Oct 2012 0738 EST

Consult Order

Referring Provider: SALTER, CAROLYN A

Date of Request: 12 Oct 2012

Priority: ASAP

Provisional Diagnosis:

IBD vs mass

Reason for Request:

27 y/o male w/ ascending colon inflammation s/p colonoscopy 12 OCT. Pt needs GI f/u to discuss results.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 24 Oct 2012 1003

Note Written by COPSEY, HELEN C @ 24 Oct 2012 1004 EST

(Added after encounter was signed.)

PATH

PATH

Spoke with Dr. Barner re: patient's pathology results- not yet placed into CHCS. Biopsies of left-colon show benign colonic mucosa, without active inflammation, chronicity or architectural distortion.

Note Written by COPSEY, HELEN C @ 08 Nov 2012 1503 EST

(Added after encounter was signed.)

MRE results

MRE d/w patient- essentially nl specifically right colon/T1, will review at IBD conference. Pt denies any continued pain. Will defer repeat COLO for now, however reconsider pending progress. Would re-check CRP, which should be down from hospitalization. Pt v/u.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

12 Oct 2012 at WRNMMC, Wounded Warrior GWOT by AGOSTO, ROBERT

Encounter ID: BETH-11525944 Primary Dx: Conditions influencing health status

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: WALTER REED
NATIONAL MILITARY MEDICAL CNTR
Patient Status: Inpatient

Date: 12 Oct 2012 0805 EDT
Clinic: WOUNDED WARRIOR GWOT
Inpatient Location: ABAA

Appt Type: ACUT
Provider: AGOSTO, ROBERT

Reason for Appointment: Written by AGOSTO, ROBERT @ 12 Oct 2012 0805 EDT
Admission screening for CM services

A/P Last Updated by AGOSTO, ROBERT @ 12 Oct 2012 0808 EDT

1. Conditions Influencing health status (OTHER SPECIFIED CONDITIONS INFLUENCING HEALTH STATUS OTHER):
WRNMMC Case Management Department reviews active duty inpatient admissions to assess potential need for case management services. In reviewing this ADMS medical record we have determined case management services by WRNMMC staff are not indicated at this time because: Patient is enrolled to Kimbrough and we have contacted that MTF's NCM ms Deborah Jolissaint, RN via email to advise of admission; .
Robert Agosto, LPN
Case Management Assistant, WRNMMC
301-295-0657

Procedure(s): -COORDINATED CARE FEE, MAINTENANCE RATE x 1
-CASE MANAGEMENT, EACH 15 MINUTES x 1

Disposition Last Updated by AGOSTO, ROBERT @ 12 Oct 2012 0809 EDT
Continued Stay

Signed By AGOSTO, ROBERT (LPN Case Management Assistant) @ 12 Oct 2012 0809
Co-Signed By MELENDEZ-WARREN, DORIS J (RN Case Manager, NNMC Bethesda) @ 12 Oct 2012 0920

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

14 May 2012 at NH Pensacola FL, Corry MHP by BRADLEY, RACHAEL NAOMI

Encounter ID: PENS-6872482

Primary Dx:

VIRAL SYNDROME

Patient: MERWIN, DANIEL DENNIS

Date: 14 May 2012 0855 CDT

Appt Type: ACUT

Treatment Facility: NBHC NTTC

Clinic: CORRY MED HOME CLINIC

Provider: BRADLEY, RACHAEL NAOMI

Pensacola

Patient Status: Outpatient

AutoCites Refreshed by BRADLEY, RACHAEL N @ 14 May 2012 0901 CDT**Problems****Chronic:**

- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Viral syndrome

Family History

- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

cough/fever

Appointment Comments:

mmr

VitalsVitals Written by GARZA, OMAR @ 14 May 2012 0844 CDT

BP: 120/76, HR: 90, RR: 14, T: 98.5 °F, HT: 69 in, WT: 146 lbs, BMI: 21.56, BSA: 1.807 square meters,

Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 0 Pain Free

Comments: NKDA

POC -8506028501

SO Note Written by BRADLEY, RACHAEL NAOMI @ 15 May 2012 1520 CDT**Chief complaint**

The Chief Complaint is: Cough/vomiting.

History of present illness

The Patient is a 27 year old male.

27 ADM presents to medical due to Cough/vomiting x 3 weeks. Pt is taking mucinex, is eating and drinking normally. Pt vomited at 0700 14MAY12 from coughing. Cough has been gradually worsening. No blood noted. Also has some nasal congestion. No ear pain, mild sore throat.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling, fever, and chills.

Cough.

Nausea and vomiting.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Current medication

Mucinex.

Past medical/surgical history

Reported:

Medical: Reported medical history

none.

Surgical / Procedural: Surgical / procedural history

none.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Review of systems

Systemic: No night sweats.

Head: Headache.

Eyes: No vision problems, no blurred vision, and no eye pain.

Otolaryngeal: No hearing loss and no earache. Nasal discharge. No sore throat.

Pulmonary: No dyspnea and no wheezing.

Gastrointestinal: No abdominal pain, no bright red blood per rectum, and no diarrhea.

Psychological: Not thinking about suicide. No homicidal thoughts.

Physical findings

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Normal. • Well developed. • Well nourished. • In no acute distress.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Eyes:

General/bilateral:

Pupils: • PERRL.

External: • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Tympanic Membrane: • Normal.

Nose:

General/bilateral:

Cavity: • Nasal mucosa normal.

Sinus Tenderness: • No sinus tenderness.

Pharynx:

Oropharynx: • Posterior pharyngeal wall was abnormal + PND. • Tonsils showed no abnormalities.

Lymph Nodes:

• Cervical lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Clear to auscultation. • No wheezing was heard. • No rhonchi were heard.

• No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Lab Result Cited by BRADLEY,RACHAEL N @ 15 May 2012 1526 CDT

Throat Culture

Order #	120510-04943 (NH Pensacola)
Filter #	120510 MI 3241 (NH Pensacola)
Status:	Final
Ordering Provider:	GUNTER, ROGER WILLIAM
Priority:	ASAP
Date Ordered:	10 May 2012 1652
Date Resulted:	11 May 2012 0845
COLLECT_SAMPLE:	PHARYNX
BACTERIOLOGY RESULT:	FINAL REPORT RESULTS: NORMAL FLORA
Specimen:	Pharynx
Collected:	10 May 2012 1248

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Results:

Final report

Lab Result Cited by BRADLEY, RACHAEL N @ 15 May 2012 1526 CDT**Streptococcus Group A Ag Rapid**
Streptococcus pyogenes Ag Rapid Strep**Site/Specimen**
PHARYNX**10 May 2012 1248**

NEGATIVE, INTERNAL CONTROL ACCEPTABLE

Lab Result Cited by BRADLEY, RACHAEL N @ 15 May 2012 1526 CDT**CBC****Site/Specimen****10 May 2012 1248**

WBC

BLOOD

6.3

RBC

BLOOD

4.73

Hemoglobin

BLOOD

14.8

Hematocrit

BLOOD

43.0

MCV

BLOOD

90.9

MCH

BLOOD

31.3

MCHC

BLOOD

34.4

RDW CV

BLOOD

12.5

Platelets

BLOOD

315

MPV

BLOOD

10.6

Neutrophils

BLOOD

63.9

Lymphocytes

BLOOD

23.9

Monocytes

BLOOD

10.5

Eosinophils

BLOOD

1.4

Basophils

BLOOD

0.3

Neutrophils

BLOOD

4.0

Lymphocytes

BLOOD

1.5

Monocytes

BLOOD

0.7

Eosinophils

BLOOD

0.1

Basophils

BLOOD

0.0

Lab Result Cited by BRADLEY, RACHAEL N @ 15 May 2012 1526 CDT**Infectious Mononucleosis Screen****Site/Specimen****10 May 2012 1248**

Heterophile Ab

SERUM

NEGATIVE, INTERNAL CONTROL ACCEPTABLE

A/P Written by BRADLEY, RACHAEL N @ 15 May 2012 1527 CDT

1. **VIRAL SYNDROME:** Labs drawn on 10 May all normal. Lungs sounds clear. Instructed to continue Mucinex PSE, hydrate and RTC if sx's persist or worsen.

Disposition Written by BRADLEY, RACHAEL N @ 15 May 2012 1527 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY MED HOME CLINIC clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By BRADLEY, RACHAEL N (Independent Duty Corpsman) @ 15 May 2012 1527****CHANGE HISTORY****The following SO Note Was Overwritten by BRADLEY, RACHAEL N @ 14 May 2012 1011 CDT:****SO Note Written by GARZA, OMAR @ 14 May 2012 0849 CDT****Chief complaint**

The Chief Complaint is: Cough/vomiting.

History of present illness

The Patient is a 27 year old male.

27 ADM presents to medical due to Cough/vomiting x 3 weeks. Pt is taking mucinex, is eating and drinking normally. Pt vomited at 0700 14MAY12, cough and fever have worsen in the past week.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling, fever, and chills.

Chest pain or discomfort.

Dyspnea and cough.

Nausea and vomiting.

No lightheadedness.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1014

AR 1059

Case 1:17-cv-01000-TMD Document 1 Filed 02/08/18 Page 1060 of 1060

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Mucinex.

Past medical/surgical history

Reported:

Medical: Reported medical history

none.

Surgical / Procedural: Surgical / procedural history

none.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Review of systems

Otolaryngeal: No sore throat.

Gastrointestinal: No abdominal pain, no bright red blood per rectum, and no diarrhea.

Psychological: Not thinking about suicide. No homicidal thoughts.

Physical findings

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Well developed. • Well nourished. • In no acute distress.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

10 May 2012 at NH Pensacola FL, Corry MHP by GUNTER, ROGER WILLIAM

Encounter ID: PENS-6859398 Primary Dx: VIRAL SYNDROME

Patient: MERWIN, DANIEL DENNIS

Date: 10 May 2012 1235 CDT

Appt Type: EST

Treatment Facility: NBHC NYTC

Clinic: CORRY MED HOME CLINIC

Provider: GUNTER, ROGER WILLIAM

Pensacola

Patient Status: Outpatient

AutoCites Refreshed by GUNTER, ROGER WILLIAM @ 10 May 2012 1238 CDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

chronic fever feelings

Appointment Comments:

aaw

VitalsVitals Written by RATHBUN, TONYA @ 10 May 2012 1226 CDT

BP: 112/68, HR: 72, RR: 12, T: 98.4 °F, HT: 69 in, WT: 146 lbs, BMI: 21.56, BSA: 1.807 square meters,

Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 0 Pain Free

Comments: NKDA

POC: 850-602-8501

SO Note Written by GUNTER, ROGER WILLIAM @ 10 May 2012 1646 CDT**Chief complaint**

The Chief Complaint is: Viral malaise, fever.

History of present illness

The Patient is a 27 year old male.

27yo ADM reports to medical with a cough and hot flashes x 1 month. Symptoms began with hot flashes and a cough then recently about two weeks ago he began having congestion as well. Pt has taken Dayquil and Nyquil which he states was a minimally effective.

<<Note accomplished in TSWF CORE>>

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling and chills.

Headache.

Nasal discharge, nasal passage blockage, and sore throat.

Cough.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Dayquil

Nyquil

Albuterol.

Past medical/surgical history**Reported:**

Medical: Reported medical history none

Surgical / Procedural: Surgical / procedural history none

Medications: No medication noncompliance.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Review of systems**Systemic:** No fever.**Otolaryngeal:** No earache.**Gastrointestinal:** No nausea and no vomiting.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Well developed. • Well nourished. • In no acute distress.

Neck:

Appearance: • Of the neck was normal.

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Ears:

General/bilateral:

Tympanic Membrane: • Normal.

Nose:

General/bilateral:

Cavity: • Nasal mucosa normal.

Pharynx:

Oropharynx: • Posterior pharyngeal wall was normal.

Lymph Nodes:

• Cervical lymph nodes were not enlarged. • Submandibular lymph nodes were not enlarged. • Supraclavicular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Clear to auscultation. • No wheezing was heard. • No rhonchi were heard.

• No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal S1 and S2. • No S3 heard. • No gallop was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Edema: • Not present.

A/P Written by GUNTER, ROGER WILLIAM @ 10 May 2012 1649 CDT

1. VIRAL SYNDROME: Exam is completely normal. No lymphadenopathy or objective findings on exam. Will continue on his OTC meds for symptom control as needed. I will obtain some basic labs to rule out Mono and strep but suspect he has a viral syndrome. HIV drawn in FEB this year was negative.

Laboratory(ies): -CBC PROFILE (Routine); MONONUCLEOSIS SCREEN (Routine); RAPID STREP A (Routine)

Disposition Written by GUNTER, ROGER WILLIAM @ 10 May 2012 1653 CDT**Released w/o Limitations****Follow up:** as needed in 1 week(s) with PCM and/or in the CORRY MED HOME CLINIC clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By GUNTER, ROGER WILLIAM (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 10 May 2012 1654****CHANGE HISTORY***The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 10 May 2012 1648 CDT:**SO Note Written by RATHBUN, TONYA @ 10 May 2012 1228 CDT***History of present illness**

The Patient is a 27 year old male.

27yo ADM reports to medical with a cough and hot flashes x 1 month. Pt began condition with hot flashes and a cough then recently about two weeks ago he began having congestion. Pt has taken Dyquil and Nyquil which he states was a little effective.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling and chills.

Headache.

Nasal discharge, nasal passage blockage, and sore throat.

Cough.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Dyquil

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Nyquil
Albuterol.

Past medical/surgical history

Reported:

Medical: Reported medical history none

Surgical / Procedural: Surgical / procedural history none

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Review of systems

Systemic: No fever.

Otolaryngeal: No earache.

Gastrointestinal: No nausea and no vomiting.

Psychological: Not thinking about suicide. No homicidal thoughts.

Physical findings

Vital Signs:

* Temperature: Reviewed. * RR: Reviewed. * PR: Reviewed. * Blood pressure: Reviewed.

General Appearance:

* Well developed. * Well nourished. * In no acute distress.

Medical Record

06 Mar 2012 at NH Pensacola FL, Readiness Center by TREVEN, LAUREN A

Encounter ID: PENS-5802127 Primary Dx: Visit for: occupational health / fitness exam

Patient: MERWIN, DANIEL DENNIS Date: 06 Mar 2012 1330 CDT Appt Type: WELL
Treatment Facility: NH Pensacola Clinic: DEPLOYMENT HEALTH CLINIC Provider: TREVEN, LAUREN A
Patient Status: Outpatient

Reason for Appointment: PHA PART II / VA

Appointment Comments:
CAC-DBM

AutoCites Refreshed by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1328 CDT

Allergies

• OTHER: Unknown (SEE MED RECORD)

Screening Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1328 CDT

Reason For Appointment: PHA PART II / VA

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : pha;

Vitals

Vitals Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1337 CST

BP: 110/70 Left Arm, Adult Cuff, HR: 70 Regular, Radial Artery, RR: 17, HT: 69 in, WT: 151 lbs
Upright Scale, Actual, With Shoes, BMI: 22.3,
BSA: 1.833 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1334 CDT

History of present illness

The Patient is a 27 year old male.
He reported: Currently on active duty. Visit is not deployment-related.
Good general overall feeling.

Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

None.

Past medical/surgical history

Reported History:

Medical: Reported medical history

-Diabetes- no
-Cancer- no
-HTN- no
-High Cholesterol- no
-Heart Disease- no
-Metal issues- no
-Kidney issue- no
-Seizures- no
Obesity - no
Heart attack - no
Asthma - self

Surgical / procedural: Surgical / procedural history
none.

Personal history

Social history reviewed none.

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol Screening Date:

History ANNUAL SCREENING DATE:

What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:
Advanced directives completed? ☐ Yes ☒ No
Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
Are you enrolled in EFMP? ☐ Yes ☒ No
Do you use a Personal Health Record (PHR)? ☒ Yes ☐ No Specify:

Contact info:

Family history

Family medical history
-Diabetes- father side of family
-Cancer- no
-HTN- no
-High Cholesterol- no
-Heart Disease- father side of family
-Metal issues- no
-Kidney issue- no
-Seizures- no
Obesity - side of family
Heart attack - no
Asthma - no

SQ Note Written by TREVEN, LAUREN A @ 06 Mar 2012 1344 CDT

Chief complaint

The Chief Complaint is: PHA, works at NIOC.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF CORE>>

Presents for PHA. Denies complaints or concerns.

Review of systems

Systemic symptoms: No fever and no chills.

Head symptoms: No headache.

Cardiovascular symptoms: No chest pain or discomfort.

Pulmonary symptoms: No cough.

Gastrointestinal symptoms: No nausea, no vomiting, no abdominal pain, no diarrhea, and no constipation.

A/P Written by TREVEN, LAUREN A @ 06 Mar 2012 1524 CDT

1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION): Annual TB risk assessment completed with responses determined to be minimal risk. No further testing recommended. See NAVMED 6224/8.

Record review completed. Reviewed deployment health history and individual medical readiness. Counseling on avoidable health risk factors and screening per clinical preventive service guidelines provided.

Member completed Fleet and Marine Corps Health Risk Assessment. Counseled on identified risks.

Counseled on lab results for PHA and discussed at length ways to improve through lifestyle changes; exercise, weight management, supplements and better nutrition. Teaching materials given. Encouraged follow-up with PCM for any health problems or concerns as needed.

Medically fit for full duty.

PHA complete

Disposition Written by TREVEN, LAUREN A @ 06 Mar 2012 1524 CDT

Released w/o Limitations

Follow up: as needed with PCM.

Signed By TREVEN, LAUREN A (Physician Assistant, Deployment Health Clinic) @ 06 Mar 2012 1524

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

02 Nov 2011 at NH Pensacola FL, Corry MHP by GRIMM, CHRISTOPHER T

Encounter ID: PENS-4417339 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC NTTC
Pensacola
Patient Status: OutpatientDate: 02 Nov 2011 1101 CST
Clinic: CORRY MED HOME CLINICAppt Type: WELL
Provider: GRIMM, CHRISTOPHER TODD

Reason for Appointment: flu SHOT

Vitals

Vitals Written by STANDLEY, CHAD J @ 02 Nov 2011 1424 CDT

Comments: N/A

SO Note Written by STANDLEY, CHAD J @ 02 Nov 2011 1424 CST

History of present illness

The Patient is a 26 year old male.

Barriers to learning were identified as: None.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**

Reported medications: No medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Taking medication and no contraindications to live vaccine were noted on medication reconciliation.

Physical findings

Patient monitored 15 minutes for adverse reaction/complications.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by STANDLEY, CHAD J @ 02 Nov 2011 1425 CST

1. Vaccines Prophylactic Need Against InfluenzaProcedure(s): -Immunization Administration One Vaccine x 1
-Influenza Split Virus Vacc Age 3+ Years IM Preservative Free x 1

Disposition Last Updated by STANDLEY, CHAD J @ 02 Nov 2011 1425 CST

Released w/o Limitations

Follow up: as needed with PCM and/or in the CORRY MED HOME CLINIC clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GRIMM, CHRISTOPHER T (Physician/Workstation) @ 02 Nov 2011 1518

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

07 Oct 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-4182237 Primary Dx: POSTSURGICAL STATE OF EYE AND
ADNEXA

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 07 Oct 2011 0800 CDT
Clinic: Ophthalmology Clinic

Appt Type: EST
Provider: ROPP, CORBY D

Reason for Appointment:

A/P Last Updated by ROPP, CORBY D @ 07 Oct 2011 0836 CDT

1. Postsurgical state of eye and adnexa

Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1
-Determination Of Refractive State x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Last Updated by ROPP, CORBY D @ 07 Oct 2011 0836 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 07 Oct 2011 0836

Note Written by CEPEDA, SERGIO JAVIER @ 10 Oct 2011 0517 CDT
(Added after encounter was signed.)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

P. 100
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L. 100

MERWIN, DANIEL DENNIS
20/ [REDACTED]
7 Oct 2011, 0721

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Exam Date	Last Name	First Name	MI	Last 4
SLIT LAMP EXAM				
OD		OS		
Lids / Lashes / Lac	<input type="checkbox"/>	Lids / Lashes / Lac	<input type="checkbox"/>	
Conjunctiva	<input type="checkbox"/>	Conjunctiva	<input type="checkbox"/>	
Cornea	<input type="checkbox"/>	Cornea	<input type="checkbox"/>	
Mac	<input type="checkbox"/>	Mac	<input type="checkbox"/>	
Ret	<input type="checkbox"/>	Ret	<input type="checkbox"/>	
Lens	<input type="checkbox"/>	Lens	<input type="checkbox"/>	
IOP		IOP		
TOPOGRAPHY		IMPRESSION / PLAN		
Not Performed	<input type="checkbox"/>	<p>A) 6 mo post-op. mild NBS C. nigrum Sx. P.) ↑ Refractive error. Try DTL nigrum Rx → F/L 2 Pen. F/L 2 + 5000 m</p>		
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
Comments				
FUNDUS				
Not Performed	<input type="checkbox"/>			
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
Comments				
Eye Care Provider		Flight Surgeon Stamp/Signature		
RECOMMENDATION		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Referred <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Referred		
SR O'Connell MD		CAPT MC USN		
Naval Hospital Pensacola		FAX		
E-mail		stephen.oconnell@med.navy.mil		

MERWIN, DANIEL DENNIS
20 [REDACTED]
7 Oct 2011, 0721

27 Jul 2011 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-3154362 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL D**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**

Date: **27 Jul 2011 0845 CDT**
Clinic: **DERMATOLOGY CLINIC**

Appt Type: **EST\$**
Provider: **BRUMWELL, ERIC**

Reason for Appointment: f/u skin check

AutoCites Refreshed by BRUMWELL, ERIC @ 27 Jul 2011 0851 CDT

Problems

Chronic:

- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	INSTILL 1 DROP IN EACH 5 of 6 EYE EVERY 5 TO 10 MINUTES AS NEEDED X 5 DAYS, THEN AS NEEDED		04 May 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3 RF3		14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	INS 1 G OU QID X 7 DAYS #1 RF1	1 of 1	14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010

Vitals

Vitals Written by CONLEY, KARLA E @ 27 Jul 2011 0842 CDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by BRUMWELL, ERIC @ 27 Jul 2011 0852 CDT

Chief complaint

The Chief Complaint is: F/U PHOT OR HEAT INDUCED FOLLICULITIS-- PT HAD PROBLEM LAST YEAR AND RECENTLY HAD RECURRENCE 2 WEEKS AGO AFTER WORKING IN YARD--TNTC SMALL PUSTULES ON FACE/NECK AND UPPER BACK THAT LASTED A FEW DAYS THEN WENT AWAY--NO TOPICALS USED OTHER THAN VASELINE LOTION, NO MEDS TAKEN.

Reason for Visit

Visit for: screening for dermatological disorders.

Referred here

From Primary Care.

History of present illness

The Patient is a 26 year old male.

He reported: Military service.

Concerns about cosmetic appearance.

Allergies

An allergy to drugs.

Current medication

current medication [Use for free text].

Past medical/surgical history

Reported History:

Reviewed.

Reported medications: Taking medication MEDICINE RECONCILIATION PERFORMED.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings

Vital signs:

• Pain level (0-10) 0.

Neurological:

Speech: ° Normal.

Psychiatric Exam:

Affect: ° Congruent with the mood.

Skin:

° Normal except as noted EXAM ESSENTIALLY NORMAL--NO ACTIVE SKIN DISEASE. ° No lesions on the scalp. ° No lesions on the ear. ° No lesions on the face. ° No lesions on the neck. ° No lesions on the shoulders. ° No lesions on the upper extremities.

A/P Written by BRUMWELL, ERIC @ 27 Jul 2011 0857 CDT

1. FOLLICULITIS: PREVIOUSLY BIOPSY AND DIAGNOSIS C/W PITYROSPORUM FOLLICULITIS HOWEVER HISTORY SEEMS MUCH BETTER FOR MILIARIA

ADVISED PT TO START TOPICAL KETOCONAZOLE AGAIN FOR PITYROSPORUM AND WILL ADD LAC HYDRIN AND CLINDA TOPICALLY TO TREAT CONCURRENTLY FOR MILIARIA AND BACTERIAL FOLLICULITIS. ADVISED PT TO WEAR LOOSE SUN PROTECTIVE CLOTHING AND TO COOL OFF IMMEDIATELY AFTER HOT ACTIVITY

WILL F/U W/ NEXT EPISODE FOR REPEAT BIOPSY/CULTURE WHEN ABLE

Medication(s):	-AMMONIUM LACTATE--TOP 12% LOTN - AAA TRUNK AND NECK DAILY #2 RF4 Qt: 2 Rf: 4 -CLINDAMYCIN--TOP 1% SOLN - APPLY TO UPPER TRUNK AND NECK DAILY-- THIS IS THE ANTIBIOTIC #2 RF3 Qt: 2 Rf: 3
Patient instruction(s):	-Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure -Avoid Exposure Bright Sunlight -Education And Counseling -Instructions For Patient

Disposition Written by BRUMWELL, ERIC @ 27 Jul 2011 0857 CDT

Released w/o Limitations

Follow up: as needed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Parent who indicated understanding.

Signed By BRUMWELL, ERIC (Department Head/Staff Physician, Dermatology Clinic, Naval Hospital Pensacola) @ 27 Jul 2011 0858

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Medical Record

CHANGE HISTORY
The following SO Note Was Overwritten by BRUMWELL, ERIC @ 27 Jul 2011 0852 CDT:
SO Note Written by CONLEY, KARLA E @ 27 Jul 2011 0843 CDT
Chief complaint
The Chief Complaint is: F/U skin check.
Current medication
current medication (Use for free text).

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

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1027 Page

26 Jul 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T

Encounter ID: PENS-3141764 Primary Dx: ASTHMA

Patient: **MERWIN, DANIEL D** Date: **26 Jul 2011 1100 CDT** Appt Type: **EST**
Treatment Facility: **NH Pensacola** Clinic: **PULMONARY DISEASE CLINIC** Provider: **LEWIS, CHRISTOPHER T**
Patient Status: **Outpatient**

Reason for Appointment: PULM/LAB RESULTS/MEDS/20MIN
Appointment Comments:
CAC BD

Screening Written by **CURRY, JEREMY T @ 26 Jul 2011 1104 CDT**
Reason For Appointment: PULM/LAB RESULTS/MEDS/20MIN

Allergen information verified by **CURRY, JEREMY T @ 26 Jul 2011 1103 CDT**

Vitals

Vitals Written by **CURRY, JEREMY T @ 26 Jul 2011 1104 CDT**

BP: 104/64, HR: 72, RR: 16, T: 98.0 °F, HT: 68 in, WT: 150 lbs, SpO2: 96%, BMI: 22.81.
BSA: 1.809 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by **LEWIS, CHRISTOPHER T @ 26 Jul 2011 1127 CDT**

Chief complaint

The Chief Complaint is: Follow up PFTs.

History of present illness

The Patient is a 26 year old male.

He reported: Feeling fine, Excellent, Very Good or Good.

Pain Severity 0 / 10.

Pt is a 26 yo male who presents for follow up of pulmonary function tests. He was last seen in March 2011. Since that time he has done well. He exercises regularly without difficulty. He will have occasional chest tightness when around cats, but other wise is asymptomatic. He presents today for routine follow up.
Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

Advair diskus pm.

Past medical/surgical history

Reported History:

Past medical history Past Medical History:

- 1) childhood asthma
- 2) allergies.

Personal history

-Tob: none

-EtOH: none.

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol Screening Date:

History ANNUAL SCREENING DATE:

What is Your Preferred Method of Learning?

(Specify):

☒ Verbal ☐ Written ☐ Visual ☐ Other

Learning Disability, Language or Learning Barriers?

☐ Yes ☒ No

Advanced Directives Completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Contact Info:

Review of systems

Systemic symptoms: Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.

Head symptoms: No sinus pain.

Pulmonary symptoms: No dyspnea, no cough, and no wheezing.

Physical findings

Vital signs:

* Current vital signs reviewed.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

General appearance:

° Well-appearing. ° Awake. ° Alert. ° In no acute distress.

Tests

Laboratory studies:

Pulmonary Function Tests:

Pulmonary function tests were performed on 17MAR11 and revealed normal spirometry, very mild decrease in TLC, and a normal DLCO. Following the administration of 16mg/ml of methacholine there was a significant decrease in FEV1 consistent with a positive methacholine challenge.

A/P Written by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1135 CDT

1. **ASTHMA (ASTHMA, UNSPECIFIED, MILD):** Pt with a symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. His symptoms are confined to allergen exposure, particularly to cats. Given the mild intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS. Follow up in 6 months.

Disposition Written by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1135 CDT

Released w/o Limitations

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 26 Jul 2011 1135

CHANGE HISTORY

The following SO Note Was Overwritten by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1127 CDT:

SO Note Written by CURRY, JEREMY T @ 26 Jul 2011 1105 CDT

History of present illness

The Patient is a 26 year old male.

He reported: Feeling fine, Excellent, Very Good or Good.

Pain Severity 0 / 10.

Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

Advair diskus.

Personal history

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol. Screening Date:

History ANNUAL SCREENING DATE:

What is Your Preferred Method of Learning?

Learning Disability, Language or Learning Barriers?

Advanced Directives Completed?

Do you have any cultural or religious beliefs that may affect your care?

Are you enrolled in EFMP?

Contact info:

[x] Verbal [] Written [] Visual [] Other (Specify):

[] Yes [x] No

[] Yes [x] No

[] Yes [x] No

[] Yes [x] No

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-2 DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1029

AR 1074

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-2275325 Primary Dx: POSTSURGICAL STATE OF EYE AND ADNEXA

Patient: MERWIN, DANIEL D
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 06 Jun 2011 0815 CDT
Clinic: OPHTHALMOLOGY CLINIC

Appt Type: EST
Provider: ROPP,CORBY D

Reason for Appointment: prk f/u
Appointment Comments:
sjc

AutoCites Refreshed by ROPP,CORBY D @ 06 Jun 2011 0822 CDT

Problems

Chronic:

- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	INSTILL 1 DROP IN EACH 5 of 6 EYE EVERY 5 TO 10 MINUTES AS NEEDED X 5 DAYS, THEN AS NEEDED		04 May 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3 RF3		14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	INS 1 G OU QID X 7 DAYS #1 RF1	1 of 1	14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS	6 of 6	20 Jul 2010

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

NO SOAP) #2 RF6

A/P Written by ROPP, CORBY D @ 06 Jun 2011 0829 CDT

1. Postsurgical state of eye and adnexa

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Written by ROPP, CORBY D @ 06 Jun 2011 0829 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 06 Jun 2011 0829

Encounter ID:	PENS-2273083	Primary Dx:	POSTSURGICAL STATE OF EYE AND ADNEXA
---------------	--------------	-------------	--------------------------------------

Appt Type: EST
Provider: ROPP, CORBY D

AP Last Updated by ROPP, CORBY D @ 06 Jun 2011 1243 CDT

- Disposition Last Updated by ROPP, CORBY D @ 06 Jun 2011 1243 CDT

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Note Written by CEPEDA, SERGIO JAVIER @ 07 Jun 2011 1305 CDT
(Added after encounter was signed.)

Created: 30 Oct 2017

MERVIN DANIEL
 20
 6 Jan 2011, 0724

C. Zapp
L. M. M. M. M.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Exam Date	Last Name	First Name	Sex	Age
00				
SLIT LAMP EXAM				
Left / Lesion / Loc	Right / Lesion / Loc	FINDINGS		
Conjunctiva	Conjunctiva			
Cornea	Cornea			
Iris	Iris			
AC	AC			
PC	PC			
LOA	LOA			
LOP	LOP			
TOPOGRAPHY				
Not Performed	Comments			
Normal				
Abnormal				
PUPILS				
Not Performed	Comments			
DPE				
Non-DPE				
Normal				
Abnormal				
Eye Care Provider	Anterior Media AF Flight Vision Standards	Yes	No	Full Duty
RECOMMENDATION	Workshop Media AF Duty Vision Standards	Yes	No	Full Duty
Eye Care Provider	SP O'Connell, MD	Flight Surgeon Stamp/Signature		
Postflight	CAPT MC LEM			
Base	Naval Hospital Pensacola			
DOB	PAX			
E-mail	stephen.dunn@naval.mil			
Lab/AF Post-Op, Services				

Handwritten notes:
 A) On target & expected
 B) LPM
 continue U.V. protection
 Flu 2 no for 3 mo

MERWIN, DANIEL D
 2
 6 JUN 2011, 0724

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

04 May 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1912953 Primary Dx: SUPERFICIAL INJURY - ABRASION OF CORNEA

Patient: MERWIN, DANIEL D
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 04 May 2011 0817 CDT
Clinic: OPHTHALMOLOGY CLINIC

Appt Type: EST
Provider: ROPP,CORBY D

Reason for Appointment: prk f/u

A/P Last Updated by ROPP,CORBY D @ 04 May 2011 0859 CDT

1. SUPERFICIAL INJURY - ABRASION OF CORNEA

Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1

Disposition Last Updated by ROPP,CORBY D @ 04 May 2011 0900 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 04 May 2011 0900

Note Written by CEPEDA, SERGIO JAVIER @ 04 May 2011 1053 CDT
(Added after encounter was signed.)

Created: 30 Oct 2017

C. S. P.
me udu

Medical Record


Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Exam Date	Last Name	First Name	MR	Line #
00				
SLIT LAMP EXAM				
OD Left / Lashes / Lac <input type="checkbox"/> <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea <input type="checkbox"/> Irid <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A/C <input type="checkbox"/> Lens <input type="checkbox"/> Ret <input type="checkbox"/> Opt <input type="checkbox"/>	OS Left / Lashes / Lac <input type="checkbox"/> <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea <input type="checkbox"/> Irid <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A/C <input type="checkbox"/> Lens <input type="checkbox"/> Ret <input type="checkbox"/> Opt <input type="checkbox"/>	PHENOS 		
TOPOGRAPHY OD OS Not Performed <input type="checkbox"/> <input type="checkbox"/> Manual <input type="checkbox"/> <input type="checkbox"/> Automated <input type="checkbox"/> <input type="checkbox"/>				
PURDUS OD OS Not Performed <input type="checkbox"/> <input type="checkbox"/> DPE <input type="checkbox"/> <input type="checkbox"/> Non-DPE <input type="checkbox"/> <input type="checkbox"/> Manual <input type="checkbox"/> <input type="checkbox"/> Automated <input type="checkbox"/> <input type="checkbox"/>				
Eye Exam Provider Assistant Master AF Flight Vision Standards <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Flight Surgeon Signature <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
Signature CAPT MC (R) Date <input type="text"/> Time <input type="text"/> Signature <input type="text"/>				

Handwritten notes in the center of the form:

- A) Healing abrasion (OS).
- B) Uveitis = 010 (OS).
- Left eye - 710.
- Right eye - 710.

NERWIN, DANIEL D
20/
4 May 2011, 0618

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

26 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1783025 Primary Dx: Aftercare Following Surgery Of Sense Organs

Patient: MERWIN, DANIEL D
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 26 Apr 2011 0755 CDT
Clinic: OPHTHALMOLOGY CLINIC

Appt Type: EST
Provider: ROPP,CORBY D

Reason for Appointment: 1 WEEK PRK F/U

A/P Last Updated by ROPP,CORBY D @ 26 Apr 2011 0819 CDT

1. Aftercare following surgery of the sense organs

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Postsurgical state of eye and adnexa

Disposition Last Updated by ROPP,CORBY D @ 26 Apr 2011 0819 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 26 Apr 2011 0820

Note Written by CEPEDA,SERGIO JAVIER @ 26 Apr 2011 1518 CDT
(Added after encounter was signed.)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Knee Post Operative Form

SURGERY DATE: 21/1/19		POD 1 Date:		POD 3 Date: 26 APR 19	
UCVA ^R PN		OD 20	OS 20	OD 20 50+2	OS 20 30
CHIEF COMPLAINT		1 week PRK FL Blurriness OD OF 10			
Pain 0-10 (0 = None)					
MEDICATIONS					
Antibiotic 4x/day Neomycin		Yes	No	Yes	No
Vitamin 1/2 tsp 4x/day		Yes	No	Yes	No
PF 1% (PML)		Yes	No	Yes	No
Artificial Tears		Refresh Q 3x/day PRN			
Miotics		BOS			
Painkillers		4			
Prescription		4			
Other		Keratogen 4x/day			
LAS 1st Exam		2			
Cord. Monitor		2			
Cornea		2			
Sclera		2			
Intraocular Pressure		2			
Infection		Yes	No	Yes	No
A/C Reaction		Yes	No	Yes	No
DCL		AV Change 8.4 AV Change 8.4 AV Change 8.4 AV Change 8.4			
ASSESSMENT / PLAN:					
2nd Exam		Continue	Stop	Continue 2 days then stop	Continue 2 days then stop
PF 1% (PML)		Continue	Stop	Continue	Continue
Artificial Tears		Continue	Stop	Continue	Continue
Cord. Monitor as directed		Continue	Stop	Continue	Continue
Antibiotic		Continue	Stop	Continue	Continue
Other: T241 HES		Continue	Stop	Continue	Continue
FOLLOW UP		1 2 3 4 5 6 9 12 Day Week Month		1 2 3 4 5 6 9 12 Day Week Month	

MERWIN, DANIEL D
20/ [REDACTED]
26 Apr 2011, 0758

→ C. Post
MC 411

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

22 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1748025 Primary Dx: POSTSURGICAL STATE OF EYE AND ADNEXA

Patient: MERWIN, DANIEL D
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 22 Apr 2011 0800 CDT
Clinic: Ophthalmology Clinic

Appt Type: EST
Provider: ROPP, CORBY D

Reason for Appointment:

A/P Last Updated by ROPP, CORBY D @ 22 Apr 2011 0934 CDT

1. POSTSURGICAL STATE OF EYE AND ADNEXA

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Last Updated by ROPP, CORBY D @ 22 Apr 2011 0934 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 22 Apr 2011 0935

Note Written by CEPEDA, SERGIO JAVIER @ 25 Apr 2011 1213 CDT
(Added after encounter was signed.)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Kessler Post-Operative Form

SURGERY DATE: 21 Oct 2011		POD 1 Date:		POD 3 Date:	
UCVA ^R PH		OD 20/30	OS 20/40	OD 20/	OS 20/
CHIEF COMPLAINT		Myopia			
Pain 0-10 (0 = None)		0	1		
MEDICATIONS					
Anker 4xDay		Yes	No	Yes	No
Zofran 4xDay		Yes	No	Yes	No
POD 1 PML		D.O.			
Anesthetic Type		Retrolux V&N			
Mobile		0			
Posture		0			
Phonology		0			
Other		Retrolux			
L&L Edema		0			
Cook Intention		0			
Circles		<div> <div>0</div> <div>1/4</div> <div>1/2</div> <div>3/4</div> <div>Full</div> </div>			
Edema		0			
Impulse Cuts		0			
Infection		Yes	No	Yes	No
AVC Reaction		0			
BCI		AV Charge 8.4	AV Charge 8.4	AV Charge 8.4	AV Charge 8.4
ASSIGNMENT / PLAN					
Post-Op Day 1		Continue	Stop	Continue	Stop
Post-Op Day 2		Continue	Stop	Continue	Stop
Post-Op Day 3		Continue	Stop	Continue	Stop
Post-Op Day 4		Continue	Stop	Continue	Stop
Post-Op Day 5		Continue	Stop	Continue	Stop
Post-Op Day 6		Continue	Stop	Continue	Stop
Post-Op Day 7		Continue	Stop	Continue	Stop
Post-Op Day 8		Continue	Stop	Continue	Stop
Post-Op Day 9		Continue	Stop	Continue	Stop
Post-Op Day 10		Continue	Stop	Continue	Stop
Post-Op Day 11		Continue	Stop	Continue	Stop
Post-Op Day 12		Continue	Stop	Continue	Stop
FOLLOW UP		1 2 3 4 5 6 7 8 9 10 11 12	6 Week Type	1 2 3 4 5 6 7 8 9 10 11 12	6 Week Type

NERWIN, DANIEL D
21 Oct 2011, 0717

1 DAY XRAY FLO

21 Apr 2011 at 81st Medical Group, Refractive Surgery by ROPP, CORBY D

Encounter ID: KSLR-874047 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL D** Date: **21 Apr 2011 0928 CDT** Appt Type: **PROC**
 Treatment Facility: **81ST MEDICAL GROUP** Clinic: **REFRACTIVE SURGERY** Provider: **ROPP,CORBY D**
 Patient Status: **Outpatient**

Reason for Appointment: PRK Sx

AutoCites Refreshed by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1113 CDT

Problems Chronic: <ul style="list-style-type: none"> • Dyspnea • Skin neoplasm of uncertain behavior • Removal of sutures • Extrinsic asthma • Folliculitis • Rosacea • Lattice peripheral retinal degeneration • Myopia • Allergic rhinitis • Visit for: occupational health/fitness exam • Parent education about immunizations • Visit for: military services physical • Exposure to venereal disease • Inquiry and counseling about contraceptive practices • Visit for: administrative purposes Acute: <ul style="list-style-type: none"> • Visit for: preoperative exam 	Family History No Family History Found.	Allergies • OTHER: Unknown (SEE MED RECORD)
---	---	---

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Nepafenac 0.1%, Suspension, Ophthalmic	Active	INS 1 G OU TID - QID NR		14 Apr 2011
IBUPROFEN, 800 MG, TABLET, ORAL	Active	PRN SEVERE PAIN #1 RFO T1 TAB PO Q8H PP #30 NR		14 Apr 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3		14 Apr 2011
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	INS 1 G OU EVERY 5-10 MIN PRN X 5 DAYS, THEN	6 of 6	14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	PRN INS 1 G OU QID X 7 DAYS #1 RF1	1 of 1	14 Apr 2011
Fluorometholone 0.1%, Suspension, Ophthalmic	Active	INSTILL 1 DROP OU QID NR X 1 WEEK, THEN TID X 1 WEEK, THEN BID X 2 WEEKS, THEN DAILY X 2 WEEKS AND STOP #2 RFO		14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY	4 of 4	13 Oct 2010

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	AS DIRECTED #2 RF4 INH 2 PF PO Q4H FOR	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	WHEEZING #1 RF1 T1 TAB PO QD F	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	ALLERGIES UD #30 RF2 INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT**1. Myopia**

Procedure(s): -PHOTOREFRACTIVE KERATECTOMY (PRK) x 1 (50-BILATERAL PROCEDURE)

Disposition Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT**Released w/o Limitations**Note Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ALLEGRETTO**WaveLight**

Treatment report

MERWIN [REDACTED] DANIEL

OD

[REDACTED]-1985

Male

ID: 125100386

Status: Finished

Treatment		Ablation Profile	
Type:	WFOptimized S 001	Date:	04-21-2011
Correction:	-2.75 D -0.50 D @ 100°		
Clinical:	-2.75 D ^ -0.50 D @ 100°		
Target Ref:	0.00 D ^ 0.00 D @ 100°		
Optical Zone:	6.50 mm		
Transition Zone:	1.25 mm		
Ablation zone:	9.00 mm		
Vertex Distance:	12.0 mm		
K-reading (K1):	40.50 D @ 83°		
K-reading (K2):	40.75 D @ 173°		
Pupil Diameter:	7.00 mm	Maximum Depth:	49.14 µm
Applied Drugs:		Central Depth:	49.14 µm
Entry made by:	BLG	Cornel Thickness:	583 µm
Surgeon:	ROPP	Device:	
Confirmed by:		Flap Thickness:	60 µm
		Stroma:	483 µm

Memo and postOP-Comments

S-PO CORONA L-BRIAN T-70 H-43
<i>min 2 sec applied 15 sec</i>
<i>2</i>
<i>[Signature]</i>
<i>[Signature]</i>

WaveLight AG
 Am Wellenfeld 5
 D-91056 Erlangen - Germany
 Phone: +49 (0)180 6026002

Note Written by SCHOEMANN, LINDA CIV @ 21 Apr 2011 1115 CDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

ALLEGRETTO**WaveLight**

Treatment report

MERWIN [REDACTED] DANIEL


OS

[REDACTED] 1985

Male

ID: 125100386

Status: Finished

Treatment		Ablation Profile	
Type: WFOptimized S 001 Date: 04-21-2011			
Correction:	-2.75 D -0.25 D @ 75°		
Clinical:	-2.75 D ^ -0.25 D @ 75°		
Target Ref.:	0.00 D ^ 0.00 D @ 75°		
Optical Zone:	6.00 mm		
Transition Zone:	1.25 mm		
Ablation zone:	6.00 mm		
Vertex Distance:	12.0 mm		
K-reading (K1):	40.50 D @ 82°		
K-reading (K2):	40.75 D @ 172°		
Pupil Diameter:	7.00 mm		
Applied Drugs:			
Entry made by:	BLG	Maximum Depth: 45.47 µm	
Surgeon:	ROPP	Central Depth: 45.47 µm	
Confirmed by:		Corneal Thickness: 577 µm	
		Device:	
		Flap Thickness: 50 µm	
		Stroma: 481 µm	

Memo and postOP-Comments

S-PO CORDOVA L-IBAN T-76 H-43

Thick 0.02% X 15 for

WaveLight AG
 Am Wolfenbuttel 1
 D-91056 Euerfelden - Germany
 Phone: +49 (0) 390 673300

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 21 Apr 2011 1456

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

29 Mar 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1494230 Primary Dx: Visit for: preoperative exam

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 29 Mar 2011 1330 CDT
Clinic: OPHTHALMOLOGY CLINIC

Appt Type: SPEC
Provider: ROPP, CORBY D

Reason for Appointment: PRK Screen
Appointment Comments:
CJC

AutoCites Refreshed by ROPP, CORBY D @ 29 Mar 2011 1335 CDT

Problems

- Chronic:
 - Dyspnea
 - Skin neoplasm of uncertain behavior
 - Removal of sutures
 - Extrinsic asthma
 - Folliculitis
 - Rosacea
 - Lattice peripheral retinal degeneration
 - Myopia
 - Allergic rhinitis
 - Visit for: occupational health/fitness exam
 - Parent education about immunizations
 - Visit for: military services physical
 - Exposure to venereal disease
 - Inquiry and counseling about contraceptive practices
 - Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	ALLERGIES UD #30 RF2 INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by ROPP, CORBY D @ 29 Mar 2011 1446 CDT

1. visit for: preoperative exam: The risks and benefits and CRS alternatives eligible for this patient were discussed including PRK/LASIK options.

PRK was discussed as use of a brush to create a large abrasion like defect which will take several days to heal with aid of a CL. Potential of pain/discomfort was mentioned. Risks of haze which may cause loss of best vision was discussed. Significantly slower visual recovery than LASIK (up to 6 months) worsening of dry eye or causing dry eye, and infection were discussed. Glare and

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

halos, new dry eye that may persist for 6 months or longer was mentioned. The use of MMC as surgeon preference in order to minimize risk of corneal haze development was discussed as well as it's unknown long-term effects on the cornea and that it is not FDA approved for CRS. It was mentioned that the Navy has a long history of successful application of MMC with much less haze formation and minimal side effects.

The LASIK option was discussed as creation of a corneal flap which establishes a thinner corneal structure than PRK, but faster and less painful visual recovery. The lesser risk of haze was mentioned. The potential for re-lifting the flap if necessary for debris, folds, or re-treatment and risk for epithelial down-growth was discussed. The risk of flap dislocation although small was discussed. The risk for flap infection although small was discussed. The risk of worsening or creation of dry eye symptoms due to the corneal incision, as well as glare and halos at night during the healing process were discussed. The risk of worsened dry eye with age was also discussed, and that its long-term effects not known. The risk for multiple suction loss events, even during flap creation w/ potential for resultant aberrations was discussed.

It was mentioned that people who have either PRK or LASIK are generally happy and most would recommend to a friend w/ a few exceptions

After a discussion of the risks and benefits the patient elected to have PRK with MMC application.

Procedure(s): -Ophthalmological New Patient Start Comprehensive Care x 1
-Determination Of Refractive State x 1
-Corneal Pachymetry Both Eyes x 1
-Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral x 2 (50-BILATERAL PROCEDURE) - WaveScan, low RMS, okay for Allegretto
PentaCam - nl A/P floats and Belin-Ambrosio scans ou - Hard copy on file on system - no printer ink
-Computerized Corneal Topography x 1

2. REFRACTIVE ERROR - MYOPIA

Disposition Written by ROPP,CORBY D @ 29 Mar 2011 1446 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by CORDOVA,CARLOS @ 29 Mar 2011 1219 CDT

Consult Order

Referring Provider: ZENT, JOHN W

Date of Request: 16 Mar 2011

Priority: Routine

Provisional Diagnosis:

Lattice peripheral retinal degeneration

Reason for Request:

Clinic will make appointment.CRS, please eval peripheral retinal lesion OD for correct diagnosis and possible laser retinopathy.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 29 Mar 2011 1447

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

17 Mar 2011 at NH Pensacola FL, Pulmonary Function Lab by LEWIS, CHRISTOPHER T

Encounter ID: PENS-1447190 Primary Dx: Difficulty breathing (dyspnea)

Patient: MERWIN, DANIEL DENNIS

Date: 17 Mar 2011 1300 CDT

Appt Type: PROC\$

Treatment Facility: NH Pensacola

Clinic: PULMONARY FUNCTION LAB

Provider: LEWIS, CHRISTOPHER T

Patient Status: Outpatient

Reason for Appointment: difficulty breathing (dyspnea)

Appointment Comments:

LHM

A/P Last Updated by MCGEE, LINDA H @ 24 Mar 2011 1225 CDT

1. difficulty breathing (dyspnea)

Procedure(s):

- Special Dr. Services Analysis Of Computerized Data x 1
- Pulse Oximetry x 1
- Pulmonary Function MVV x 1
- Pulmonary Function FRC (% Predicted Normal) x 1
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) x 1
- Bronchial Challenge With Methacholine x 1
- Spirometry Pre-bronchodilator x 1
- Spirometry Post-bronchodilator x 1

Disposition Last Updated by MCGEE, LINDA H @ 24 Mar 2011 1225 CDT

Released w/o Limitations

Note Written by DAW, PAMELA J @ 17 Mar 2011 1300 CDT

Consult Order

Referring Provider: LEWIS, CHRISTOPHER T

Date of Request: 16 Feb 2011

Priority: Routine

Provisional Diagnosis:

difficulty breathing (dyspnea)

Reason for Request:

clinic will schedule. Per Ms McGee. Pt is a 26 yo male with chest tightness and dyspnea. Please evaluate with baseline PFTs and a methacholine challenge study if necessary to rule out asthma.

Note Written by MCGEE, LINDA H @ 24 Mar 2011 1224 CDT

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

SAO: [REDACTED]
Pulmonary Function Test

SP Reference: None/None

Patient: MERWIN, DANIEL

Id: [REDACTED]

Physician: LEWIS, CHRISTOPHER

Room: BAAA

Any Info: NAVYAD

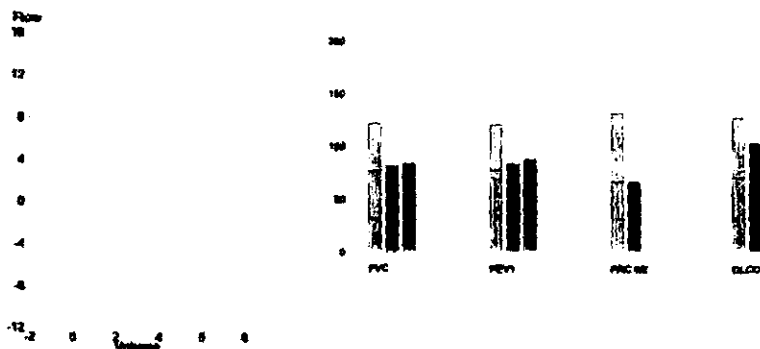
Diagnosis: Dyspnea

Date: 6/17/11

Age: 26
Gender: Male
Height(in): 69
Weight(lb): 153
Race: CAUCASIAN
Smoker: Yes
How Long: 1
Quit: Yes
Stopped: 2

Measure	Unit	Ref	Pre Mean	Pre % Ref
FVC	Liters	5.25	4.20	81
FEV1	Liters	4.21	3.53	84
FEV1/FVC	%	79	83	
FEF25-75%	L/sec	4.35	3.80	79
FEF50%	L/sec	5.41	4.71	87
PEF	L/sec	9.82	7.66	78
MMV	L/min	178	124	70
TLC	Liters	8.81	5.35	79
RV	Liters	1.99	1.10	85
RV/TLC	%	26	20	
FRC NG	Liters	5.72	2.50	67

DLCO	mL/min-g/min	28.0	30.0	100
DLCO/VA	mL/min-g/min	4.79	5.23	109
DLVA Adj	mL/min-g/min	5.23	5.23	
VA	Liters	6.82	5.74	84



Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

109 - 2

1. **Introduction**
 2. **Background**
 3. **Methodology**
 4. **Results**
 5. **Discussion**
 6. **Conclusion**
 7. **References**
 8. **Appendix**
 9. **Index**
 10. **Table of Contents**
 11. **Abstract**
 12. **Summary**
 13. **Key Words**
 14. **Keywords**
 15. **Subject Headings**
 16. **Classification**
 17. **Indexing**
 18. **References**
 19. **Appendix**
 20. **Index**
 21. **Table of Contents**
 22. **Abstract**
 23. **Summary**
 24. **Key Words**
 25. **Keywords**
 26. **Subject Headings**
 27. **Classification**
 28. **Indexing**
 29. **References**
 30. **Appendix**
 31. **Index**
 32. **Table of Contents**
 33. **Abstract**
 34. **Summary**
 35. **Key Words**
 36. **Keywords**
 37. **Subject Headings**
 38. **Classification**
 39. **Indexing**
 40. **References**
 41. **Appendix**
 42. **Index**
 43. **Table of Contents**
 44. **Abstract**
 45. **Summary**
 46. **Key Words**
 47. **Keywords**
 48. **Subject Headings**
 49. **Classification**
 50. **Indexing**
 51. **References**
 52. **Appendix**
 53. **Index**
 54. **Table of Contents**
 55. **Abstract**
 56. **Summary**
 57. **Key Words**
 58. **Keywords**
 59. **Subject Headings**
 60. **Classification**
 61. **Indexing**
 62. **References**
 63. **Appendix**
 64. **Index**
 65. **Table of Contents**
 66. **Abstract**
 67. **Summary**
 68. **Key Words**
 69. **Keywords**
 70. **Subject Headings**
 71. **Classification**
 72. **Indexing**
 73. **References**
 74. **Appendix**
 75. **Index**
 76. **Table of Contents**
 77. **Abstract**
 78. **Summary**
 79. **Key Words**
 80. **Keywords**
 81. **Subject Headings**
 82. **Classification**
 83. **Indexing**
 84. **References**
 85. **Appendix**
 86. **Index**
 87. **Table of Contents**
 88. **Abstract**
 89. **Summary**
 90. **Key Words**
 91. **Keywords**
 92. **Subject Headings**
 93. **Classification**
 94. **Indexing**
 95. **References**
 96. **Appendix**
 97. **Index**
 98. **Table of Contents**
 99. **Abstract**
 100. **Summary**
 101. **Key Words**
 102. **Keywords**
 103. **Subject Headings**
 104. **Classification**
 105. **Indexing**
 106. **References**
 107. **Appendix**
 108. **Index**
 109. **Table of Contents**
 110. **Abstract**
 111. **Summary**
 112. **Key Words**
 113. **Keywords**
 114. **Subject Headings**
 115. **Classification**
 116. **Indexing**
 117. **References**
 118. **Appendix**
 119. **Index**
 120. **Table of Contents**
 121. **Abstract**
 122. **Summary**
 123. **Key Words**
 124. **Keywords**
 125. **Subject Headings**
 126. **Classification**
 127. **Indexing**
 128. **References**
 129. **Appendix**
 130. **Index**
 131. **Table of Contents**
 132. **Abstract**
 133. **Summary**
 134. **Key Words**
 135. **Keywords**
 136. **Subject Headings**
 137. **Classification**
 138. **Indexing**
 139. **References**
 140. **Appendix**
 141. **Index**
 142. **Table of Contents**
 143. **Abstract**
 144. **Summary**
 145. **Key Words**
 146. **Keywords**
 147. **Subject Headings**
 148. **Classification**
 149. **Indexing**
 150. **References**
 151. **Appendix**
 152. **Index**
 153. **Table of Contents**
 154. **Abstract**
 155. **Summary**
 156. **Key Words**
 157. **Keywords**
 158. **Subject Headings**
 159. **Classification**
 160. **Indexing**
 161. **References**
 162. **Appendix**
 163. **Index**
 164. **Table of Contents**
 165. **Abstract**
 166. **Summary**
 167. **Key Words**
 168. **Keywords**
 169. **Subject Headings**
 170. **Classification**
 171. **Indexing**
 172. **References**
 173. **Appendix**
 174. **Index**
 175. **Table of Contents**
 176. **Abstract**
 177. **Summary**
 178. **Key Words**
 179. **Keywords**
 180. **Subject Headings**
 181. **Classification**
 182. **Indexing**
 183. **References**
 184. **Appendix**
 185. **Index**
 186. **Table of Contents**
 187. **Abstract**
 188. **Summary**
 189. **Key Words**
 190. **Keywords**
 191. **Subject Headings**
 192. **Classification**
 193. **Indexing**
 194. **References**
 195. **Appendix**
 196. **Index**
 197. **Table of Contents**
 198. **Abstract**
 199. **Summary**
 200. **Key Words**
 201. **Keywords**
 202. **Subject Headings**
 203. **Classification**
 204. **Indexing**
 205. **References**
 206. **Appendix**
 207. **Index**
 208. **Table of Contents**
 209. **Abstract**
 210. **Summary**
 211. **Key Words**
 212. **Keywords**
 213. **Subject Headings**
 214. **Classification**
 215. **Indexing**
 216. **References**
 217. **Appendix**
 218. **Index**
 219. **Table of Contents**
 220. **Abstract**
 221. **Summary**
 222. **Key Words**
 223. **Keywords**
 224. **Subject Headings**
 225. **Classification**
 226. **Indexing**
 227. **References**
 228. **Appendix**
 229. **Index**
 230. **Table of Contents**
 231. **Abstract**
 232. **Summary**
 233. **Key Words**
 234. **Keywords**
 235. **Subject Headings**
 236. **Classification**
 237. **Indexing**
 238. **References**
 239. **Appendix**
 240. **Index**
 241. **Table of Contents**
 242. **Abstract**
 243. **Summary**
 244. **Key Words**
 245. **Keywords**
 246. **Subject Headings**
 247. **Classification**
 248. **Indexing**
 249. **References**
 250. **Appendix**
 251. **Index**
 252. **Table of Contents**
 253. **Abstract</**

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$\mathcal{H}_{1,1}$	$\mathcal{H}_{2,1}$	$\mathcal{H}_{3,1}$	$\mathcal{H}_{4,1}$	$\mathcal{H}_{5,1}$	$\mathcal{H}_{6,1}$	$\mathcal{H}_{7,1}$	$\mathcal{H}_{8,1}$	$\mathcal{H}_{9,1}$	$\mathcal{H}_{10,1}$

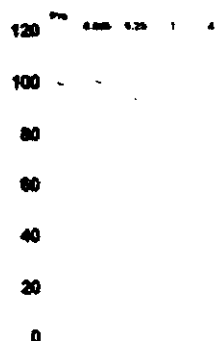
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Case
#12345
Date

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Page 3

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

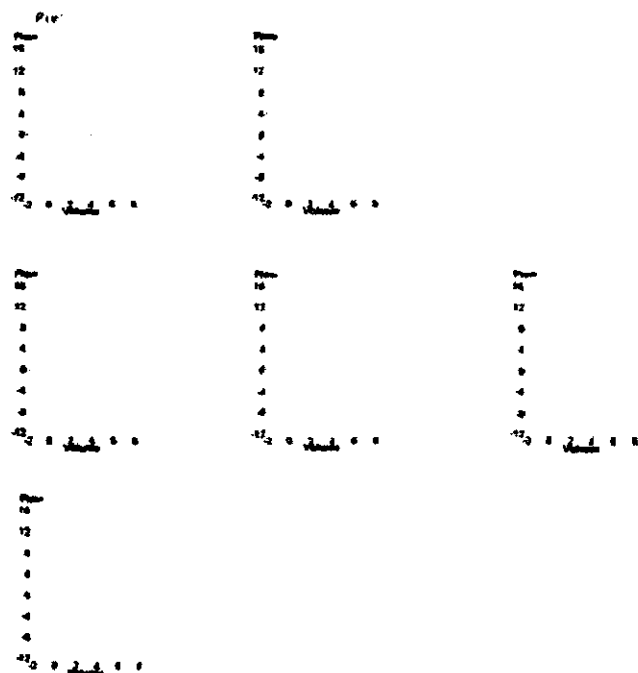
DoD ID: 1286180538

Created: 30 Oct 2017

Any Info: NAVY/AF

ID: 415 12 2485

Name: ME RUDIN, DANIEL



Comments

Interpretation

Pulmonary function test results are consistent with normal lung volumes and normal airflow. No evidence of obstructive or restrictive lung disease. The patient's results are within normal limits for age, sex, and height.

Robert Merges, CPT MC USN, Pulmonologist Internal Medicine

Christopher Lewis, CDR MC USN, Pulmonologist

Wendell Colberg, M.D. Allergist, Allergy Clinic

Page 1

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 25 Mar 2011 1117

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

16 Mar 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-1434732 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: MERWIN, DANIEL DENNIS

Date: 16 Mar 2011 0900 CDT

Appt Type: SPEC

Treatment Facility: NBHC NAS Pensacola

Clinic: NASP OPTOMETRY CLINIC

Provider: ZENT, JOHN W

Patient Status: Outpatient

Reason for Appointment: NASP/EVAL PRK/NO CONTACTS 30 DAYS/20/UNIF/MED LIST

Appointment Comments:

cac-mam

AutoCites Refreshed by ZENT, JOHN W @ 16 Mar 2011 1348 CDT

Problems**Chronic:**

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by SCHUSTER, ELIZABETH D @ 16 Mar 2011 0852 CDT

Reason For Appointment: NASP/EVAL PRK/NO CONTACTS 30 DAYS/20/UNIF/MED LIST

Allergen information verified by SCHUSTER, ELIZABETH D @ 16 Mar 2011 0852 CDT

Vitals

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1052

AR 1097

Vitals Written by SCHUSTER, ELIZABETH D @ 16 Mar 2011 0852 CDT
Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by SCHUSTER, ELIZABETH D @ 16 Mar 2011 0852 CDT
Reason for Visit

Visit for: military services physical.

History of present illness

The Patient is a 26 year old male. Source of patient information was patient.
Barriers to learning were identified as: None
Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.
Reliability of source of patient information was good.
In the Navy and currently on active duty. Visit is not deployment-related. Paygrade E5.

Past medical/surgical history

Reported History:

Surgical / procedural: Surgical / procedural history reviewed and updated in Patient's Problem List.
Reported medications: Medication history reviewed and updated in Medication module.
Physical trauma: No trauma to the eye.

Diagnosis History:

No glaucoma.
No hypertension.
No hyperlipidemia.
No diabetes mellitus

Family history

Family medical history: Reviewed in Problem List.

Review of systems

Cardiovascular symptoms: No cardiovascular symptoms.

Pulmonary symptoms: No pulmonary symptoms.

Physical findings

Eyes:

General/bilateral:

Visual Assessment: • Lensometry:
OD: -2.25 -0.50 x103
OS: -2.50 -0.25 x069.

Right eye:

Visual Assessment:	Value
Distance right acuity with current Rx: 20/	20

Left eye:

Visual Assessment:	Value
Distance left acuity with current Rx: 20/	20

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by ZENT, JOHN W @ 16 Mar 2011 1351 CDT

1. Myopia

Procedure(s): -Ophthalmological Prior Patient Start Intermediate Level Care x 1
-Determination Of Refractive State x 1

2. Lattice peripheral retinal degeneration: Likely flat retinoschisis, difficulty observing today even with 3-mirror funduscopy. Best view with BIO/scleral depression.

Consult(s): -Referred To: OPHTHALMOLOGY CONSULT (Routine) Specialty: OPHTHALMOLOGY Clinic:
OPHTHALMOLOGY CLINIC Primary Diagnosis: Lattice peripheral retinal degeneration

Disposition Written by ZENT, JOHN W @ 16 Mar 2011 1404 CDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Note Written by SIMIEN, LATOSHA D @ 16 Mar 2011 1000 CDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Monday			X		20'		X		20
Tuesday			X		20		X		20
Wednesday			X		20'		X		20
PERLA <input type="checkbox"/>				TA	0	PERLA <input type="checkbox"/>		TA	

A ① Malignant cell
② Distal part retroscapular cord
? ①-2 increased central canal pre CTG.

LT Zeno, John W., OP USA

CONTRAINDICATIONS / WARNINGS (per FDA)	
> 80 dB change in high or low to past 12 days	YES (NO)
Pregnant	YES (NO)
Feeding during last 6 months	YES (NO)
Substance abuse / immunosuppression	YES (NO)
Seizure history	YES (NO)
Neurological or sensory abnormality	YES (NO)
History of HIV / HIV positive	YES (NO)
Current use of:	
Anticoagulant/antiplatelet	YES (NO)
Anticancer chemotherapy	YES (NO)
Anticancer hormonal	YES (NO)
Statins	YES (NO)
Viral	YES (NO)
Recent eye exam / recent surgery	YES (NO)
Concomitant	YES (NO)
Recent medical history	YES (NO)
Active infectious disease	YES (NO)
Current HIV + recent high viral	YES (NO)
Recent Fluoride/antibiotic therapy doses	YES (NO)
Is of any infectious origin	YES (NO)
CONTRAINDICATIONS / WARNINGS (per USAP Panel)	
Age < 21	YES (NO)
CD4 > 22 / disease progressing to HIV/AIDS	YES (NO)
Recent Surgery	YES (NO)

Name: _____
 Last 4: _____
 PID#: _____

Signed By ZENT, JOHN W (Physician/Workstation) @ 16 Mar 2011 1404

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

17 Feb 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-1189878 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: MERWIN, DANIEL DENNIS Date: 17 Feb 2011 1000 CST Appt Type: SPEC
Treatment Facility: NBHC NAS Pensacola Clinic: NASP OPTOMETRY CLINIC Provider: ZENT, JOHN W
Patient Status: Outpatient

Reason for Appointment: NASP 3600/ROUT EYE EXAM/ME DLIST/CTD/20/REC/UOD

Appointment Comments:

CAC-EH

AutoCites Refreshed by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Problems

Chronic:

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Social History

No Social History Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
PEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Registry Items

Screening Written by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Reason For Appointment: NASP 3600/ROUT EYE EXAM/ME DLIST/CTD/20/REC/UOD

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Allergen information verified by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Vitals

Vitals Written by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Tobacco Use: No, Pain Scale: 0 Pain Free

SO Note Written by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Reason for Visit

Visit for: military services physical.

History of present illness

The Patient is a 26 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Reliability of source of patient information was good.

In the Navy and currently on active duty. Visit is not deployment-related. Paygrade E5.

Past medical/surgical history

Reported History:

Surgical / procedural: Surgical / procedural history reviewed and updated in Patient's Problem List.

Reported medications: Medication history reviewed and updated in Medication module.

Physical trauma: No trauma to the eye.

Diagnosis History:

No cataract

No macular degeneration

No glaucoma.

No hypertension.

No hyperlipidemia.

No diabetes mellitus

Family history

Family medical history: Reviewed in Problem List.

Review of systems

Cardiovascular symptoms: No cardiovascular symptoms.

Pulmonary symptoms: No pulmonary symptoms.

Physical findings

Eyes:

General/bilateral:

Visual Assessment: • Lensometry:

OD: -2.25 -0.50 x096

OS: -2.50 -0.25 x080.

Right eye:

Visual Assessment:

Distance right acuity with current Rx: 20/

Value

20

Right eye:

Intraocular Pressure:

Value

15 mmHg

Left eye:

Visual Assessment:

Distance left acuity with current Rx: 20/

Value

20

Left eye:

Intraocular Pressure:

Value

16 mmHg

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by ZENT, JOHN W @ 17 Feb 2011 1043 CST

1. Myopia: Pt. educated about CRS and its complications/benefits/alternatives. PRK and LASIK were discussed. Pt. K reading are near limit for CRS.

Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1

-Corneal Pachymetry Both Eyes x 1

Disposition Written by ZENT, JOHN W @ 17 Feb 2011 1044 CST

Released w/o Limitations

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Follow up: 1 to 2 month(s) or sooner if there are problems. - Comments: complete screening after 30 days out of CLs
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by ZENT, JOHN W @ 17 Feb 2011 1042 CST

Chief Complaint:		Pt. here for CRS screening, no visual or asthenopic complaints. 1.5 year retainability, wore CLs today						
Significant History:		(see above) -f/f, -dryness, -itch, -burn						
Confrontation Fields:		FTFC Central & Peripheral OD, OS		Cover Test:		cc	Ortho distance	Ortho' near
Extraocular Muscles:		Smooth, Accurate, Full, No Pain		Pupils:		Equal	Round	4+ Reactivity
auto		Sphere	Cylinder	Axis	DVA		Drops: @	
OD	-2.50	-0.50	099	OD	20/20	20/20	0.5% Proparacaine	
OS	-2.50	-0.50	070	OS	20/20		0.5% Tropicamide	
Prism		Add		NVA		2.5% Phenylephrine		
OD			OD		20/20	20/20	1% Cyclopentolate	
OS			OS		20/20		0.25%/0.4% Fluress	
Slit Lamp:		90D		Undilated		Ancillary Testing		
L/L	OD	OS		PACHYMETRY: OD 586 OS 576				
Conj.	Clear	Clear		Auto Ks: OD 40.25 @ 084 40.75 @ 174				
Cornea	Clear	Clear		OS 40.75 sphere				
Tear Layer	Clear	Clear						
A/C	D & Q	4X4	4X4	D & Q	Final Spec Rx		No SpRx Released	Add
Iris	Clear			Clear	OD	-2.50	-0.50	099 pl
Lens	Clear			Clear	OS	-2.50	-0.50	070 pl
Vitreous	Clear			Clear	PD			
C/D	.3/.3	.3/.3		No CL Fitting		Sol'n: Clear Care		
Margins	Pink/Distinct	Pink/Distinct		Brand	OD:	0	OS:	0
Macula	+FR, Clear	+FR, Clear		OD		pl	sph	0
A/V	2/3	2/3		OS		pl	sph	0
Periphery	Not Assessed	Not Assessed		Replace:		Continuous Wear: No		
Notes		-Medication reconciliation was performed. However, no new medications were added and no old medications have been discontinued by the provider. Pt was offered a copy of med list.						
Pt ed @ S/S ret tear/detach								

Signed By ZENT, JOHN W (Physician/Workstation) @ 17 Feb 2011 1044

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Feb 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T

Encounter ID: PENS-1168201 Primary Dx: Difficulty breathing (dyspnea)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**Date: **16 Feb 2011 0830 CST**
Clinic: **PULMONARY DISEASE CLINIC**
Appt Type: **SPEC**
Provider: **LEWIS, CHRISTOPHER T****Reason for Appointment:** ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN**Appointment Comments:**
CAC-CN**Screening Written by** LEE, BRANDON G @ 16 Feb 2011 0803 CST**Reason For Appointment:** ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN

Allergen information verified by LEE, BRANDON G @ 16 Feb 2011 0803 CST

Vitals**Vitals Written by** LEE, BRANDON G @ 16 Feb 2011 0803 CSTBP: 123/74, HR: 85, RR: 15, HT: 69 in, WT: 157 lbs, SpO2: 98%, BMI: 23.18, BSA: 1.864 square meters,
Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free**SO Note Written by** LEWIS, CHRISTOPHER T @ 16 Feb 2011 0905 CST**Chief complaint**

The Chief Complaint is: Chest tightness.

History of present illnessThe Patient is a 26 year old male.
He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression Screen: Negative PHQ-2 (Score < 3).
Pt is a 26 yo male with a history of allergies and childhood asthma. He notes a history of asthma in childhood which was associated with allergic symptoms. He remarks on 1 hospitalization for his asthma as a child but none since. Since the age of 8 he has been doing well and was not maintained on any inhalers. He is very active and is an active marathoner. Recently he has noted increased symptoms of chest tightness associated with exposure to cats and dogs. He was briefly treated with advair, but is currently being maintained on zyrtec and flonase as well as allergen avoidance with excellent control of his symptoms. He will have one weekly chest tightness and albuterol use, but is otherwise doing well, and recently completed a marathon. He presents for routine follow up.

Pain Severity 0 / 10.

Past medical/surgical history**Reported History:**

Past Medical History:

- 1) childhood asthma
- 2) allergies.

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history 1) T&A.

Reported medications: Medication history Zyrtec t1 tab po qd
Flonase.**Personal history**

-Tob: none

-EtOH: none

Originally from California. Lived in PA and NJ. USN for 5 years. Works as a cryptologist. Deployed to Japan recently, but no other travel or occupational exposure.

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Review of systems**Military service:** Visit is not deployment-related Location:

Date:

Systemic symptoms: Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.**Pulmonary symptoms:** No dyspnea, not coughing up sputum, no hemoptysis, and no wheezing.**Gastrointestinal symptoms:** No heartburn, no nausea, and no vomiting.**Physical findings**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Vital signs:

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Awake. ° Alert. ° In no acute distress.

Neck:

Palpation: ° Of the neck revealed no abnormalities.

Nose:

General/bilateral:

Nasal Discharge: ° No nasal discharge seen.

Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: ° Uvula was not enlarged. ° Tonsils were not enlarged.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° No wheezing was heard. ° No rhonchi were heard. ° No prolonged expiratory time. ° No rales/crackles were heard.

Cardiovascular system:

Jugular Venous Pressure: ° JVP was normal.

Jugular Venous Distention: ° JVD not increased.

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° S1 normal. ° S2 normal. ° No S3 heard. ° No S4 heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Palpation: ° Abdomen was not soft. ° No abdominal tenderness.

Skin:

° No generalized cyanosis.

A/P Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0930 CST

1. **difficulty breathing (dyspnea):** Pt is a 26 yo male with a history of childhood asthma and allergy type symptoms. His clinical history is suggestive of mild intermittent asthma, and his symptoms are under excellent control with control of his allergies with zyrtec and flonase. He will continue on these medications and prn albuterol for now, and will be referred for baseline PFTs and methacholine challenge study to definitive rule in/out asthma. Even with a positive study, his symptoms are under excellent control on his current therapy, and if needed he can be successfully controlled with an inhaled steroid. He is highly functional, and even if a diagnosis of asthma is established this in no way should impact upon his fitness for duty. He is currently fit for duty and fit for world wide deployment. He will follow up in 3-4 weeks to review the results of his PFTs.

Consult(s): -Referred To: PULMONARY FUNCTION STUDIES (Routine) Specialty: PULMONARY DISEASE Clinic:
PULMONARY FUNCTION LAB Primary Diagnosis: difficulty breathing (dyspnea)

Disposition Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0931 CST

Released w/o Limitations

Administrative Options: Consultation requested

Note Written by AEPPLI, CAROL @ 16 Feb 2011 0755 CST

Consult Order

Referring Provider: BROWN, TRAVIS S

Date of Request: 08 Feb 2011

Priority: Routine

Provisional Diagnosis:

ASTHMA EXTRINSIC

Reason for Request:

LVM ON CELL PHONE 25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment. thank you. contact phone # 850 292 7149

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 16 Feb 2011 0931

CHANGE HISTORY

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

The following SO Note Was Overwritten by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0905 CST.

SO Note Written by LEE, BRANDON G @ 16 Feb 2011 0806 CST

Chief complaint

The Chief Complaint is: ASTHMA.

History of present illness

The Patient is a 28 year old male.

He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PS). No depression Screen: Negative PHQ-2 (Score < 3).

Pain Severity 0 / 10.

Past medical/surgical history

Reported History:

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history N/A.

Reported medications: Medication history Zyrtec t1 tab po qd

Flonase.

Personal history

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Review of systems

Military service: Visit is not deployment-related Location:

Date:

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

08 Feb 2011 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S

Encounter ID: PENS-1057895 Primary Dx: Visit for: occupational health / fitness exam

Patient: MERWIN, DANIEL DENNIS Date: 08 Feb 2011 0830 CST Appt Type: WELL
Treatment Facility: NH Pensacola Clinic: DEPLOYMENT HEALTH CLINIC Provider: BROWN, TRAVIS SCOTT
Patient Status: Outpatient

Reason for Appointment: pha/jacc/15 min/rec/rx/ct
Appointment Comments:
cac-cjm

AutoCites Refreshed by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Problems	Family History	Allergies
Chronic: <ul style="list-style-type: none"> • Skin neoplasm of uncertain behavior • Removal of sutures • Extrinsic asthma • Folliculitis • Rosacea • Lattice peripheral retinal degeneration • Myopia • Allergic rhinitis • Visit for: occupational health/fitness exam • Parent education about immunizations • Visit for: military services physical • Exposure to venereal disease • Inquiry and counseling about contraceptive practices • Visit for: administrative purposes 	No Family History Found.	• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Reason For Appointment: pha/jacc/15 min/rec/rx/ct

Allergen information verified by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST
Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : pha;

Vitals

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

Vitals Written by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0835 CST

BP: 120/74 Left Arm, Adult Cuff, HR: 58 Regular, Radial Artery, RR: 20, HT: 69 in Actual, With Shoes,

WT: 156 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/25, Corr OS: 20/25, Corr OU: 20/25, BMI: 23.04, BSA: 1.859 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by BROWN, TRAVIS SCOTT @ 08 Feb 2011 1027 CST

Chief complaint

The Chief Complaint is: PHA.

History of present illness

The Patient is a 25 year old male.

Barriers to learning were identified as: None

Barriers considered were, social, cultural, emotional, motivational, physical, religious, cognitive and language.

Problem list reviewed.

Member has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results.

Current medication

Albuterol HFA inhaler prn

Advair prn

Zyrtec

Flonase

Past medical/surgical history

Reported History:

Past Medical History:

Fracture of right 5th phalanx 2008 - resolved.

Surgical / procedural: Surgical / procedural history Past Surgical History: noncontributory.

Review of systems

Cardiovascular symptoms: No cardiovascular symptoms.

Gastrointestinal symptoms: No gastrointestinal symptoms.

Genitourinary symptoms: No genitourinary symptoms.

Musculoskeletal symptoms: No musculoskeletal symptoms.

Psychological symptoms: No psychological symptoms.

A/P Written by BROWN, TRAVIS S @ 08 Feb 2011 1031 CST

1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION): Annual TB risk assessment completed with responses determined to be minimal risk. No further testing recommended. See NAVMED 6224/8.

Record review completed. Reviewed deployment health history and individual medical readiness. Counseling on avoidable health risk factors and screening per clinical preventive service guidelines provided.

Counseled on triglyceride results from PHA and discussed at length ways to improve through lifestyle changes; exercise, weight management, supplements and better nutrition. Teaching materials given.

No recent fasting glucose done, will repeat lipids in 2 months after he makes lifestyle modifications and get fasting glucose at that time.

Contact phone # 850 292 7149

Medically fit for full duty.

Laboratory(ies):

-GLUCOSE FASTING (Routine) Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT; LIPID PANEL (HDL, LDL, CHOL, TRIG (Routine) Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

2. ASTHMA EXTRINSIC (EXTRINSIC ASTHMA, UNSPECIFIED, MILD): Pulmonary consult placed to determine diagnosis, treatment recommendations and any deployment limiting concerns.

Consult(s):

-Referred To: PULMONARY DISEASES CONSULT (Routine) Specialty: PULMONARY DISEASE Clinic: PULMONARY DISEASE CLINIC Primary Diagnosis: ASTHMA EXTRINSIC

Disposition Written by BROWN, TRAVIS S @ 08 Feb 2011 1032 CST

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1063

AR 1108

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By **BROWN, TRAVIS S** (NP-C, NH Pensacola FL) @ 08 Feb 2011 1032

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

24 Jan 2011 at NH Pensacola FL, Corry Prime Care by WIEDL, ERICA KITCHELL

Encounter ID: PENS-927132 Primary Dx: ALLERGIC RHINITIS

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC NTTC**
Pensacola
Patient Status: **Outpatient**Date: **24 Jan 2011 1250 CST**
Clinic: **CORRY PRIME CARE**Appt Type: **ACUT**
Provider: **MILLER, ERICA KITCHELL****Reason for Appointment: MED REFILL****Appointment Comments:**
CSW**AutoCites Refreshed by MILLER, ERICA K @ 24 Jan 2011 1312 CST****Problems****Chronic:**

- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP 4 of 4 BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR)	Active	KETOCONAZOLE 2%	4 of 4	13 Oct 2010
Device Not Specified Miscellaneous		SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4		
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Vitals**Vitals Written by STANDLEY, CHAD J @ 24 Jan 2011 1313 CST**BP: 120/60, HR: 64, RR: 14, T: 98.3 °F, HT: 69 in, WT: 147 lbs, BMI: 21.71, BSA: 1.812 square meters, Tobacco Use: No, Alcohol Use: No,
Pain Scale: 0 Pain Free**Questionnaire AutoCites Refreshed by MILLER, ERICA K @ 24 Jan 2011 1312 CST****Questionnaires****SO Note Written by STANDLEY, CHAD J @ 24 Jan 2011 1320 CST****Chief complaint**Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

The Chief Complaint is: Med refill.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical for a refill on advair. pt states that he has no negative reactions to the medication. pt states that he only uses advair once a day.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Advair, albuterol

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergies, asthma. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter;

Surgical / procedural: Surgical / procedural history: Reviewed

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

Behavioral history: No tobacco use.

Alcohol: Not using alcohol.

Family history

Family medical history: Reviewed

Review of systems**Systemic symptoms:** No fever and no chills.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

• Normal. • Oriented to time, place, and person. • Well developed. • Well nourished. • In no acute distress.

Neurological:

• No learning disability was noted (barriers to learning).

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by MILLER,ERICA K @ 24 Jan 2011 1341 CST**1. ALLERGIC RHINITIS**

Medication(s):

-FLONASE (TYPE)-NAS 0.05% SPRA - INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3

Qt: 1 Rf: 3 Ordered By: MILLER,ERICA K Ordering Provider: MILLER, ERICA KITCHELL

-CETIRIZINE (ZYRTEC)-PO 10MG TAB - T1 TAB PO HS #30 RF5 Qt: 30 Rf: 5 Ordered By:

MILLER,ERICA K Ordering Provider: MILLER, ERICA KITCHELL

Disposition Last updated by MILLER,ERICA K @ 24 Jan 2011 1352 CST**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 25 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Note Written by MILLER,ERICA K @ 24 Jan 2011 1344 CST**

Pt is a 25 yo AD WM with a hx of childhood SAR/possible asthma sx. His congestion and breathing troubles are triggered by proximity of cats and dogs. Pt had no asthma/SAR sx while overseas for 3 years and not exposed to animals. Pt had return of sx

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1066

AR 1111

when dating and individual with cats and recently a roommate attained a dog. Pt was aggressively tx with albuterol and high dose advair for resp sx. At the time he was on antihistamines for a dermat condition. Over time he was only using one puff of advair daily for sx that occurred only when reclining for the evening. Pt denies any wheezing sx. Pt is s/p tonsilectomy (has adnoids) as a child.

alert AF NAD VSS
heent sinus nt tms wnl nares pale boggy clear drainage
OP healed tonsilectomy no edema
neck supple
skin type one red hair/blue eyes.

Described constellation and continuum of allergy, atopy, asthma. Pt seems to have very good control of sx when not around critters. To rule out severe asthma and possible medical DQ pt will be managed on oral antihistamines and intranasal steroids. If there is further difficulty breathing, pt had albuterol and should report to medical. Consider methacholine challenge and allergen testing if sx are not controlled. consider Adnoidectomy as sx are worst when reclining. Pt understands and agrees with plan. Pt will f/u as needed.

Signed By MILLER, ERICA K (Physician, NBHC Cherry Point) @ 24 Jan 2011 1352

CHANGE HISTORY

The following Disposition Note Was Overwritten by MILLER, ERICA K @ 24 Jan 2011 1352 CST:

The Disposition section was last updated by MILLER, ERICA K @ 24 Jan 2011 1352 CST - see above. Previous Version of Disposition section was entered/updated by STANDLEY, CHAD J @ 24 Jan 2011 1312 CST.

Released w/o Limitations

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.

No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

24 Nov 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-807839 Primary Dx: SKIN NEOPLASM UNCERTAIN BEHAVIOR

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 24 Nov 2010 0830 CST
Clinic: DERMATOLOGY CLINICAppt Type: EST\$
Provider: BRUMWELL, ERIC

Reason for Appointment: f/u skin check

Appointment Comments:

kec

AutoCites Refreshed by BRUMWELL, ERIC @ 24 Nov 2010 0834 CST**Problems****Chronic:**

- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP 4 of 4 BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

SO Note Written by BRUMWELL, ERIC @ 24 Nov 2010 0834 CST**Chief complaint**

The Chief Complaint is: PT KNOWN TO ME-- RED HEAD, NUMEROUS EPILIDES AND H/O SEVERE PROLONGED SUN EXPOSURE W/ NEW DARK LESION ON LOWER MUCOSAL LIP.

Reason for Visit

Visit for: follow-up exam (Noise Free F/U 1 or F/U2). Visit for: screening for dermatological disorders.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1068

AR 1113

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Military service.

Allergies

An allergy to drugs.

Current medication

No meds.

Past medical/surgical history

Reported History:

Reviewed.

Reported medications: Taking medication MEDICINE RECONCILIATION PERFORMED.

Diagnosis History:

No malignant melanoma of the skin

No basal cell carcinoma of the skin

No squamous cell carcinoma of the skin

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Head symptoms: No concerns about cosmetic appearance.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings

Vital signs:

• Pain level (0-10): Reviewed.

• Current vital signs reviewed.

General appearance:

• Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Oral cavity:

Lips: • Lower lip was abnormal 3MM DARK BROWN MACULE.

Pharynx:

Oropharynx: • Normal.

Lymph Nodes:

• No adenopathy IN H/N.

Neurological:

Speech: • Normal.

Psychiatric Exam:

Affect: • Congruent with the mood.

Skin:

• Normal except as noted EXAM LIMITED TO HEAD/NECK-- SEE MUCOSAL LIP FINDING.

Tests

UNIVERSAL PROTOCOL REQUIREMENTS WERE MET

Shave Biopsy ~

site verified with patient: Time <0830 >~site labeled with surgical marking pen~consent signed~area cleansed/prepped~anesthesia- 1% lidocaine with epi~hemostasis with drysol~closure: < >~bandage applied~wound care discussed~Estimated Blood Loss: <2 ml ~pt educated on wound care.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by BRUMWELL, ERIC @ 24 Nov 2010 0840 CST

1. SKIN NEOPLASM UNCERTAIN BEHAVIOR: LIP LESION APPEARS TO BE AN EPILIDE/SOLAR LENTIGO HOWEVER H/O CHANGE WARRANTS BX

Procedure(s):	-Biopsy Skin x 1
Laboratory(ies):	-TISSUE EXAM (Routine)
Patient Instruction(s):	-Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure
	-Avoid Exposure Bright Sunlight
	-Change Dressing Daily As Instructed
	-Clean Incision As Instructed
	-Education And Counseling
	-Instructions For Patient

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

2. visit for: screening exam malignant neoplasm skin: D/W PT ABCDS, MSE, SUN AVOIDANCE, NEW/CHANGING LESIONS

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by KENT.AHMAD J @ 24 Nov 2010 0840 CST

MEDICAL RECORD		REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES	
A. CERTIFICATION			
Is (Area of approach being) _____ IN OR OUT			
CONSENT TO PROCEEDS	LOCATION	Shave body	
ANESTHETIC	PREPARATION		
B. STATEMENT OF REQUEST			
I, the nature and purpose of the operation or procedure, present alternative methods of treatment, and may involve, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made as to the concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be taking the operation or procedure in patient's language.			
After learning and local anesthesia, a piece of tissue will be placed off with a surgical blade, either through the skin surface or shaved skin with skin surface. A scar will form. There may include bleeding, infection and recurrence.			
Which is to be performed by or under the direction of Dr. Scott			
I request the performance of the above named operation or procedure and at such additional operations or procedures as are found to be necessary or derivable from the judgment of the professional staff of the below named medical facility during the course of the above named operation or procedure.			
I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below named medical facility.			
I consent to surgery or anesthesia, if any to:			
of hand to hand			
I request the disposal by incineration of the below named medical facility of any tissues or parts which it may be necessary to remove.			
I understand that photographs and x-rays may be taken of the operation, and that they may be reviewed by various personnel undergoing training or reduce radiation at one or other facilities. I consent to the taking of such pictures and observation of the operation by a authorized personnel subject to the following conditions:			
a. The name of the patient and neither family is not used to identify said picture.			
b. Said pictures be used only for purposes for medical educational study or research.			
I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.			
(Check any of each point where which are not applicable)			
C. SIGNATURES			
Appropriate lines to parts A and B must be completed before signature.			
I, CONSULTING PHYSICIAN/SURGEON: I have examined this patient as to the nature of the proposed procedure(s), stated my diagnosis, and anticipated results as described above. I have also discussed potential problems related to recognition, possible results of non-compliance, signed my name, and affixed my signature.			
Signature of Consulting Physician			
TO PATIENT: Understanding the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.			
Signature of Patient			
SIGNATURE OF GUARDIAN: (When patient is a minor or unable to give consent)			
Signature of Guardian			
Understanding the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.			
Signature of Anesthesia Provider			
Signature of Anesthesia Nurse/Certified			
Date and Time			
FACILITY'S CREDIT CARD		PAYER'S ID	
MERWIN, DANIEL DENNIS		REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES	
20 [REDACTED]		Medical Record	
24 Nov 2010, 0837		OPTIONAL FORM 523	

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** OoD ID: 1286180538 Created: 30 Oct 2017
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**PRE-PROCEDURE CHECKLIST
UNIVERSAL PROTOCOL**

I. PHYSICIAN'S PRE-PROCEDURE ASSESSMENT

Procedure: Stent

II. UNIVERSAL PROTOCOL TIMEOUT: Verifying the Correct Patient - Correct Procedure - Correct Procedure Site Checklist.

- | | |
|--|--|
| 1. Pre-procedural verification: Patient states name and DOB which is compared to the following (as appropriate): | YES |
| • Documents- History & Physical, Nursing Assessment | <input checked="" type="checkbox"/> |
| • Consent Form | |
| • Diagnostic Test Results | |
| • Blood Products, implants, devices, Special Equipment | |
| 2. Site Marking: (patient involvement if possible) | YES/NA |
| • By provider doing the procedure | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| TIME OUT CONDUCTED AUDIBLY when | YES/NA |
| Anesthetics/Fluid for irrigation (if needed) | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| Patient- 2 identifiers (name and DOB) | <input checked="" type="checkbox"/> |
| Procedure- correct procedure documented on consent | <input checked="" type="checkbox"/> |
| Laterality- Surgical site marked | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| Equipment- if needed | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| Position- Verified | <input checked="" type="checkbox"/> |
| Implants- if needed | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| Exams- Diagnostic tests (radiographs etc.) | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| Safety Precautions- Based upon outpatient history and profile | <input checked="" type="checkbox"/> <input type="checkbox"/> |

Comments (optional)

Provider Signature

Date/Time

11/29/17

Pat Info

Signed By **BRUMWELL, ERIC** (Physician/Workstation) @ 24 Nov 2010 1124

CHANGE HISTORY

The following SO Note Was Overwritten by **BRUMWELL, ERIC** @ 24 Nov 2010 0834 CST:

SO Note Written by **BUROKER, JONATHAN G** @ 24 Nov 2010 0827 CST

Chief complaint

The Chief Complaint is: Check check.

Reason for Visit

Visit for: follow-up exam (Noise Free F/U 1 or F/U2).

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural, religious, emotional, motivational, physical, and cognitive.

Current medication

No meds.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

* Pain level (0-10): Reviewed.

* Current vital signs reviewed.

General appearance:

* Well-appearing. * Alert. * Oriented to time, place, and person. * Well nourished. * Well hydrated.

Therapy

* No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

15 Nov 2010 at NH Pensacola FL, Corry Prime Care by WILLIAMS, TREVOR MICHAEL

Encounter ID: PENS-791398 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC NTTC
Pensacola
Patient Status: OutpatientDate: 15 Nov 2010 1336 CST
Clinic: CORRY PRIME CAREAppt Type: WELL
Provider: WILLIAMS, TREVOR M**Reason for Appointment:** flumist**Appointment Comments:** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1336 CST
lwc**Vitals****Vitals** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1339 CST**Comments:** n/a**SO Note** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1339 CST**Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 25 year old male.

He reported: Past medical history reviewed.

Allergies

Reviewed an allergy. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

: up to date.

• Received dose of influenza live virus vaccine, for intranasal use Vaccine lot #, manufacturer, and location given recorded in immunization module. Patient provided and reviewed current CDC Vaccine Information Sheet. Vaccine inspected for discoloration/particulates and Exp Date verified

Past medical/surgical history**Reported History:**

Recent events: No active illness.

Review of systems**Systemic symptoms:** No fever.**A/P Last Updated by** CRUMPTON, LATAIJA W @ 15 Nov 2010 1340 CST**1. Vaccines Prophylactic Need Against Influenza****2. Parent Education: Immunizations (MEDICATION EDUCATION)**Procedure(s):
-Influenza Virus Vaccine Live Intranasal x 1
-Immunization Administration One Vaccine x 1**Disposition Last Updated by** CRUMPTON, LATAIJA W @ 15 Nov 2010 1341 CST**Released w/o Limitations****Follow up:** as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** WILLIAMS, TREVOR M (Physician/Workstation) @ 15 Nov 2010 1401

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

13 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-731275 Primary Dx: FOLLICULITIS

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 13 Oct 2010 0845 CDT
Clinic: DERMATOLOGY CLINICAppt Type: EST\$
Provider: BRUMWELL, ERIC

Reason for Appointment: F/u biopsy

Appointment Comments:

tjn

AutoCites Refreshed by BRUMWELL, ERIC @ 13 Oct 2010 0838 CDT**Problems****Chronic:**

- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

SQ Note Written by BRUMWELL, ERIC @ 13 Oct 2010 0854 CDT**Chief complaint**

The Chief Complaint is: FOLLICULITIS--NO NEW EPISODES BUT HAS NBOT BEEN OUT IN SUN OR IN WATER LATELY.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

Military service in the Navy, currently on active duty, and paygrade E5.

Concerns about cosmetic appearance.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

An allergy to drugs.

Current medicationAllegra
albuterol
advair.**Past medical/surgical history**

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Reported History:

Reported medications: Including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Currently taking medication MEDICINE RECONCILIATION PERFORMED.

Personal history

-Tob:n

-EtOH:y

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

• Current vital signs reviewed.

General appearance:

• Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Neurological:

Speech: • Normal.

Psychiatric Exam:

Affect: • Congruent with the mood.

Skin:

• Normal except as noted NO ACTIVE SKIN LESIONS.

Therapy

• Herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Lab Result Cited by BRUMWELL, ERIC @ 13 Oct 2010 0839 CDT**Tissue Exam**

Date Collected:	28 Sep 2010 0821	
POC Enc:	E847233	
Enc Fac:	NH Pensacola FL	
Clinician:	BRUMWELL, ERIC	
Status:	Certify	
Procedure:	TISSUE EXAM	
Order #:	101005-04215	
Provider:	BRUMWELL, ERIC	
Ordered Date:	05 Oct 2010 1421	
Priority:	ROUTINE	
Specimen:	TISSUE	
Resulted Date:	05 Oct 2010 1421.1-0500	
100929 SP 2595	Col: 28Sep10@0821	TISSUE(TISSUE)
Hcp:	BRUMWELL, ERIC	Req Loc: DERMATOL
TISSUE E	C: DMR05Oct10@1421	
	CoPath Report	
Patient:	MERWIN, DANIEL DENNIS	Specimen #:
S10-2595		
Accessioned:	09/29/10	
Pathologist:	DAVID M ROGERS, LT MC USN	
SPECIMEN:		
	A: SKIN, CHEST, PUNCH BX B: SKIN, BACK, PUNCH BX	
CLINICAL DIAGNOSIS AND HISTORY:		
AFTER EXPOSURE TO WATER	A/B- PUSTULES ON A-CHEST AND B-BACK THAT DEVELOP	
TRUNK AND FACE--HAS	AND SUN AT BEACH--PT HAS THESE LESIONS ON UPPER	
AREAS	HISTORY OF SEVERE SUNBURN AS A CHILD IN THESE	
	PRE-OPERATIVE DIAGNOSIS:	

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

FUNGAL STAINS AS WELL

POST-OPERATIVE DIAGNOSIS:

GROSS DESCRIPTION:

patient's name "Merwin," and
skin excised to a depth
0.3cm creamy-white lesion.

patient's name "Merwin," and
tan skin excised to a
a 0.3cm white-tan area.

FINAL DIAGNOSIS:

A) SKIN, "CHEST," PUNCH BIOPSY:

CONSISTENT WITH ACUTE

B) SKIN, "RIGHT BACK," PUNCH BIOPSY:

CONSISTENT WITH ACUTE

Electronically Signed **

Comment:

Langerhans' cells with
microabscess cavities is
biopsies from both the
units. These findings are
stains are

MILIARIA PUSTULOSA VS FOLLICULITIS--PLEASE DO

Operative Findings: SAA
Post-operative Diagnosis: SAA

A) Received in Formalin, labeled with the
designated "Chest" is a 0.4cm punch biopsy of tan
of 0.5cm. The skin surface is remarkable for a
Bisected. 2/1/NG hh
B) Received in Formalin, labeled with the
designated "Right Back" is a 0.5cm punch biopsy of
depth of 0.6cm. The skin surface is remarkable for
Bisected. 2/1/NG hh

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES,
FOLLICULITIS.
- SEE COMMENT.

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES,
FOLLICULITIS.
- SEE COMMENT.
dmr/10/05/10 ** Report

DAVID M ROGERS, LT MC USN

A mixture of acute inflammatory cells and
associated necroinflammatory debris forming
present within the infundibulum of follicles in
chest and back, extending into the sebaceous
consistent with an acute folliculitis. Fungal
non-contributory.
SNOMED CODES
1. P1148; T02424
2. M41780; M47401; T01000
3. E4000
4. P1148; T02450
5. M41780; M47401; T01000
6. E4000

CPT Codes:

; 88305 ; TISSUE LEVEL IV
; 88305 ; TISSUE LEVEL IV
; 88313 ; SPECIAL STAINS OTHER
; 88313 ; SPECIAL STAINS OTHER

Lab Result Cited by BRUMWELL, ERIC @ 13 Oct 2010 0839 CDT

Tissue Culture+Smear

Order # 100928-00627 (NH Pensacola)
Filler # 100928 MI 3893 (NH Pensacola)
Status: Final
Ordering Provider: BRUMWELL, ERIC
Priority: ROUTINE
Date Ordered: 28 Sep 2010 0827
Date Resulted: 01 Oct 2010 0918

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1076

AR 1121

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

COLLECT_SAMPLE:

TISSUE

Order Comment:

PLEASE DO FUNGAL, AFB AND BACTERIAL

BACTERIOLOGY RESULT (CULT TISSUE -- Final): NO GROWTH IN 24 HOURS

BACTERIOLOGY RESULT (CULT TISSUE -- Final): NO GROWTH IN 48 HOURS

HOURS

BACTERIOLOGY RESULT (CULT TISSUE -- Final): FINAL REPORT RESULTS: NO GROWTH AT 72

GRAM STAIN (GRAM STAIN -- Final): NO WBCs OR ORGANISMS NOTED

Specimen:

Tissue

Collected:

28 Sep 2010 0851

Results:

Final report

Lab Result Cited by BRUMWELL, ERIC @ 13 Oct 2010 0839 CDT**Acid Fast Bacilli Culture**

Order #

100928-00798 (NH Pensacola)

Filler #

100928 STB 48 (NH Pensacola)

Status:

Intermediate

Ordering Provider:

BRUMWELL, ERIC

Priority:

ROUTINE

Date Ordered:

28 Sep 2010 0847

Date Resulted:

30 Sep 2010 0938

COLLECT_SAMPLE:

TISSUE

Order Comment:

left back

MYCOBACTERIUM:

Negative for M. tuberculosis complex rRNA

MYCOBACTERIUM:

Performed by Fl. Dept. of Health Lab. Jacksonville

ACID FAST STAIN:

No Acid Fast Bacilli seen on smear.

ACID FAST STAIN:

Performed by Fl. Dept. of Health Lab. Jacksonville

Specimen:

Tissue

Collected:

28 Sep 2010 0851

Results:

I

Lab Result Cited by BRUMWELL, ERIC @ 13 Oct 2010 0839 CDT**Wound Culture+Smear**

Order #

100928-00865 (NH Pensacola)

Filler #

100928 MI 3904 (NH Pensacola)

Status:

Final

Ordering Provider:

BRUMWELL, ERIC

Priority:

ROUTINE

Date Ordered:

28 Sep 2010 0854

Date Resulted:

28 Sep 2010 1134

COLLECT_SAMPLE:

SKIN LESION

Order Comment:

FROM PUSTULE OF BACK

GRAM STAIN (GRAM STAIN -- Final): NO WBCs OR ORGANISMS NOTED

BACTERIOLOGY RESULT (CULT AEROBIC WOUND -- Final): NO GROWTH IN 24 HOURS

GROWTH IN 48 HOURS

BACTERIOLOGY RESULT (CULT AEROBIC WOUND -- Final): FINAL REPORT RESULTS: NO

Specimen:

Skin

Collected:

28 Sep 2010 0954

Results:

Final report

A/P Written by BRUMWELL, ERIC @ 13 Oct 2010 0901 CDT

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1077

AR 1122

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

1. FOLLICULITIS: PATH/LABS SHOW ONLY STERILE FOLLICULITIS-- SUSPECT PITYROSPORUM DUE TO LOCATION

WILL UNDERGO TRIAL OF TOPICAL KETOCONAZOLE SHAMPOO AND HAVE PT F/U FOR FURTHER EVAL AFTER THE HOLIDAYS

Medication(s): -NON-FORMULARY DRUG REQUEST (NFDR)--MISC - KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4 Qt: 2 Rf: 4 Start Date: 10/12/2010
Comment: DERM REQUIRES
Patient Instruction(s): -Instructions For Patient
-Education And Counseling

Disposition Written by BRUMWELL, ERIC @ 13 Oct 2010 0901 CDT

Released w/o Limitations

Follow up: 3 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By BRUMWELL, ERIC (Physician/Workstation) @ 13 Oct 2010 0901

CHANGE HISTORY

The following SQ Note Was Overwritten by BRUMWELL, ERIC @ 13 Oct 2010 0854 CDT:

SQ Note Written by GIBSON, CHARLES A @ 13 Oct 2010 0842 CDT

Chief complaint

The Chief Complaint is: Fu biopsy.

Referred here

Referred by:

History of present illness

The Patient is a 26 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.
In the Navy, currently on active duty, and paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Allegro
albuterol
advair.

Personal history

-Tob:n

-EtOH:y

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

* Pain level (0-10): Reviewed.

* Current vital signs reviewed.

General appearance:

* Well-appearing. * Alert. * Oriented to time, place, and person. * Well nourished. * Well hydrated.

Therapy

* Herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: [REDACTED]

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

04 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-715986 Primary Dx: Removal Of Sutures

Patient: MERWIN, DANIEL DENNIS

Date: 04 Oct 2010 0755 CDT

Appt Type: EST\$

Treatment Facility: NH Pensacola

Clinic: DERMATOLOGY CLINIC

Provider: BRUMWELL, ERIC

Patient Status: Outpatient

Reason for Appointment: Suture Removal

AutoCites Refreshed by BRUMWELL, ERIC @ 04 Oct 2010 0837 CDT**Problems****Chronic:**

- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by BRUMWELL, ERIC @ 04 Oct 2010 0838 CDT**1. Removal Of Sutures**Disposition Written by BRUMWELL, ERIC @ 04 Oct 2010 0838 CDT**Released w/o Limitations**

Follow up: 2 week(s) or sooner if there are problems. - Comments: TO REVIEW ALL LABS WHEN BACK

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By BRUMWELL, ERIC (Physician/Workstation) @ 04 Oct 2010 0838

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

28 Sep 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-706703 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**Date: **28 Sep 2010 0815 CDT**
Clinic: **DERMATOLOGY CLINIC**Appt Type: **EST\$**
Provider: **BRUMWELL, ERIC**

Reason for Appointment: f/u skin check

AutoCites Refreshed by BRUMWELL, ERIC @ 28 Sep 2010 0755 CDT**Problems****Chronic:**

- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by WEST, ALEXANDER D @ 28 Sep 2010 0800 CDT

Reason For Appointment: f/u skin check

Allergen information verified by WEST, ALEXANDER D @ 28 Sep 2010 0800 CDT

SO Note Written by BRUMWELL, ERIC @ 28 Sep 2010 0817 CDT**Chief complaint**

The Chief Complaint is: RECURRENT PUSTULES AND UPPER TRUNK AFTER SWIMMING AT BEACH/BEING IN SUN--DOES NOT OCCUR W/ ONLY SUN EXPOSURE.

Reason for Visit

Visit for: screening for dermatological disorders.

Referred here

Referred by: from Primary Care.

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Military service in the Navy, currently on active duty, and paygrade E5.

Concerns about cosmetic appearance.

Allergies

An allergy to drugs.

Current medication

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

Cetaphil
allegria
triamcinolone
albuterol
advair.

Past medical/surgical history**Reported History:**

Reviewed.

Reported medications: Including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Taking medication MEDICINE RECONCILIATION PERFORMED.

Personal history

-Tob:n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings**Vital signs:**

- Pain level (0-10): Reviewed.

- Current vital signs reviewed.

General appearance:

- Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Neurological:

- Speech: • Normal.

Psychiatric Exam:

- Affect: • Congruent with the mood.

Skin:

- Lesions on the face. • Normal except as noted <1MM PUSTULES ON FOREHEAD AND UPPER BACK/CHEST--MANY IN VARIOUS STAGES OF EVOLUTION/BEING EXCORIATED.

Tests

UNIVERSAL PROTOCOL REQUIREMENTS WERE MET

Shave Biopsy -

site verified with patient: Time 0815 >~site labeled with surgical marking pen~consent signed~area cleansed/prepped~anesthesia- 2% lidocaine with epi~hemostasis with drysol~closure: < 4-0PROL >~bandage applied~wound care discussed~Estimated Blood Loss: <2 ml~suture removal 10 days~pt educated on wound care.

Therapy

- No herbal medicines.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by BRUMWELL, ERIC @ 28 Sep 2010 0854 CDT

1. FOLLICULITIS: PER PT ONLY W/ COMBINATION OF HEAT/SUN AND WATER AT BEACH

SUSPECT FOLLICULITIS VS MILIARIA PUSTULOSA- PT TO AVOID SUN/BEACH ENVIRONMENT UNTIL RESULTS DISCUSSED W/ HIM

BIOPSIES PERFORMED FOR H&E AS WELL AS TRIPLE CULTURE

Procedure(s):	-Biopsy Skin x 1 -Biopsy Skin Each Additional Lesion x 1
Laboratory(ies):	-TISSUE EXAM (Routine); CULTURE TISSUE PANEL (Routine); PLEASE DO FUNGAL, AFB AND BACTERIAL Start Date: 09/27/2010; CULTURE AEROBIC WOUND PANEL (Routine): FROM PUSTULE OF BACK Start Date: 09/27/2010
Patient Instruction(s):	-Clean Incision As Instructed -Education And Counseling -Instructions For Patient -Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure -Post-Op Teaching About Wound Care

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1081

Case 1:24-cv-01000-TMD Document 1 Filed 01/08/25 Page 1127 of 1353

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Disposition Written by BRUMWELL, ERIC @ 28 Sep 2010 0855 CDT

Released w/o Limitations

Follow up: 10 day(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By BRUMWELL, ERIC (Physician/Workstation) @ 28 Sep 2010 0855

CHANGE HISTORY

The following SO Note Was Overwritten by BRUMWELL, ERIC @ 28 Sep 2010 0817 CDT:

SO Note Written by WEST, ALEXANDER D @ 28 Sep 2010 0803 CDT

Chief complaint

The Chief Complaint is: Skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

In the Navy, currently on active duty, and paygrade E5.

Current medication

Cetaphil

allegria

triamcinolone

albuterol

advair.

Past medical/surgical history

Reported History:

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tobacco

-EIOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

* Pain level (0-10): Reviewed.

* Current vital signs reviewed.

General appearance:

* Well-appearing. * Alert. * Oriented to time, place, and person. * Well nourished. * Well hydrated.

Therapy

* No herbal medicines.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

01 Sep 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-665023 Primary Dx: ASTHMA EXTRINSIC

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC NTTC
Pensacola
Patient Status: OutpatientDate: 01 Sep 2010 0850 CDT
Clinic: CORRY PRIME CAREAppt Type: ACUT
Provider: GUNTER, ROGER WILLIAM**Reason for Appointment:** poss. allergic reaction**Appointment Comments:**
mr.AutoCites Refreshed by GUNTER, ROGER WILLIAM @ 01 Sep 2010 0848 CDT**Allergies**

• OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by STANDLEY, CHAD J @ 01 Sep 2010 0839 CDTBP: 120/84, HR: 76, RR: 16, T: 98.0 °F, HT: 69 in, WT: 145 lbs, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,
Pain Scale: 0 Pain Free**Comments:** 850-292-7149SO Note Written by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1423 CDT**Chief complaint**

The Chief Complaint is: Possible allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with allergies to cats and dogs which makes it hard for the pt to breathe. If he's in the same room with these animals, the pt feels tightness in chest. and becomes short of breath. He has to remove him self and uses an OTC epinephrine inhaler. pt states that when he does have an onset it can take up to 2days for the symptoms to go away completely. He had severe childhood asthma but no symptoms for years since 11 or 12.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Itching of the eyes.

Dyspnea, paroxysmal nocturnal dyspnea, orthopnea: sleeping upright or with extra pillows, and wheezing.

Current medication

Current medications reviewed and reconciled.

fexofenadine HCL 100mg, ceraphil/aquanil.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

childhood asthma. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Taking OTC medications. Not taking dietary supplements and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

• Normal. • Oriented to time, place, and person. • Well developed. • Well nourished. • In no acute distress.

Neck:

Palpation: • No tenderness of the neck.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: • PERRL.

External Eye: • Conjunctiva exhibited no abnormalities.

Sclera: • Normal.

Ears:

General/bilateral:

Tympanic Membrane: • Normal.

Pharynx:

Oropharynx: • Posterior pharyngeal wall was normal.

Lymph Nodes:

• Cervical lymph nodes were not enlarged. • Submandibular lymph nodes were not enlarged. • Supraclavicular lymph nodes were not enlarged.

Lungs:

• Respiration rhythm and depth was normal. • Exaggerated use of accessory muscles for inspiration was not observed.

• Clear to auscultation. • No wheezing was heard. • No rhonchi were heard: • No rales/crackles were heard.

Cardiovascular system:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • S1 normal. • S2 normal. • No S3 heard. • No S4 heard. • No gallop was heard. • No pericardial friction rub heard.

Murmurs: • No murmurs were heard.

Neurological:

• No learning disability was noted (barriers to learning).

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1438 CDT

1. ASTHMA EXTRINSIC/EXTRINSIC ASTHMA, UNSPECIFIED, MILD PERSISTENT): exposure to cats and dogs. DC Primatine Mist. Patient is already on daily Claritin per Dermatology for skin rash - 1 week so far. Is supposed to follow up with Derm after 1 month and if no improvement will get skin biopsies. He's to continue on the Claritin. Will add a long acting B agonist and Albuterol for rescue inhaler in case he has any acute exacerbations of his symptoms. I have advised him to practice avoidance - not be around cats and dogs as much as possible. he has none in his home but does visit with people that have pets. If the Claritin, avoidance and Advair are not effective will refer to Allergist.

Medication(s): -ALBUTEROL *HFA* MDI-INH 90MCG/PUFF AERP - INH 2 PF PO Q4H FOR WHEEZING #1 RF1 Qt:
1 Rf: 1
-ADVAIR 250-50MCG--PO INHA - INHALE 1 PUFF ORALLY BID #1 RF1 Qt: 1 Rf: 1

Disposition Last updated by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1439 CDT**Released w/o Limitations**

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 01 Sep 2010 1439**CHANGE HISTORY****The following Disposition Note Was Overwritten by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1439 CDT:**

The Disposition section was last updated by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1439 CDT - see above. Previous Version of Disposition section was entered/updated by STANDLEY, CHAD J @ 01 Sep 2010 0913 CDT.

Released w/o Limitations

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1084

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.

No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1423 CDT.

SO Note Written by STANDLEY, CHAD J @ 01 Sep 2010 1002 CDT

Chief complaint

The Chief Complaint is: Possible allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with complaints of allergic reaction. pt has allergies to cats and dogs which makes it hard for the pt to breath. pt feels tightness in chest, when this happens the pt has to remove him self and use a epinephrine inhaler. pt states that when he does have an onset it can take up to 2days for the symptoms to go away. pt also mentioned that he also gets headaches.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Itching of the eyes.

Dyspnea, paroxysmal nocturnal dyspnea, orthopnea: sleeping upright or with extra pillows, and wheezing.

Current medication

Current medications reviewed and reconciled.

fexofenadine HCL 100mg, ceraphil/aquanil.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

childhood asthma. No previous hospitalizations that are associated with the reason for this encounter; and no previous emergency room visit that are associated with the reason for this encounter.

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Taking OTC medications. Not taking dietary supplements and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems

Systemic symptoms: No fever and no chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Psychological symptoms: Not thinking about suicide. No homicidal thoughts.

Physical findings**Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

* Temperature: Reviewed. * RR: Reviewed. * PR: Reviewed.

General appearance:

* Normal. * Oriented to time, place, and person. * Well developed. * Well nourished. * In no acute distress.

Lungs:

* Respiration rhythm and depth was normal. * Exaggerated use of accessory muscles for inspiration was not observed. * Clear to auscultation. * No wheezing was heard. * No rhonchi were heard: * No rales/crackles were heard.

Neurological:

* No learning disability was noted (barriers to learning).

Therapy

* No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

1085

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

25 Aug 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P

Encounter ID: PENS-653628 Primary Dx: FOLLICULITIS

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 25 Aug 2010 0830 CDT
Clinic: DERMATOLOGY CLINICAppt Type: EST\$
Provider: SMITH, ERIC P

Reason for Appointment: f/u skin check

AutoCites Refreshed by SMITH, ERIC P @ 25 Aug 2010 0850 CDT**Problems****Chronic:**

- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by WEST, ALEXANDER D @ 25 Aug 2010 0842 CDT

Reason For Appointment: f/u skin check

Allergen information verified by WEST, ALEXANDER D @ 25 Aug 2010 0842 CDT

SO Note Written by SMITH, ERIC P @ 25 Aug 2010 0908 CDT**Chief complaint**

The Chief Complaint is: Fu skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.
Barriers to learning were identified as: None
Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.
In the Navy, currently on active duty, and paygrade E5.

Presents in follow-up. He was seen for a papular follicular-based rash that appeared to occur when exposed to sunlight, primarily on the weekends. After his last visit he stopped using his soaps and use Cetaphil for two weeks. He also switched to a nonchemical sunscreen but did not notice any improvement in his symptoms overall. He has subsequently returned to using his antibacterial soap or old spice, and has used a chemical sunscreen (baby sunscreen SPF 70) and states that this weekend he did not have a breakout at all, in spite of being in the sun 11 to two.
He states that the rash has characteristically only lasted for about two to 3 days before going away without sequelae. It is tender but not necessarily itchy. He has pictures of his breakout which occurred primarily on his neck face and upper chest.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Claritan.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tob: n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

• Current vital signs reviewed.

General appearance:

• Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Skin:

• Lesions: No rash today. No evidence of scarring.

Photographs showed demonstrate raised erythematous papules on his chest with several that appear to be pustular.

• General appearance was normal.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by SMITH, ERIC P @ 25 Aug 2010 0911 CDT

1. **FOLLICULITIS:** Recurrent short-lived folliculitis. Discussed that switching to Cetaphil for only two weeks may not have been long enough to reduce chemical exposure from other soaps. There is still no clear etiology for his rash although it does appear to be sun related. Discussed trying to avoid histamine release as well symptomatically treatment.

Plan:

Start Allegra one tablet daily for 30 days.

Triamcinolone cream two to 3 times a day for two to 3 days at onset of his rash.

Return in one month, sooner as needed.

Medication(s): -FEXOFENADINE (ALLEGRA) -PO 180MG TAB - T1 TAB PO QD F ALLERGIES UD #30 RF2 Qt: 30
Rf: 2
-TRIAMCINOLONE 0.025%-TOP 80GM CREA - AAA BID TO TID FOR 2-3 DAYS AT ONSET OF
RASH UD #1 RF0 Qt: 1 Rf: 0

Disposition Written by SMITH, ERIC P @ 25 Aug 2010 0912 CDT**Released w/o Limitations****Follow up:** 1 month(s) in the DERMATOLOGY CLINIC clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By SMITH, ERIC P (Physician, NH Pensacola FL) @ 25 Aug 2010 0912****CHANGE HISTORY***The following SO Note Was Overwritten by SMITH, ERIC P @ 25 Aug 2010 0908 CDT:**SO Note Written by WEST, ALEXANDER D @ 25 Aug 2010 0843 CDT***Chief complaint**

The Chief Complaint is: Fu skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

In the Navy, currently on active duty, and paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Claritan.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tob: n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

• Current vital signs reviewed.

General appearance:

• Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1088

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Jul 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P

Encounter ID: PENS-597452 Primary Dx: FOLLICULITIS

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 20 Jul 2010 0920 CDT
Clinic: DERMATOLOGY CLINICAppt Type: SPEC
Provider: SMITH, ERIC P**Reason for Appointment:** ROSACEA/DERM-NHP/MED LIST/CTD/20/RECORDS/UNIFORM**Appointment Comments:**
CAC-EHAutoCites Refreshed by SMITH, ERIC P @ 20 Jul 2010 0948 CDT**Problems****Chronic:**

- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

SO Note Written by SMITH, ERIC P @ 20 Jul 2010 1115 CDT**Chief complaint**

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related / deployment-related. Paygrade E5.

Presents for evaluation of her recurrent rash that has been occurring over the past two summers. He states that when he spends time in the sun and especially in the water he will develop crops of pustules across his forehead, cheeks, and somewhat on his back and chest. These are typically painful and he tends to puncture these or pick them. He did that this morning and does not have any significant acute lesions. He denies breakouts on other sun exposed areas of his skin.

He has tried many different types of sunscreens, but most recently used a baby sunscreen that one time helped prevent a breakout and the other time did not.

He does not take medications regularly, though occasionally takes Aleve.

He does relate that he had MRSA 3 times, and has been using an antibacterial soap on all of his skin since April of 2009.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

- Pain level (0-10): Reviewed.
- Current vital signs reviewed.

General appearance:

- Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Skin:

- Lesions: See add note for details.

Also noted to have very fair skin and fairly moderate photo damage with hundreds of ephelids. • General appearance was normal.

Therapy

- No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by SMITH, ERIC P @ 20 Jul 2010 1643 CDT

1. FOLLICULITIS: Appears to developing pustules of unclear etiology. The sudden onset following sun exposure may point towards a photosensitive reaction which could be photo drug or photo toxic or photoallergic. He only takes Aleve occasionally, and this could be a potential cause of pseudo-porphyrria though he has no lesions on the back of his hands and no milia. It would be atypical for acne, even though he complains of blackheads, as the sun tends to be more immunosuppressive rather than causing acne breakouts.

He may have a reaction to sunscreen products, though states that he is broken out even when not wearing sunscreen. There does not appear to be a likely interaction between water in his skin. These lesions are not urticarial.

There may be a relationship to him starting his antibacterial soap and the onset of this rash. Discussed the importance of good skin care without damaging the surface.

Pityrosporum folliculitis is also in the differential diagnosis.

Recommended:

Stop antibacterial soap.

Start Dove or Cetaphil for washing his body.

They tried different sunscreens on his skin to see if there is a relationship between outbreaks.

Return 3 to 6 weeks for reevaluation

Medication(s): -CETAPHIL (AQUANIL)CLNSR 240ML -TOP SOAP - INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6 Qt: 2 Rf: 6

Disposition Written by SMITH, ERIC P @ 20 Jul 2010 1645 CDT**Released w/o Limitations**

Follow up: 2 to 6 week(s) in the DERMATOLOGY CLINIC clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by NEWTON, TYLER JEROME @ 20 Jul 2010 0916 CDT**Consult Order**

Referring Provider: GUNTER, ROGER WILLIAM

Date of Request: 14 Jun 2010

Priority: Routine

Provisional Diagnosis:

ROSACEA

Reason for Request:

1ST L/M ON VM25 yo male active duty member with 9 months of facial break outs - pustules, papules on forehead, nose and cheeks with any sun exposure. Patient has tried every sun screen he knows but every time he goes out to the beach or has any outdoor time for 4 or more hours he'll break out. Clears after about 2-4 days but comes back every time he gets sun exposure. It has some features of Rosacea but a very unusual onset and resolution. Please evaluate and treat definitively.

Note Written by NEWTON, TYLER JEROME @ 20 Jul 2010 1154 CDT

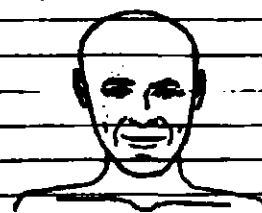
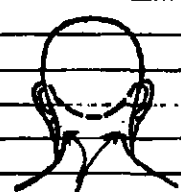
Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

4010 700-000-0000 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	Symptoms, Diagnosis, Treatment, Treating Organization (not on duty)	DATE	Symptoms, Diagnosis, Treatment, Treating Organization (not on duty)
DERMATOLOGY CLINIC, NH PENSACOLA FL			
Date: 09/20/10	1. Visit today related to deployment? Yes/No		
Doctor: Smith	2. Appointment in 14 days? Yes/No		
Appointment time: 0920	3. Appointment in 14 days? Yes/No		
Time in:	4. Appointment in 14 days? Yes/No		
Drug allergies: None/Other	5. Appointment in 14 days? Yes/No		
<p>It has a reaction whenever goes to the beach a break out appear on his face, chest, and back. White head pimples last 3-4 days</p>			
 <p>Giggleman's people 5 (man) Pimples</p>		 <p>9 from anti-J6 pimples</p>	
<p>20 Jul 20100920 SPEC KERNY, DANIEL DENN PO2</p>			
<p>CHRONOLOGICAL RECORD OF MEDICAL CARE KERNY, DANIEL DENN STANDARD FORM 600-REV 6-97 Prescribed by 09-0220 F-100 141 0-10 201 0 200 1</p>			

Signed By SMITH, ERIC P (Physician, NH Pensacola FL) @ 20 Jul 2010 1646

CHANGE HISTORY

The following SO Note Was Overwritten by SMITH, ERIC P @ 20 Jul 2010 1115 CDT:
SO Note Written by MATTHEWS, KARLA M @ 20 Jul 2010 0923 CDT

Chief complaint

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related (deployment-related). Paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Past medical/surgical history

Reported History:

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

* Pain level (0-10): Reviewed.

* Current vital signs reviewed.

General appearance:

* Well-appearing. * Alert. * Oriented to time, place, and person. * Well nourished. * Well hydrated.

Therapy

* No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

14 Jun 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-547172

Primary Dx: ROSACEA

Patient: MERWIN, DANIEL DENNIS

Date: 14 Jun 2010 1010 CDT

Appt Type: ACUT

Treatment Facility: NBHC NTTC

Clinic: CORRY PRIME CARE

Provider: GUNTER, ROGER WILLIAM

Pensacola

Patient Status: Outpatient

Reason for Appointment: allergic reaction**Appointment Comments:**

mso

AutoCites Refreshed by GUNTER, ROGER WILLIAM @ 14 Jun 2010 1012 CDT**Allergies**

• OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by STANDLEY, CHAD J @ 14 Jun 2010 0953 CDT

BP: 114/68, HR: 72, RR: 16, T: 98.5 °F, HT: 69 in, WT: 145 lbs, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 5/10 Moderate, Pain Scale Comments: forehead

Comments: 850-292-7149

SO Note Written by GUNTER, ROGER WILLIAM @ 14 Jun 2010 1236 CDT**Chief complaint**

The Chief Complaint is: Allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with complaints of allergic reaction x1year. pt stated that when he first arrived to florida he was fine for x2months. now every time he goes outside he breaks out with pustules all over his face. pt has tried using sunscreen with no success. pt denies taking any medication to treat the reaction. pt does notice more pustules when in the sun but he still gets them when its cloudy outside. No problems with alcohol or hot beverages. No history of Rosacea though he's had acne since he was a teen - that's cleared for the most part and hasn't had any problems of this kind until he got to floriday about 9 months ago. Originally from California and has spent his whole life out doors in the sun.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Current medications reviewed and reconciled.

none.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergic all outdoor items and pets. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter.

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Pulmonary symptoms:** No dyspnea, no cough, and no wheezing.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

1093

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

Vital signs:

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:• General appearance: • Not oriented to time, place, and person pustules all over pt face. ° Well developed. ° Well nourished.
° In no acute distress.**Neurological:**

° No learning disability was noted (barriers to learning).

Skin:

• Showed erythema entire face is red and dusky. Three hours of sun exposure with sun screen. • Pustules were seen on forehead and nose primarily.

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by GUNTER, ROGER WILLIAM @ 14 Jun 2010 1239 CDT**1. ROSACEA:** Some features of Rosacea but may just be an acneiform eruption. Patient insists there are no triggers other than prolonged sun exposure. Will refer to Dermatology for evaluation and treatment.

Consult(s):

-Referred To: DERMATOLOGY CONSULT (Routine) Specialty: DERMATOLOGY Clinic: UTILIZATION
MANAGEMENT OFFICE Primary Diagnosis: ROSACEADisposition Written by GUNTER, ROGER WILLIAM @ 14 Jun 2010 1239 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requestedSigned By GUNTER, ROGER WILLIAM (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 14 Jun 2010 1240**CHANGE HISTORY**The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 14 Jun 2010 1228 CDT:SO Note Written by STANDLEY, CHAD J @ 14 Jun 2010 0957 CDT**Chief complaint**

The Chief Complaint is: Allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with complaints of allergic reaction x1year. pt stated that when he first arrived to florida he was fine for x2months. now every time he goes outside he breaks out with pustules all over his face. pt has tried using sunscreen with no success. pt denies taking any medication to treat the reaction. pt does notice more pustules when in the sun but he still gets them when its cloudy outside.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Current medications reviewed and reconciled.

none.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergic all outdoor items and pets. No previous hospitalizations that are associated with the reason for this encounter; and no previous emergency room visit that are associated with the reason for this encounter.

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Pulmonary symptoms:** No dyspnea, no cough, and no wheezing.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

• General appearance: • Not oriented to time, place, and person pustules all over pt face. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Medical Record

* No learning disability was noted (barriers to learning).

Skin: * Pustules were seen.

Therapy * No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

Anderson, Daniel Dennis DOB: 10 Feb 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

21 Apr 2010 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-468299 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL DENNIS** Date: **21 Apr 2010 0800 CDT** Appt Type: **SPEC**
 Treatment Facility: **NBHC NAS Pensacola** Clinic: **NASP OPTOMETRY CLINIC** Provider: **ZENT,JOHN W**
 Patient Status: **Outpatient**

Reason for Appointment: EYE EXAM-CONSULT FOR PRK/BLD 3600/UOD/REC/MEDS/GLASSES/CDT/20MINS**Appointment Comments:**

CAC-ANT

AutoCites Refreshed by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Problems****Chronic:**

- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
LORATADINE, 10 MG, TABLET, ORAL	Active	T 1 TABLET PO QD PRN NR FOR ALLERGIES #100 RFO		17 Mar 2010
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Reason For Appointment:** EYE EXAM-CONSULT FOR PRK/BLD 3600/UOD/REC/MEDS/GLASSES/CDT/20MINS

Allergen information verified by MERRELL, SHAUNTE T @ 21 Apr 2010 0806 CDT

VitalsVitals Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT

Pain Scale: 0 Pain Free

SO Note Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Reason for Visit**

Visit for: routine eye exam.

Referred here

referred here.

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Reliability of source of patient information was good.

In the Navy, currently on active duty, and paygrade E5.

No eye pain.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Physical trauma: No trauma to the eye.

Diagnosis History:

No iritis / Uveitis

No cataract

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

No macular degeneration
 No glaucoma.
 No hypertension.
 No hyperlipidemia.
 No diabetes mellitus

Review of systems**Cardiovascular symptoms:** No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Physical findings****Eyes:**

General/bilateral:

Visual Assessment: • Lensometry:

OD:-2.00-0.25x090

OS:-1.75sph.

Intraocular Pressure: ° Normal NCT IOP.

Visual Fields Exam: • A limited visual fields exam was performed. ° Peripheral vision was full to confrontation.

Right eye:

Visual Assessment:

Value

Distance right acuity with current Rx: 20/

20

Right eye:

Intraocular Pressure:

Value

12 mmHg

Left eye:

Visual Assessment:

Value

Distance left acuity with current Rx: 20/

30

Left eye:

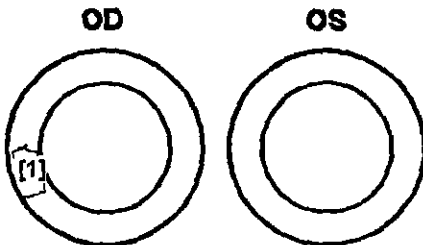
Intraocular Pressure:

Value

13 mmHg

Drawing/Image Written by ZENT,JOHN W @ 23 Apr 2010 1644 CDT

1. pigmented crescent with no holes or tears

**A/P** Written by ZENT,JOHN W @ 23 Apr 2010 1644 CDT**1. REFRACTIVE ERROR - MYOPIA**

Procedure(s):

-Ophthalmological New Patient Start Comprehensive Care x 1

-Spectacles Services Fitting Monofocals (Not For Aphakia) x 1

-Determination Of Refractive State x 1

-Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia x 1

2. PERIPHERAL RETINAL DEGENERATION - LATTICE: abnormal apperance OS, possibly lattice, or very flat typical retinoschisis.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

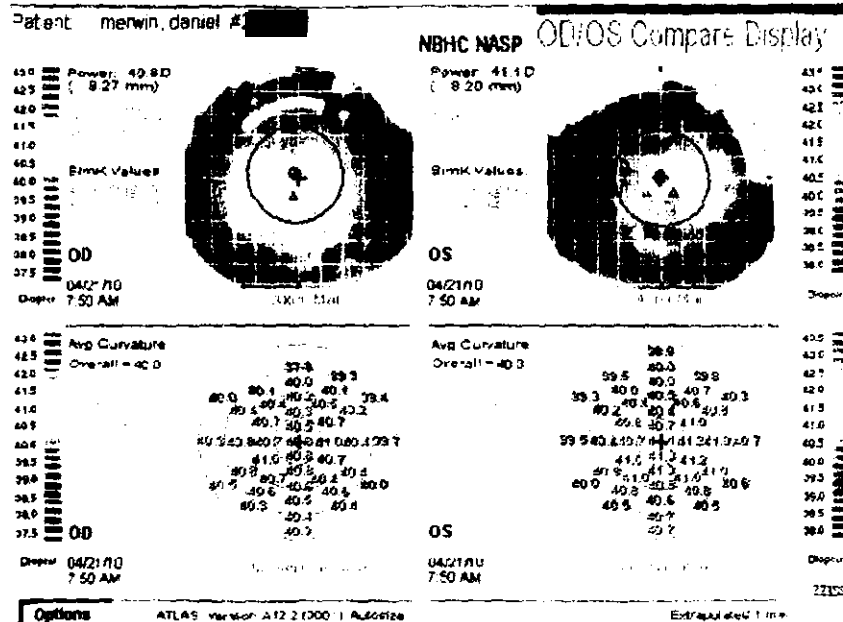
Disposition Written by ZENT,JOHN W @ 23 Apr 2010 1645 CDT

Released w/o Limitations

Follow up: 12 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by SIMIEN,LATOSHA D @ 21 Apr 2010 1301 CDT



Note Written by ZENT,JOHN W @ 23 Apr 2010 1642 CDT

Chief Complaint: Pt. here for CRS screening, no visual or asthenopic complaints

Significant History: (see above) -f/f, -dryness, -itch, -burn

Confrontation Fields: FTFC Central & Peripheral OD, OS **Cover Test:** cc Ortho distance Ortho' near

Extraocular Muscles: Smooth, Accurate, Full, No Pain **Pupils:** Equal Round 4+ Reactivity -APD

MRx Sphere Cylinder Axis DVA Drops: @ 0820

OD	-2.25	-0.50	098	OD	20/20	20/20	0.5% Proparacaine
OS	-2.50	-0.25	083	OS	20/20	20/20	1gt OU 0.5% Tropicamide
Prism Add NVA				1gt OU 2.5% Phenylephrine			
OD				OD	20/20	20/20	1% Cyclopentolate
OS				OS	20/20	20/20	0.25%/0.4% Fluress

Slit Lamp: 78D & 20D Dilated

	OD	OS
L/L	Clear	Clear
Conj.	Clear	Clear
Cornea	Clear	Clear
Tear Layer	Clear	Clear
A/C	D & Q 4X4	4X4
Iris	Clear	Clear

Ancillary Testing Pt. educated that too large of an Rx change for CRs

Final Spec Rx	Full Time Wear	Add
OD -2.25	-0.50	098
		pl

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

17 Mar 2010 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S

Encounter ID: PENS-413309 Primary Dx: Visit for: occupational health / fitness exam

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 17 Mar 2010 0730 CDT
Clinic: DEPLOYMENT HEALTH CLINIC
Appt Type: WELL
Provider: BROWN, TRAVIS SCOTT**Reason for Appointment:** PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD**Appointment Comments:**
cac-jabAutoCites Refreshed by WHITE, PAMELA J @ 17 Mar 2010 0727 CDT**Allergies**

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT**Reason For Appointment:** PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD

Allergen information verified by WHITE, PAMELA J. @ 17 Mar 2010 0730 CDT

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : PHA PART 2;**Vitals**Vitals Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT

BP: 102/60, HR: 72, RR: 20, HT: 69.5 in Actual, With Shoes, WT: 150 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/30, Corr OS: 20/20, Corr OU: 20/20, BMI: 21.83, BSA: 1.838 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: OCC., Pain Scale: 0 Pain Free

SO Note Written by BROWN, TRAVIS SCOTT @ 17 Mar 2010 0807 CDT**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 25 year old male.

Barriers to learning were identified as: None

Barriers considered were, social, cultural, emotional, motivational, physical, religious, cognitive and language.

Problem list reviewed.

Head symptoms States he has a history of allergy to dogs and cats. Approximately 3 weeks ago he was at a friend's house who had a dog. since that time, he has had problems with head and nasal congestion and sneezing. Also reports one episode of shortness of breath when running approximately 2 weeks ago. States he has been using Primatene OTC. No other meds. On exam today the pharynx and nasal septum with mild erythema, no inflammation or drainage. Lungs clear to auscultation over all fields bilaterally. No wheezing noted.

Current medication

Primatene - OTC

Past medical/surgical history**Reported History:**

Past Medical History:

Fracture of right 5th phalanx - 2008 -Resolved

Surgical / procedural: Surgical / procedural history Past Surgical History:
noncontributory.**Review of systems****Neck symptoms:** No neck symptoms.Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Psychological symptoms: No psychological symptoms.

A/P Written by BROWN, TRAVIS S @ 17 Mar 2010 0815 CDT

1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION): Annual TB risk assessment completed. He has been in Asia over the past year. Recommend placing PPD today. See NAVMED 6224/8.

Counseled on lab results, triglycerides and discussed at length ways to improve through lifestyle changes; exercise, supplements and better nutrition. Teaching materials given.
 Medically fit for full duty.

2. ALLERGIC RHINITIS: Place him on claritin and mucinex. f/u with PCM if symptoms not improved in 3-4 days. member states he was treated by an allergist as a child. Explained he could discuss this with his PCM if symptoms remain persistent.

Medication(s): -LORATADINE (CLARITIN)--PO 10MG TAB - T 1 TABLET PO QD PRN FOR ALLERGIES #100 RF0
 Qt: 100 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT
 -GUAIFENESIN PSE --PO 600MG-60MG TAB - TAKE ONE TABLET TWICE DAILY **MAX 50 TABS
 PER FILL** #40 RF0 Qt: 40 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

Disposition Written by BROWN, TRAVIS S @ 17 Mar 2010 0817 CDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By BROWN, TRAVIS S (NP-C, NH Pensacola FL) @ 17 Mar 2010 0817

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

09 Mar 2010 at NH Pensacola FL, Corry Prime Care by THOMAS, JOSHUA L

Encounter ID: PENS-400052 Primary Dx: Vaccine needed prophylactically against bacterial diseases

Patient: MERWIN, DANIEL DENNIS

Date: 09 Mar 2010 0824 CDT

Appt Type: ACUT

Treatment Facility: NBHC NTTC

Clinic: CORRY PRIME CARE

Provider: THOMAS, JOSHUA L

Pensacola

Patient Status: Outpatient

Reason for Appointment: Anthrax Vaccine**Appointment Comments:** Written by THOMAS, JOSHUA L @ 09 Mar 2010 0824 CDT

jlt

Vitals**Vitals** Written by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CST**Comments:** n/a**SO Note** Written by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CDT**History of present illness**

The Patient is a 25 year old male.

Barriers to learning were identified as: None.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Not taking medication and no contraindications to live vaccine were noted on medication reconciliation.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by WILLIAMS, TREVOR M @ 09 Mar 2010 1504 CDT**1. Vaccine needed prophylactically against bacterial diseases**

Procedure(s): -Anthrax Vaccine, For Subcutaneous Use x 1

Disposition Last Updated by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current

prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.

No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Anderson, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

Signed By THOMAS, JOSHUA L (Physician/Workstation) @ 09 Mar 2010 1512

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

22 Dec 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-281825 Primary Dx: Parent Education: Immunizations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC NTTC**
Pensacola
Patient Status: **Outpatient**Date: **22 Dec 2009 1100 CST**
Clinic: **CORRY PRIME CARE**Appt Type: **OPAC**
Provider: **GUNTER,ROGER WILLIAM****Reason for Appointment:** H1N1**Appointment Comments:** Written by LINVILLE,TREVOR S @ 22 Dec 2009 1100 CST
TSL**Vitals****Vitals** Written by SYDA,KRISTIE LYNN @ 22 Dec 2009 1114 CST**Comments:** n/a**SO Note** Written by SYDA,KRISTIE LYNN @ 22 Dec 2009 1114 CST**History of present illness**The Patient is a 24 year old male.
Barriers to learning were identified as: None.**Allergies**

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.
Not taking medication and no contraindications to live vaccine were noted on medication reconciliation.**Counseling/Education**

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by SYDA,KRISTIE LYNN @ 22 Dec 2009 1115 CST**1. Parent Education: Immunizations(MEDICATION EDUCATION)**Procedure(s): -Immunization Administration One Vaccine x 1
-Influenza Virus Vaccine Pandemic Formulation x 1**Disposition Last Updated by SYDA,KRISTIE LYNN @ 22 Dec 2009 1115 CST****Released w/o Limitations****Follow up:** as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in AHLTA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By GUNTER, ROGER WILLIAM** (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 22 Dec 2009 1201

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

23 Sep 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-140818 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NBHC NTTC
Pensacola
Patient Status: OutpatientDate: 23 Sep 2009 1438 CDT
Clinic: CORRY PRIME CAREAppt Type: OPAC
Provider: GUNTER, ROGER WILLIAM**Reason for Appointment:** influenza**Appointment Comments:** Written by SYDA, KRISTIE LYNN @ 23 Sep 2009 1438 CDT
kis**AutoCites Refreshed by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT****Problems**

- visit for: administrative purpose
- Inquiry And Counseling: Contraceptive Practices
- exposed to venereal disease
- visit for: military services physical

Active Family History

No Active Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Vitals**Vitals Written by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT****Comments:** n/a**SO Note Written by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT****Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 24 year old male. Source of patient information was patient. Past medical history reviewed.

Allergies

Reviewed an allergy. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

: up to date.

- Received dose of influenza live virus vaccine, for intranasal use Vaccine lot #, manufacturer, and location given recorded in Immunization module. Patient provided and reviewed current CDC Vaccine Information Sheet. Vaccine inspected for discoloration/particulates and Exp Date verified

Past medical/surgical history**Reported History:**

Recent events: No active illness.

Review of systems**Systemic symptoms:** No fever.**Counseling/Education**

- Patient education about adverse reactions to medication Patient instructed to remain in clinic for 20 minutes post vaccination. Patient educated regarding possible side effects: soreness\, redness\, or swelling at the site of injection, Fever\

AMP Last Updated by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**1. Vaccines Prophylactic Need Against Influenza**

Procedure(s): -Influenza Virus Vaccine Live Intranasal x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

-Immunization Administration One Vaccine x 1

2. Parent Education: Immunizations(MEDICATION EDUCATION)

Disposition Last Updated by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT

Released w/o Limitations

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, NH Jacksonville, FL) @ 23 Sep 2009 1532

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

16 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM

Encounter ID: PENS-128312 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC NTTC**
Pensacola
Patient Status: **Outpatient**Date: **16 Sep 2009 1430 CDT**
Clinic: **CORRY PHYS EXAMS**Appt Type: **WELL**
Provider: **GUNTER, ROGER WILLIAM****Reason for Appointment:** re-enlistment Phy**Appointment Comments:**

clw

AutoCites Refreshed by THORNTON, JAMES M @ 16 Sep 2009 1454 CDT**Problems****Chronic:**

- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

SO Note Written by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1541 CDT**History of present illness**

The Patient is a 24 year old male.

He reported: Encounter Background Information: 24 y/o adm coming to medical for re-enlistment pe. Last PE greater than 2 years so will repeat his full physical to include 2808 and 2807. Labs recorded. Audiogram completed today. Eye exam was done in town but patient will bring in a copy. No changes in health history since last PE. PHA was done on ship in FEB 09 as an annual flight deck PE. Complete in scope. See DD 2808 and 2807 for details of PE. Fit for reenlistment.

Physical findings**General appearance:**

° Well-appearing. ° Patient did not appear uncomfortable.

Lab Result Cited by THORNTON, JAMES M @ 16 Sep 2009 1454 CDT

Rapid Plasma Reagin	Site/Specimen	20 Aug 2009 1007Units	Ref Rng
Reagin Ab	SERUM	NON-REACTIVE	

Lab Result Cited by THORNTON, JAMES M @ 16 Sep 2009 1454 CDT

Lipid Profile	Site/Specimen	15 Sep 2009 0724 <o>	Units
		Ref Rng	
Cholesterol	PLASMA	190 <i>	mg/dL (25-199)
HDL Cholesterol	PLASMA	56 <i>	mg/dL
Triglyceride	PLASMA	221 (H) <i>	mg/dL (20-150)
LDL Cholesterol	PLASMA	90 <i>	mg/dL (25-100)

A/P Written by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT

1. visit for: military services physical (ARMED FORCES MEDICAL EXAMINATION): Reenlistment PE. Fit for reenlistment. See DD 2808 and 2807 in health record. Unable to scan into AHLTA.

Disposition Last updated by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT**Released w/o Limitations**

Follow up: as needed with PCM and/or in the CORRY PHYS EXAMS clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, NH Jacksonville, FL) @ 16 Sep 2009 1544

CHANGE HISTORY

The following Disposition Note Was Overwritten by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT:

The Disposition section was last updated by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT - see above. Previous Version of Disposition section was entered/updated by THORNTON, JAMES M @ 16 Sep 2009 1457 CDT.

Released w/o Limitations

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1541 CDT:

SO Note Written by THORNTON, JAMES M @ 16 Sep 2009 1455 CDT

History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: 24 y/o adm coming to medical for re-enlistment pe.

Physical findings**General appearance:**

* Well-appearing. * Patient did not appear uncomfortable.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

20 Aug 2009 at NH Pensacola FL, Corry Prime Care by HEDARIA, ELIZABETH A

Encounter ID: PENS-94296 Primary Dx: Exposure to STD

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: OutpatientDate: 20 Aug 2009 0930 CDT
Clinic: CORRY PRIME CAREAppt Type: ACUT
Provider: HEDARIA, ELIZABETH A**Reason for Appointment:** REQUEST FOR LABS/JACC/20/MED LIST/CTD**Appointment Comments:**
CAC-AJB**Vitals****Vitals Written by COLE, ASHLEY @ 20 Aug 2009 0923 CDT**

BP: 120/79, HR: 82, RR: 16, T: 98.2 °F, HT: 68 in, WT: 145 lbs, BMI: 22.05, BSA: 1.783 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: aac**SO Note Written by HEDARIA, ELIZABETH A @ 20 Aug 2009 1522 CDT****Chief complaint**

The Chief Complaint is: Pt would like a male examination.

History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Denies painful urination or discharge from penis.

Subjective

Pt is a 24 yo active duty male who reports to medical for yearly male examination. Pt states that he would prefer blood wrk if possible.

Physical findings**Vital signs:**

° Normal.

General appearance:

° Normal.

Eyes:

General/bilateral:

° Eyes: normal.

Ears, Nose, Throat:

° ENT: normal.

Lymph Nodes:

° Normal.

Urinary system:

° Normal.

° Genital findings were normal.

Genitalia:

° Normal.

A/P Written by HEDARIA, ELIZABETH A @ 20 Aug 2009 1003 CDT**1. exposed to venereal disease**

Laboratory(ies): -CHLAMYDIA/GC NAAT PANEL (Routine); RAPID PLASMA REAGIN (Routine)

Disposition Last updated by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By HEDARIA, ELIZABETH A (NURSE PRACTITIONER, NH Pensacola FL) @ 20 Aug 2009 1532**Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017
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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

CHANGE HISTORYThe following Disposition Note Was Overwritten by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT:

The Disposition section was last updated by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT - see above. Previous Version of Disposition section was entered/updated by COLE, ASHLEY @ 20 Aug 2009 0927 CDT.

Released w/o Limitations**Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following SO Note Was Overwritten by HEDARIA, ELIZABETH A @ 20 Aug 2009 1522 CDT:SO Note Written by COLE, ASHLEY @ 20 Aug 2009 0922 CDT**Chief complaint**

The Chief Complaint is: Pt would like a male examination.

Subjective

Pt is a 24 yo active duty male who reports to medical for yearly male examination. Pt states that he would prefer blood wrk if possible.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

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Page

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017

07 May 2009 at NH Pensacola FL, Corry Health Promotion And Wel by LINVILLE, TREVOR S

Encounter ID: CDR-64692598 Primary Dx: Patient Education - HIV

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC NTTC**
Pensacola
Patient Status: **Outpatient**Date: **07 May 2009 1355 CDT**
Clinic: **CORRY COMMUNITY HEALTH**Appt Type: **WELL**
Provider: **LINVILLE, TREVOR S**

Reason for Appointment: indoc

Appointment Comments:

Notes Entered by: THORNTON, JAMES M 07 May 2009 1355

jmt

AutoCites Refreshed by THORNTON, JAMES M @ 07 May 2009 1355 CDT**Problems**

- feared medical condition not demonstrated
- visit for: issue medical certificate fitness

Active Family History

No Active Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Vitals

Vitals Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT

Comments: n/a

SO Note Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT**Referred here**

Referred by:

History of present illness

The Patient is a 24 year old male

Patient participated in a 60 minute group education and counseling session on medical and dental wellness and access to care. Topics include occupational and local hazards. Specifically, MRSA, STDs, sun hazards, hydration birth control. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

A/P Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT

1. Patient Education - HIV
2. Anticipatory Guidance: Unsafe Sexual Practices
3. visit for: administrative purpose
4. Inquiry And Counseling: Contraceptive Practices

Disposition Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT**Released w/o Limitations**

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LINVILLE, TREVOR S (Physician/Workstation, NH Pensacola FL) @ 07 May 2009 1412

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538 Created: 30 Oct 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 30 Oct 2017

06 Mar 2006 at NH Pensacola FL, NATTC MHP by MAYNARD, PENELOPE A

Encounter ID: 17628314 Primary Dx: Feared medical condition not demonstrated

Patient: MERWIN, DANIEL DENNIS
Facility: Pensacola NH, FLDate: 06 Mar 2006 0815 CST
Clinic: NATTC SICK CALLAppt Type: ROUT
Provider: MAYNARD, PENELOPE AReason for Appointment: abdominal pain
Appointment Comments:
cac-ebcAutoCites Refreshed by MAYNARD, PENELOPE A @ 06 Mar 2006 0843 CST**Allergies**
OTHER (SEE MED RECORD)**Active Medications**
No Active Medications Found.**Vitals**Vitals Written by MILLER, KATHERINE R @ 06 Mar 2006 0804 CSTBP: 120/64, HR: 60, RR: 12, T: 97.6 °F, HT: 5' 8", WT: 126 lbs, BMI: 19.16, BSA: 1.679 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free, Pain Scale Comments: none
Comments: allergies:nkdaSO Text Note Written by MAYNARD, PENELOPE A @ 06 Mar 2006 0843 CST
SEE NOTE FOR RECORDA/P Written by MAYNARD, PENELOPE A @ 06 Mar 2006 0844 CST1. feared medical condition not demonstrated: ABD PAIN RESOLVED- NO PATHOLOGY
2. visit for: Issue medical certificate fitnessDisposition Written by MAYNARD, PENELOPE A @ 06 Mar 2006 0844 CST

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis with Patient who indicated understanding.

Signed By MAYNARD, PENELOPE A (MD, GS-14, GMO, Pensacola) @ 06 Mar 2006 0844

***** End of Previous Encounters *****

Daniel ANDERSON

CONFIDENTIAL

Page 1 of 67

Personal Health Information

Daniel ANDERSON

Date of birth: [REDACTED] 1985

Created on 24 Jan 2018 @ 1237 CST

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CONFIDENTIAL

Page 2 of 67

ENCOUNTERS HISTORY

Date Range: 24 Jan 1988 - 24 Jan 2018

Sorted By: Encounter Date (Descending)

Filter: Last 500 records

Reason for Visit			
Encounter Date	22 Jan 2018 @ 0900	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	22 Jan 2018
Reason for Visit	dbt skills and process		
Encounter Date	16 Jan 2018 @ 1137	Clinic	ATS Adult BE
Provider	BURTON, CARA N	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	16 Jan 2018
Reason for Visit	f/u		
Encounter Date	16 Jan 2018 @ 1106	Clinic	BH Multi-D Psy Ki
Provider	HEBERT, CANDICE	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychometric Emotional / Behavioral Assessment	Procedure Date	17 Jan 2018
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	17 Jan 2018
Reason for Visit	dbt skills and process		
Encounter Date	11 Jan 2018 @ 1507	Clinic	ATS Adult BE
Provider	DELEON, PATRICK D.	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	11 Jan 2018
Reason for Visit	f/u		
Encounter Date	09 Jan 2018 @ 0837	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	09 Jan 2018
Reason for Visit	Pain in knee when pressure applied or used.		
Encounter Date	05 Jan 2018 @ 0839	Clinic	Int Med CL E Medical Home BE
Provider	HENRY, JAMIE LEE	Facility	WRNMMC
Diagnosis	Pain in right knee		
Reason for Visit			

Daniel ANDERSON

CONFIDENTIAL

Page 3 of 67

Encounter Date	03 Jan 2018 @ 1145	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	03 Jan 2018
Reason for Visit			
Encounter Date	03 Jan 2018 @ 0920	Clinic	Beh Hlth Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	04 Jan 2018
Reason for Visit	DBt skills and process		
Encounter Date	02 Jan 2018 @ 1419	Clinic	ATS Adult BE
Provider	DELEON, PATRICK D.	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	02 Jan 2018
Reason for Visit	f/u		
Encounter Date	15 Dec 2017 @ 1248	Clinic	BH Multi-D Psy Ki
Provider	HEBERT, CANDICE	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Generalized anxiety disorder		
Procedure	Psychometric Emotional / Behavioral Assessment	Procedure Date	20 Dec 2017
Procedure	Psychiatric Diagnostic Evaluation	Procedure Date	20 Dec 2017
Reason for Visit	f/u		
Encounter Date	15 Dec 2017 @ 0832	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	15 Dec 2017
Reason for Visit			
Encounter Date	15 Dec 2017 @ 0649	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	15 Dec 2017
Reason for Visit	f/u		
Encounter Date	06 Dec 2017 @ 1216	Clinic	ATS Adult BE

Daniel ANDERSON

CONFIDENTIAL

Page 4 of 67

Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Dec 2017
Reason for Visit			
Encounter Date	06 Dec 2017 @ 0900	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Dec 2017
Reason for Visit			
Encounter Date	06 Dec 2017 @ 1309	Clinic	GI Clinic Bethesda
Provider	BHUSHAN, ANITA	Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit			
Encounter Date	05 Dec 2017 @ 0810	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit	Notes Entered by: NGUYEN,TO-VAN T 04 Dec 2017 1005 PFT		
Encounter Date	04 Dec 2017 @ 1005	Clinic	Pulmonary Function Lab
Provider	BROWNING, ROBERT F	Facility	WRNMMC
Diagnosis	Unspecified asthma, uncomplicated		
Procedure	Spirometry Pre-bronchodilator	Procedure Date	04 Dec 2017
Reason for Visit	Unspecified asthma, uncomplicated		
Encounter Date	04 Dec 2017 @ 0923	Clinic	Pulmonary Disease Clinic Bethesda
Provider	BROWNING, ROBERT F	Facility	WRNMMC
Diagnosis	Mild intermittent asthma, uncomplicated		
Reason for Visit	Security Clearance Evaluation		
Encounter Date	28 Nov 2017 @ 1305	Clinic	BH Multi-D Psy Ki
Provider	HEBERT, CANDICE	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Comprehensive Examination	Procedure Date	29 Nov 2017
Reason for Visit	f/u		

Daniel ANDERSON

CONFIDENTIAL

Page 5 of 67

Encounter Date	28 Nov 2017 @ 0843	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	28 Nov 2017
Reason for Visit	f/u		
Encounter Date	22 Nov 2017 @ 1324	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	22 Nov 2017
Reason for Visit			
Encounter Date	22 Nov 2017 @ 1023	Clinic	Pain Mgmt Clinic Bethesda
Provider	SPEVAK, CHRISTOHER J	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Reason for Visit	IOP		
Encounter Date	22 Nov 2017 @ 0919	Clinic	ATS Adult BE
Provider	DELEON, PATRICK D.	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	27 Nov 2017
Reason for Visit	IOP		
Encounter Date	20 Nov 2017 @ 1057	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	20 Nov 2017
Reason for Visit	IOP		
Encounter Date	17 Nov 2017 @ 1150	Clinic	ATS Adult BE
Provider	HARDIN, JAMES G	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	20 Nov 2017
Reason for Visit	f/u		
Encounter Date	15 Nov 2017 @ 1328	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	15 Nov 2017
Reason for Visit	IOP		
Encounter Date	15 Nov 2017 @ 1133	Clinic	ATS Adult BE

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AR 1162

Daniel ANDERSON

CONFIDENTIAL

Page 6 of 67

Provider	DELEON, PATRICK D.	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	16 Nov 2017
Reason for Visit			
Encounter Date	15 Nov 2017 @ 1039	Clinic	Pain Mgmt Clinic Bethesda
Provider	SPEVAK, CHRISTOHER J	Facility	WRNMMC
Diagnosis	Chronic pain syndrome		
Reason for Visit	IOP		
Encounter Date	13 Nov 2017 @ 1055	Clinic	ATS Adult BE
Provider	BURTON, CARA N	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	13 Nov 2017
Reason for Visit	Notes Entered by: ALLISON, WILLIAM F 09 Nov 2017 1027 Call about a limited duty memorandum request		
Encounter Date	09 Nov 2017 @ 1029	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit			
Encounter Date	08 Nov 2017 @ 0854	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	09 Nov 2017
Reason for Visit	IOP		
Encounter Date	08 Nov 2017 @ 1326	Clinic	ATS Adult BE
Provider	RAGLAND, MARY	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	13 Nov 2017
Reason for Visit			
Encounter Date	08 Nov 2017 @ 1026	Clinic	Pain Mgmt Clinic Bethesda
Provider	SPEVAK, CHRISTOHER J	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Reason for Visit	f/u		
Encounter Date	06 Nov 2017 @ 1338	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		

Daniel ANDERSON

CONFIDENTIAL

Page 7 of 67

Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Nov 2017
Reason for Visit	IOP	Clinic	ATS Adult BE
Encounter Date	06 Nov 2017 @ 1021	Facility	WRNMMC
Provider	BURTON, CARA N		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	06 Nov 2017
Reason for Visit	IOP	Clinic	ATS Adult BE
Encounter Date	03 Nov 2017 @ 1023	Facility	WRNMMC
Provider	LESKO, STACEY B		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	03 Nov 2017
Reason for Visit	rec therapy	Clinic	Occup Therap TBI Be
Encounter Date	02 Nov 2017 @ 1105	Facility	WRNMMC
Provider	NAVARRO, CARA A		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Phys Ther Ed Community Reintegration Training - Per 15 Min	Procedure Date	02 Nov 2017
Reason for Visit	Notes Entered by: KIRBY, JAMAYA K 02 Nov 2017 1040 Patient would like you to call him about medication.		
Encounter Date	02 Nov 2017 @ 1043	Clinic	GI Clinic Bethesda
Provider	BRIDGES, EDWARD E	Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit	IOP	Clinic	ATS Adult BE
Encounter Date	01 Nov 2017 @ 1306	Facility	WRNMMC
Provider	DELEON, PATRICK D.		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	03 Nov 2017
Reason for Visit		Clinic	Psychiatry Be
Encounter Date	01 Nov 2017 @ 1235	Facility	WRNMMC
Provider	TOBAR, EDEN		
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	02 Nov 2017
Reason for Visit		Clinic	Pain Mgmt Clinic Bethesda
Encounter Date	01 Nov 2017 @ 1116	Facility	WRNMMC
Provider	SPEVAK, CHRISTOHER J		

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AR 1164

Daniel ANDERSON

CONFIDENTIAL

Page 8 of 67

Diagnosis	Alcohol dependence, uncomplicated		
Reason for Visit	Notes Entered by: BILODEAU,NATALIE C 30 Oct 2017 1556 Called with results of sleep study		
Encounter Date	30 Oct 2017 @ 1557	Clinic	Sleep (Pulm) CI Be
Provider	BILODEAU, NATALIE C	Facility	WRNMMC
Diagnosis	Obstructive sleep apnea (adult) (pediatric)		
Reason for Visit	f/u		
Encounter Date	30 Oct 2017 @ 1355	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	30 Oct 2017
Reason for Visit	IOP		
Encounter Date	30 Oct 2017 @ 0937	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	30 Oct 2017
Reason for Visit	Notes Entered by: ANDRADA,TEOTIMO F 24 Oct 2017 1021 psg interpretation		
Encounter Date	24 Oct 2017 @ 1021	Clinic	Sleep (Pulm) CI Be
Provider	KHRAMTSOV, ANDREI N	Facility	WRNMMC
Diagnosis	Obstructive sleep apnea (adult) (pediatric)		
Procedure	Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older	Procedure Date	24 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 20 Oct 2017 1237 TMS		
Encounter Date	20 Oct 2017 @ 1237	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	20 Oct 2017
Reason for Visit	IOP		
Encounter Date	20 Oct 2017 @ 1233	Clinic	ATS Adult BE
Provider	HARDIN, JAMES G	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	25 Oct 2017

Daniel ANDERSON

CONFIDENTIAL

Page 9 of 67

Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 19 Oct 2017 1158	
	TMS	
Encounter Date	19 Oct 2017 @ 1159	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate	
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date 19 Oct 2017
Reason for Visit		
Encounter Date	18 Oct 2017 @ 1325	Clinic Pain Mgmt Clinic Bethesda
Provider	SPEVAK, CHRISTOHER J	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Reason for Visit	IOp	
Encounter Date	18 Oct 2017 @ 1146	Clinic ATS Adult BE
Provider	DELEON, PATRICK D.	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 23 Oct 2017
Reason for Visit	Notes Entered by: TEKELENBURG,JAAP 18 Oct 2017 0627	
	Care coordination	
Encounter Date	18 Oct 2017 @ 0627	Clinic Psychiatry Be
Provider	TEKELENBURG, JAAP	Facility WRNMMC
Diagnosis	Encounter for other administrative examinations	
Reason for Visit	Cats Allergies, Asthma	
Encounter Date	17 Oct 2017 @ 0904	Clinic Int Med CL E Medical Home BE
Provider	MEYERS, NANCY	Facility WRNMMC
Diagnosis	Unspecified asthma, uncomplicated	
Diagnosis	Irritable bowel syndrome with diarrhea	
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 16 Oct 2017 1114	
	TMS	
Encounter Date	16 Oct 2017 @ 1115	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate	
Procedure	Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date 16 Oct 2017
Reason for Visit	Notes Entered by: AGUGLIARO,ANTHONY J 16 Oct 2017 1110	
	flu shot	
Encounter Date	16 Oct 2017 @ 1111	Clinic Immunization Clinic Be
Provider	AGUGLIARO, ANTHONY J	Facility WRNMMC
Diagnosis	Encounter for immunization	

Daniel ANDERSON

CONFIDENTIAL

Page 10 of 67

Procedure	Influenza Split Virus Vaccine 0.5mL Dosage IM Preserv Free Quadrivalent	Procedure Date	16 Oct 2017
Procedure	Immunization Administration One Vaccine	Procedure Date	16 Oct 2017
Reason for Visit	IOP		
Encounter Date	16 Oct 2017 @ 1110	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	16 Oct 2017
Reason for Visit	Notes Entered by: TOBAR, EDEN 16 Oct 2017 1047 meds		
Encounter Date	16 Oct 2017 @ 1047	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit			
Encounter Date	16 Oct 2017 @ 1044	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	16 Oct 2017
Reason for Visit	IOP		
Encounter Date	13 Oct 2017 @ 1303	Clinic	ATS Adult BE
Provider	HARDIN, JAMES G	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	19 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 13 Oct 2017 1213 TMS		
Encounter Date	13 Oct 2017 @ 1213	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	13 Oct 2017
Reason for Visit	f/u		
Encounter Date	12 Oct 2017 @ 1258	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	13 Oct 2017

Daniel ANDERSON

CONFIDENTIAL

Page 11 of 67

Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 12 Oct 2017 1204		
	TMS		
Encounter Date	12 Oct 2017 @ 1204	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	12 Oct 2017
Reason for Visit	Major depressive disorder, recurrent, moderate		
Encounter Date	11 Oct 2017 @ 1247	Clinic	Occup Therap TBI Be
Provider	NAVARRO, CARA A	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Phys Ther Ed Community Reintegration Training - Per 15 Min	Procedure Date	12 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 11 Oct 2017 1158		
	TMS		
Encounter Date	11 Oct 2017 @ 1159	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	11 Oct 2017
Reason for Visit	IOP		
Encounter Date	11 Oct 2017 @ 1140	Clinic	ATS Adult BE
Provider	DELEON, PATRICK D.	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	17 Oct 2017
Reason for Visit			
Encounter Date	11 Oct 2017 @ 1044	Clinic	Pain Mgmt Clinic Bethesda
Provider	SPEVAK, CHRISTOHER J	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 10 Oct 2017 1059		
	TMS		
Encounter Date	10 Oct 2017 @ 1059	Clinic	Psych Day Hosp Be
Provider	BAHROO, BHAGWAN A	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	10 Oct 2017
Reason for Visit	process grou		
Encounter Date	06 Oct 2017 @ 1330	Clinic	ATS Adult BE

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AR 1168

Daniel ANDERSON

CONFIDENTIAL

Page 12 of 67

Provider	LESKO, STACEY B	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	06 Oct 2017
Reason for Visit	Notes Entered by: BLOBERG,BRIAN 06 Oct 2017 0854 TMS		
Encounter Date	06 Oct 2017 @ 0855	Clinic	Psych Day Hosp Be
Provider	BAHROO, BHAGWAN A	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	06 Oct 2017
Reason for Visit	Generalized anxiety disorder		
Encounter Date	06 Oct 2017 @ 0732	Clinic	Occup Therap TBI Be
Provider	NAVARRO, CARA A	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Phys Ther Ed Community Reintegration Training - Per 15 Min	Procedure Date	06 Oct 2017
Reason for Visit	Notes Entered by: ABRAHAM,FENOTE 05 Oct 2017 1349 Medical Record Release		
Encounter Date	05 Oct 2017 @ 1350	Clinic	Psychiatry Be
Provider	ABRAHAM, FENOTE	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	05 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 05 Oct 2017 1158 TMS		
Encounter Date	05 Oct 2017 @ 1200	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	05 Oct 2017
Reason for Visit	split w 3% per Dr. K		
Encounter Date	05 Oct 2017 @ 0419	Clinic	Sleep (Pulm) CI Be
Provider	KHRAMTSOV, ANDREI N	Facility	WRNMMC
Diagnosis	Sleep disorder, unspecified		
Procedure	Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older	Procedure Date	05 Oct 2017
Reason for Visit			

Daniel ANDERSON

CONFIDENTIAL

Page 13 of 67

Encounter Date	04 Oct 2017 @ 0858	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Oct 2017
Reason for Visit	F/U		
Encounter Date	04 Oct 2017 @ 1324	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	04 Oct 2017
Reason for Visit	Notes Entered by: POURZAND, MIRIAM 04 Oct 2017 1235 TMS		
Encounter Date	04 Oct 2017 @ 1235	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	04 Oct 2017
Reason for Visit	process group		
Encounter Date	04 Oct 2017 @ 1007	Clinic	ATS Adult BE
Provider	RAGLAND, MARY	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	05 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 03 Oct 2017 1147 TMS		
Encounter Date	03 Oct 2017 @ 1148	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	03 Oct 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 02 Oct 2017 1146 TMS		
Encounter Date	02 Oct 2017 @ 1147	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	02 Oct 2017
Reason for Visit	R/o obstructive sleep apnea		

Daniel ANDERSON

CONFIDENTIAL

Page 14 of 67

Encounter Date	02 Oct 2017 @ 0928	Clinic	Sleep (Pulm) CI Be
Provider	KHRAMTSOV, ANDREI N	Facility	WRNMMC
Diagnosis	Sleep disorder, unspecified		
Reason for Visit			
Encounter Date	29 Sep 2017 @ 1149	Clinic	GI Clinic Bethesda
Provider	BRIDGES, EDWARD E	Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit	ANORECTAL MANOMETRY/BALLOON EXPULSION STUDY		
Encounter Date	29 Sep 2017 @ 0843	Clinic	GI Proc CI BE
Provider	DAMIANO, MARK N	Facility	WRNMMC
Diagnosis	Fecal urgency		
Diagnosis	Fecal smearing		
Procedure	Manometry Rectal	Procedure Date	29 Sep 2017
Procedure	Rectal Balloon Distension Test	Procedure Date	29 Sep 2017
Reason for Visit	f/u		
Encounter Date	29 Sep 2017 @ 0841	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	29 Sep 2017
Reason for Visit	Notes Entered by: SANTIAGO, HANNAH L 28 Sep 2017 1304 TMS		
Encounter Date	28 Sep 2017 @ 1304	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	28 Sep 2017
Reason for Visit	IOP Discharge		
Encounter Date	27 Sep 2017 @ 1011	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	27 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 27 Sep 2017 1144 TMS		
Encounter Date	27 Sep 2017 @ 1145	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		

Daniel ANDERSON

CONFIDENTIAL

Page 15 of 67

Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	27 Sep 2017
Reason for Visit			
Encounter Date	27 Sep 2017 @ 1011	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit	IOP Discharge		
Encounter Date	26 Sep 2017 @ 0938	Clinic	Psychiatry Be
Provider	DELSESTO, BARBARA S	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit	f/u eye surgery/wrist pain		
Encounter Date	26 Sep 2017 @ 0843	Clinic	Int Med CL F Medical Home BE
Provider	ROBINSON, TYRONE L	Facility	WRNMMC
Diagnosis	Dry eye syndrome of bilateral lacrimal glands		
Diagnosis	Ingrowing nail		
Diagnosis	Pain in right wrist		
Reason for Visit	Notes Entered by: POURZAND, MIRIAM 25 Sep 2017 1105 Discharge Summary		
Encounter Date	25 Sep 2017 @ 1105	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	25 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	25 Sep 2017
Reason for Visit	Notes Entered by: HANGEMANOLE, DESPINA C 22 Sep 2017 1020 recent slip		
Encounter Date	22 Sep 2017 @ 1025	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	22 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 22 Sep 2017 0902 TMS		
Encounter Date	22 Sep 2017 @ 0902	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	22 Sep 2017

Daniel ANDERSON

CONFIDENTIAL

Page 16 of 67

Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 22 Sep 2017 0857 IOP	
Encounter Date	22 Sep 2017 @ 0857	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate	
Diagnosis	Generalized anxiety disorder	
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 22 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 22 Sep 2017
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date 22 Sep 2017

Reason for Visit	Notes Entered by: BELLE,LAVERN S 21 Sep 2017 1834 Scheduled patient for an Anorectal Manometry Procedure.	
Encounter Date	21 Sep 2017 @ 1834	Clinic GI Clinic Bethesda
Provider	BELLE, LAVERN S	Facility WRNMMC
Diagnosis	Other specified counseling	
Procedure	Non-Physician Phone Call To Pt/Provider Lengthy (21-30 min)	Procedure Date 21 Sep 2017

Reason for Visit	Notes Entered by: CLOPPER,TAMMY J 21 Sep 2017 1353 CRP	
Encounter Date	21 Sep 2017 @ 1354	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Psychiatric Therapy Group Interview	Procedure Date 21 Sep 2017

Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 21 Sep 2017 0754 TMS	
Encounter Date	21 Sep 2017 @ 0755	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date 21 Sep 2017

Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 21 Sep 2017 0751 IOP	
Encounter Date	21 Sep 2017 @ 0751	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 21 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 21 Sep 2017

Daniel ANDERSON

CONFIDENTIAL

Page 17 of 67

Reason for Visit	Notes Entered by: SMITH,JESSICA ANN 20 Sep 2017 1437	
	LST	
Encounter Date	20 Sep 2017 @ 1437	
Provider	POURZAND, MIRIAM	Clinic Psych Day Hosp Be
Diagnosis	Generalized anxiety disorder	Facility WRNMMC
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 20 Sep 2017
Reason for Visit	Notes Entered by: DEUTSCH,ANNE MARIE 20 Sep 2017 1336	
	Treatment Plan Review Team A	
Encounter Date	20 Sep 2017 @ 1337	
Provider	DONKIN, LAURA G	Clinic Psych Day Hosp Be
Diagnosis	Generalized anxiety disorder	Facility WRNMMC
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date 22 Sep 2017
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date 21 Sep 2017
Procedure	Psychologic Testing And Report Administered By Computer	Procedure Date 21 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 20 Sep 2017 1142	
	CRP	
Encounter Date	20 Sep 2017 @ 1143	
Provider	POURZAND, MIRIAM	Clinic Psych Day Hosp Be
Diagnosis	Generalized anxiety disorder	Facility WRNMMC
Procedure	Psychiatric Therapy Group Interview	Procedure Date 20 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 20 Sep 2017 0758	
	TMS	
Encounter Date	20 Sep 2017 @ 0759	
Provider	LANDE, RAYMOND G.	Clinic Psych Day Hosp Be
Diagnosis	Generalized anxiety disorder	Facility WRNMMC
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date 20 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 20 Sep 2017 0757	
	IOP	
Encounter Date	20 Sep 2017 @ 0758	
Provider	POURZAND, MIRIAM	Clinic Psych Day Hosp Be
Diagnosis	Generalized anxiety disorder	Facility WRNMMC
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 20 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 20 Sep 2017

Daniel ANDERSON

CONFIDENTIAL

Page 18 of 67

Reason for Visit			
Encounter Date	19 Sep 2017 @ 1100	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	19 Sep 2017
Reason for Visit	follow up		
Encounter Date	19 Sep 2017 @ 1256	Clinic	GI Clinic Bethesda
Provider	BHUSHAN, ANITA	Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 19 Sep 2017 1154 CRP		
Encounter Date	19 Sep 2017 @ 1155	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	19 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 19 Sep 2017 1154 TMS		
Encounter Date	19 Sep 2017 @ 1154	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	19 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 19 Sep 2017 0805 IOP		
Encounter Date	19 Sep 2017 @ 0805	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	19 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	19 Sep 2017
Reason for Visit	PCS understanding sub abuse		
Encounter Date	18 Sep 2017 @ 1300	Clinic	ATS Adult BE
Provider	LESKO, STACEY B	Facility	WRNMMC
Diagnosis	Encounter for observation for other suspected diseases and conditions ruled out		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	19 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 18 Sep 2017 1155 TRP		

Daniel ANDERSON

CONFIDENTIAL

Page 19 of 67

Encounter Date	18 Sep 2017 @ 1156	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	18 Sep 2017
Procedure	Psychiatric Therapy Group Interview	Procedure Date	18 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 18 Sep 2017 0858 TMS		
Encounter Date	18 Sep 2017 @ 0858	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	18 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 18 Sep 2017 0752 IOP		
Encounter Date	18 Sep 2017 @ 0752	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	18 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	18 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 15 Sep 2017 1149 TMS		
Encounter Date	15 Sep 2017 @ 1150	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	15 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 15 Sep 2017 1148 CRP		
Encounter Date	15 Sep 2017 @ 1149	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	15 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 15 Sep 2017 0744 IOP		
Encounter Date	15 Sep 2017 @ 0744	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC

Daniel ANDERSON

CONFIDENTIAL

Page 20 of 67

Diagnosis	Generalized anxiety disorder	
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 15 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date 15 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 15 Sep 2017
Reason for Visit		
Encounter Date	14 Sep 2017 @ 1327	Clinic Psychiatry Be
Provider	PAUL, SHERIN	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 14 Sep 2017 1238 CRP	
Encounter Date	14 Sep 2017 @ 1239	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Psychiatric Therapy Group Interview	Procedure Date 14 Sep 2017
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date 14 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 14 Sep 2017 1141 TMS	
Encounter Date	14 Sep 2017 @ 1142	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date 14 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 14 Sep 2017 0756 IOP	
Encounter Date	14 Sep 2017 @ 0756	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Diagnosis	Major depressive disorder, recurrent, moderate	
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 14 Sep 2017
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date 14 Sep 2017
Reason for Visit	Notes Entered by: DEUTSCH, ANNE MARIE 13 Sep 2017 1552 Treatment Plan Update Team A	
Encounter Date	13 Sep 2017 @ 1552	Clinic Psych Day Hosp Be
Provider	DEUTSCH, ANNE MARIE	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	

Daniel ANDERSON

CONFIDENTIAL

Page 21 of 67

Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	14 Sep 2017
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	13 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 13 Sep 2017 1159 LST		
Encounter Date	13 Sep 2017 @ 1200	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	14 Sep 2017
Procedure	Psychiatric Therapy Group Interview	Procedure Date	14 Sep 2017
Reason for Visit	f/u		
Encounter Date	13 Sep 2017 @ 1149	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	13 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 13 Sep 2017 0752 TMS		
Encounter Date	13 Sep 2017 @ 0753	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	13 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 13 Sep 2017 0750 IOP		
Encounter Date	13 Sep 2017 @ 0750	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	13 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	13 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	13 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 12 Sep 2017 1153 TRP		
Encounter Date	12 Sep 2017 @ 1153	Clinic	Psych Day Hosp Be

Daniel ANDERSON

CONFIDENTIAL

Page 22 of 67

Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 12 Sep 2017 1152 TMS		
Encounter Date	12 Sep 2017 @ 1153	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation	Procedure Date	12 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 12 Sep 2017 0755 IOP		
Encounter Date	12 Sep 2017 @ 0755	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	12 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	12 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 11 Sep 2017 1133 CRP		
Encounter Date	11 Sep 2017 @ 1134	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	11 Sep 2017
Procedure	Psychiatric Therapy Group Interview	Procedure Date	11 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 11 Sep 2017 0842 IOP		
Encounter Date	11 Sep 2017 @ 0843	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	11 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	11 Sep 2017
Reason for Visit	Notes Entered by: CLOPPER,TAMMY J 08 Sep 2017 1243 CES		
Encounter Date	08 Sep 2017 @ 1243	Clinic	Psych Day Hosp Be
Provider	GRAGNANI, CYNTHIA T	Facility	WRNMMC

Daniel ANDERSON

CONFIDENTIAL

Page 23 of 67

Diagnosis	Generalized anxiety disorder	
Procedure	Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes	Procedure Date 08 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 08 Sep 2017 1202 CRP	
Encounter Date	08 Sep 2017 @ 1203	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Psychiatric Therapy Group Interview	Procedure Date 08 Sep 2017
Reason for Visit	F/U Testing	
Encounter Date	08 Sep 2017 @ 0814	Clinic Psychology Assessment Be
Provider	BENTON, JIKESHA R	Facility WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate	
Procedure	Psychologic Testing And Report Administered By Technician	Procedure Date 08 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 08 Sep 2017 0807 SLEEP ASSESSMENT	
Encounter Date	08 Sep 2017 @ 0808	Clinic Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility WRNMMC
Diagnosis	Insomnia, unspecified	
Procedure	Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time	Procedure Date 08 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 08 Sep 2017 0800 IOP	
Encounter Date	08 Sep 2017 @ 0801	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date 08 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date 08 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date 08 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 07 Sep 2017 1213 CRP	
Encounter Date	07 Sep 2017 @ 1214	Clinic Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Psychiatric Therapy Group Interview	Procedure Date 07 Sep 2017

Daniel ANDERSON

CONFIDENTIAL

Page 24 of 67

Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	07 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 07 Sep 2017 0649 SLEEP ASSESSMENT		
Encounter Date	07 Sep 2017 @ 0649	Clinic	Psych Day Hosp Be
Provider	LANDE, RAYMOND G.	Facility	WRNMMC
Diagnosis	Insomnia, unspecified		
Procedure	Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time	Procedure Date	07 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 07 Sep 2017 0648 IOP		
Encounter Date	07 Sep 2017 @ 0648	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	08 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	07 Sep 2017
Reason for Visit	Notes Entered by: DEUTSCH,ANNE MARIE 06 Sep 2017 1355 Treatment Plan Update/BHDP Team A		
Encounter Date	06 Sep 2017 @ 1355	Clinic	Psych Day Hosp Be
Provider	DEUTSCH, ANNE MARIE	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	06 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 06 Sep 2017 1035 LST		
Encounter Date	06 Sep 2017 @ 1036	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	06 Sep 2017
Procedure	Psychiatric Therapy Group Interview	Procedure Date	06 Sep 2017
Reason for Visit			
Encounter Date	06 Sep 2017 @ 0915	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, single episode, unspecified		
Reason for Visit	Notes Entered by: CHELLAPPA,MARY R 06 Sep 2017 0739 IOP		

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AR 1181

Daniel ANDERSON

CONFIDENTIAL

Page 25 of 67

Encounter Date	06 Sep 2017 @ 0741	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	07 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	06 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	06 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 05 Sep 2017 1223 IRP		
Encounter Date	05 Sep 2017 @ 1225	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	05 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 05 Sep 2017 0808 IOP		
Encounter Date	05 Sep 2017 @ 0808	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	05 Sep 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	05 Sep 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 31 Aug 2017 1234 IRP		
Encounter Date	31 Aug 2017 @ 1235	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	31 Aug 2017
Reason for Visit	Notes Entered by: CLOPPER, TAMMY J 31 Aug 2017 0805 CES		
Encounter Date	31 Aug 2017 @ 0805	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes	Procedure Date	31 Aug 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 31 Aug 2017 0741 IOP		
Encounter Date	31 Aug 2017 @ 0741	Clinic	Psych Day Hosp Be

Daniel ANDERSON

CONFIDENTIAL

Page 26 of 67

Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	01 Sep 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	31 Aug 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	31 Aug 2017
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	31 Aug 2017
Reason for Visit	Notes Entered by: DEUTSCH, ANNE MARIE 31 Aug 2017 0718 Treatment Plan Update Team A/BHDP		
Encounter Date	31 Aug 2017 @ 0719	Clinic	Psych Day Hosp Be
Provider	DEUTSCH, ANNE MARIE	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	31 Aug 2017
Reason for Visit	Notes Entered by: DEUTSCH, ANNE MARIE 30 Aug 2017 1605 Treatment Plan Update Team A		
Encounter Date	30 Aug 2017 @ 1605	Clinic	Psych Day Hosp Be
Provider	DEUTSCH, ANNE MARIE	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	30 Aug 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 30 Aug 2017 1251 LST		
Encounter Date	30 Aug 2017 @ 1253	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	30 Aug 2017
Reason for Visit	Notes Entered by: CLOPPER, TAMMY J 30 Aug 2017 1031 CES		
Encounter Date	30 Aug 2017 @ 1032	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes	Procedure Date	30 Aug 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 30 Aug 2017 0741 IOP		
Encounter Date	30 Aug 2017 @ 0741	Clinic	Psych Day Hosp Be

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1183

Daniel ANDERSON

CONFIDENTIAL

Page 27 of 67

Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	30 Aug 2017
Procedure	Clinical Social Work Individual Outpatient Counseling 30 Minutes	Procedure Date	30 Aug 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 29 Aug 2017 1202 CRP		
Encounter Date	29 Aug 2017 @ 1203	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Group Interview	Procedure Date	29 Aug 2017
Reason for Visit	Notes Entered by: DEUTSCH, ANNE MARIE 29 Aug 2017 0933 TESTING		
Encounter Date	29 Aug 2017 @ 0933	Clinic	Psych Day Hosp Be
Provider	DEUTSCH, ANNE MARIE	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychologic Testing And Report Administered By Computer	Procedure Date	29 Aug 2017
Reason for Visit	Notes Entered by: CHELLAPPA, MARY R 29 Aug 2017 0715 INTAKE		
Encounter Date	29 Aug 2017 @ 0716	Clinic	Psych Day Hosp Be
Provider	POURZAND, MIRIAM	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Diagnostic Evaluation With Medical Evaluation And Management	Procedure Date	30 Aug 2017
Procedure	Psychiatric Diagnostic Evaluation Initial	Procedure Date	29 Aug 2017
Procedure	Intensive outpatient psychiatric services, per diem	Procedure Date	29 Aug 2017
Reason for Visit			
Encounter Date	22 Aug 2017 @ 0646	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	23 Aug 2017
Reason for Visit	f/u		
Encounter Date	22 Aug 2017 @ 0845	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		

Daniel ANDERSON

CONFIDENTIAL

Page 28 of 67

Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	22 Aug 2017
Reason for Visit	f/u	Clinic	ATS Adult BE
Encounter Date	16 Aug 2017 @ 1130	Facility	WRNMMC
Provider	DELEON, PATRICK D.		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	16 Aug 2017
Reason for Visit		Clinic	Psychiatry Be
Encounter Date	14 Aug 2017 @ 1328	Facility	WRNMMC
Provider	PAUL, SHERIN		
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	15 Aug 2017
Reason for Visit	Notes Entered by: DELSESTO, BARBARA 14 Aug 2017 1006		
	Case Management		
Encounter Date	14 Aug 2017 @ 1006	Clinic	Psychiatry Be
Provider	DELSESTO, BARBARA S	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit			
Encounter Date	10 Aug 2017 @ 0801	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Non-Physician Phone Call To Patient/Provider Brief (5-10min)	Procedure Date	10 Aug 2017
Reason for Visit	f/u	Clinic	ATS Adult BE
Encounter Date	09 Aug 2017 @ 0916	Facility	WRNMMC
Provider	HANGEMANOLE, DESPINA C		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	09 Aug 2017
Reason for Visit		Clinic	Psychiatry Be
Encounter Date	08 Aug 2017 @ 0920	Facility	WRNMMC
Provider	TOBAR, EDEN		
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	09 Aug 2017
Reason for Visit	IBS-D Follow up		

Daniel ANDERSON

CONFIDENTIAL

Page 29 of 67

Encounter Date	07 Aug 2017 @ 0801	Clinic	Int Med CL F Medical Home BE
Provider	LINKER, MARTIN	Facility	WRNMMC
Diagnosis	Major depressive disorder, single episode, moderate		
Diagnosis	Generalized anxiety disorder		
Diagnosis	Alcohol dependence, uncomplicated		
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit			
Encounter Date	31 Jul 2017 @ 0900	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	01 Aug 2017
Reason for Visit	f/u		
Encounter Date	27 Jul 2017 @ 1226	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	27 Jul 2017
Reason for Visit	med board		
Encounter Date	27 Jul 2017 @ 0847	Clinic	Int Med CL F Medical Home BE
Provider	LINKER, MARTIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, single episode, moderate		
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit			
Encounter Date	27 Jul 2017 @ 0726	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	28 Jul 2017
Reason for Visit	Intake		
Encounter Date	25 Jul 2017 @ 0905	Clinic	ATS Adult BE
Provider	HANGEMANOLE, DESPINA C	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation	Procedure Date	25 Jul 2017
Reason for Visit	Notes Entered by: DELSESTO, BARBARA 20 Jul 2017 0848 Case Management		
Encounter Date	20 Jul 2017 @ 0849	Clinic	Psychiatry Be

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1186

Daniel ANDERSON

CONFIDENTIAL

Page 30 of 67

Provider	DELSESTO, BARBARA S	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit			
Encounter Date	18 Jul 2017 @ 0735	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	19 Jul 2017
Reason for Visit	follow up		
Encounter Date	18 Jul 2017 @ 1203	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit	irritable bowel syndrome		
Encounter Date	13 Jul 2017 @ 0924	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit	IBS diet		
Encounter Date	12 Jul 2017 @ 0813	Clinic	Integrative Hlth & Well BE
Provider	THOMAS, LAUREN A	Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea		
Procedure	Medical Nutrition Therapy Initial Assessment, Intervention	Procedure Date	12 Jul 2017
Reason for Visit			
Encounter Date	10 Jul 2017 @ 0758	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	11 Jul 2017
Reason for Visit	Notes Entered by: TOBAR,EDEN 10 Jul 2017 1231 ED follow up		
Encounter Date	10 Jul 2017 @ 1231	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy For Crisis Intervention	Procedure Date	12 Jul 2017
Reason for Visit	Notes Entered by: DELSESTO,BARBARA 10 Jul 2017 0918 Case Management		
Encounter Date	10 Jul 2017 @ 0919	Clinic	Psychiatry Be

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1187

Daniel ANDERSON

CONFIDENTIAL

Page 31 of 67

Provider	DELSESTO, BARBARA S	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit	Notes Entered by: MEADOR, KRISTINE P 07 Jul 2017 0815 PCM: RODAK		
Encounter Date	07 Jul 2017 @ 0817	Clinic	Int Med CL F Medical Home BE
Provider	GROEMPING, KRISTINE P	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Procedure	Non-Physician Phone Call To Patient/Provider Brief (5-10min)	Procedure Date	10 Jul 2017
Reason for Visit			
Encounter Date	07 Jul 2017 @ 0816	Clinic	Psychiatry Be
Provider	WISE, JOSEPH E	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Reason for Visit	Notes Entered by: WORKS, LINDSAY K 06 Jul 2017 2027 safety check		
Encounter Date	06 Jul 2017 @ 2027	Clinic	Psychiatry Consult Liaison Be
Provider	WORKS, LINDSAY K	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Reason for Visit	Notes Entered by: DELSESTO, BARBARA 06 Jul 2017 1030 Case Management		
Encounter Date	06 Jul 2017 @ 1031	Clinic	Psychiatry Be
Provider	DELSESTO, BARBARA S	Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations		
Reason for Visit	f/u		
Encounter Date	27 Jun 2017 @ 1456	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	28 Jun 2017
Reason for Visit			
Encounter Date	21 Jun 2017 @ 1204	Clinic	Dermatology Clinic Bethesda
Provider	FINK, CAITLIN M	Facility	WRNMMC
Diagnosis	Epidermal cyst		
Procedure	Excision Of Lesion Trunk Benign Up to .5cm	Procedure Date	21 Jun 2017
Reason for Visit	Follow up for IBS. Notify the doctor of Physical Training and Smell trigger		
Encounter Date	19 Jun 2017 @ 0904	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1188

Daniel ANDERSON

CONFIDENTIAL

Page 32 of 67

Diagnosis	Encounter for other administrative examinations	Clinic	Dermatology Clinic Bethesda
Reason for Visit	Anogenital (venereal) warts	Facility	WRNMMC
Encounter Date	16 Jun 2017 @ 1154		
Provider	NICHOLAS, LUKE C		
Diagnosis	Anogenital (venereal) warts		
Diagnosis	Epidermal cyst		
Procedure	Destruction Of Benign Lesion By Cryosurgery	Procedure Date	16 Jun 2017
Reason for Visit	Follow up	Clinic	Psychiatry Be
Encounter Date	13 Jun 2017 @ 0653	Facility	WRNMMC
Provider	PAUL, SHERIN		
Diagnosis	Major depressive disorder, recurrent, moderate		
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	14 Jun 2017
Reason for Visit		Clinic	Psychiatry Be
Encounter Date	13 Jun 2017 @ 0858	Facility	WRNMMC
Provider	PAUL, SHERIN		
Diagnosis	Generalized anxiety disorder		
Diagnosis	Major depressive disorder, recurrent, moderate		
Reason for Visit	Depression and Anxiety	Clinic	Int Med CL F Medical Home BE
Encounter Date	12 Jun 2017 @ 0838	Facility	WRNMMC
Provider	RODAK, COLLEEN M		
Diagnosis	Mixed irritable bowel syndrome		
Reason for Visit		Clinic	Psychiatry Be
Encounter Date	08 Jun 2017 @ 1137	Facility	WRNMMC
Provider	PAUL, SHERIN		
Diagnosis	Generalized anxiety disorder		
Reason for Visit	F/U skin testing	Clinic	Allergy Clinic Bethesda
Encounter Date	07 Jun 2017 @ 1006	Facility	WRNMMC
Provider	PETERSEN, MAUREEN MICHELE		
Diagnosis	Allergic rhinitis due to animal (cat) (dog) hair and dander		
Procedure	Allergy Percutaneous tests - allergenic extracts	Procedure Date	10 Jun 2017
Reason for Visit	Notes Entered by: DUVALL, MICHAEL R 06 Jun 2017 1409 PCM/DR. RODAK - RELAY HEALTH	Clinic	Int Med CL C Medical Home BE
Encounter Date	06 Jun 2017 @ 1410	Facility	WRNMMC
Provider	SMITH, MICKALYNN J		
Diagnosis	Encounter for other administrative examinations		

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1189

Daniel ANDERSON

CONFIDENTIAL

Page 33 of 67

Procedure	Internet Med Svc Qual Nonphys Healthcare Prof Estab Patient	Procedure Date	07 Jun 2017
Procedure	Non-Physician Phone Call To Patient/Provider Brief (5-10min)	Procedure Date	07 Jun 2017
Procedure	Non-Physician Phone Call To Pt/Provider Intermed (11-20 min)	Procedure Date	06 Jun 2017
Reason for Visit	Notes Entered by: KAMARA,KADIDJA B 01 Jun 2017 1159 Correspondance with Gastroenterology		
Encounter Date	01 Jun 2017 @ 1201	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC
Diagnosis	Other specified counseling		
Diagnosis	Irritable bowel syndrome with diarrhea		
Reason for Visit	Encounter for other general examination		
Encounter Date	25 May 2017 @ 0953	Clinic	Allergy Clinic Bethesda
Provider	BANKS, TAYLOR ALLEN	Facility	WRNMMC
Diagnosis	Dyspnea, unspecified		
Procedure	Spirometry Pre-bronchodilator	Procedure Date	25 May 2017
Reason for Visit	Notes Entered by: RODAK,COLLEEN M 23 May 2017 0843 Lipid panel		
Encounter Date	23 May 2017 @ 0844	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC
Diagnosis	Other hyperlipidemia		
Reason for Visit	Notes Entered by: RAYMOND,KEVIN D 22 May 2017 1022 message sent via relayhealth - rodak		
Encounter Date	22 May 2017 @ 1023	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC
Diagnosis	Other specified counseling		
Reason for Visit	referral allergy testing		
Encounter Date	17 May 2017 @ 1341	Clinic	Int Med CL F Medical Home BE
Provider	RODAK, COLLEEN M	Facility	WRNMMC
Diagnosis	Encounter for other general examination		
Diagnosis	Irritable bowel syndrome with diarrhea		
Diagnosis	Anogenital (venereal) warts		
Reason for Visit			
Encounter Date	16 May 2017 @ 1106	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	19 May 2017

Daniel ANDERSON

CONFIDENTIAL

Page 34 of 67

Reason for Visit			Clinic	Psychiatry Be
Encounter Date	16 May 2017 @ 0926		Facility	WRNMMC
Provider	TOBAR, EDEN			
Diagnosis	Generalized anxiety disorder			
Reason for Visit	Notes Entered by: RAYMOND, KEVIN D 19 Apr 2017 1152 referral request sent via relayhealth - rodak			
Encounter Date	19 Apr 2017 @ 1200		Clinic	Int Med CL F Medical Home BE
Provider	SMITH, MICKALYNN J		Facility	WRNMMC
Diagnosis	Encounter for other administrative examinations			
Procedure	Non-Physician Phone Call To Pt/Provider Intermed (11-20 min)		Procedure Date	21 Apr 2017
Reason for Visit	follow up			
Encounter Date	13 Apr 2017 @ 1449		Clinic	GI Clinic Bethesda
Provider	WONG, ROY KWOCK		Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea			
Reason for Visit	pha/navy			
Encounter Date	05 Apr 2017 @ 1031		Clinic	Medical Readiness Clinic Bethesda
Provider	RENTA, DANA K		Facility	WRNMMC
Diagnosis	Other specified counseling			
Procedure	BMI is documented within normal parameters and no follow-up plan is required		Procedure Date	07 Apr 2017
Procedure	Annual depression screening, 15 minutes		Procedure Date	05 Apr 2017
Procedure	Pulse Oximetry		Procedure Date	05 Apr 2017
Procedure	Screening Test Of Visual Acuity, Quantitative, Bilateral		Procedure Date	05 Apr 2017
Reason for Visit	Notes Entered by: COPSEY, HELEN C 16 Mar 2017 1156 Patient email			
Encounter Date	16 Mar 2017 @ 1157		Clinic	GI Clinic Bethesda
Provider	COPSEY, HELEN C		Facility	WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea			
Reason for Visit	FOLLOW UP			
Encounter Date	01 Mar 2017 @ 1001		Clinic	Psychiatry Be
Provider	PAUL, SHERIN		Facility	WRNMMC
Diagnosis	Generalized anxiety disorder			
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes		Procedure Date	02 Mar 2017
Reason for Visit				
Encounter Date	01 Mar 2017 @ 0748		Clinic	Psychiatry Be

Daniel ANDERSON

CONFIDENTIAL

Page 35 of 67

Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	02 Mar 2017
Reason for Visit	Dx Interview		
Encounter Date	08 Feb 2017 @ 0603	Clinic	Psychology Assessment Be
Provider	BENTON, JIKESHA R	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychologic Testing And Report Administered By Physician	Procedure Date	10 Feb 2017
Procedure	Psychiatric Diagnostic Evaluation Comprehensive Examination	Procedure Date	10 Feb 2017
Reason for Visit	Generalized anxiety disorder		
Encounter Date	02 Feb 2017 @ 1446	Clinic	Psychology Assessment Be
Provider	BENTON, JIKESHA R	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychologic Testing And Report Administered By Physician	Procedure Date	07 Feb 2017
Reason for Visit	F/U		
Encounter Date	01 Feb 2017 @ 1249	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Feb 2017
Reason for Visit			
Encounter Date	01 Feb 2017 @ 0944	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC
Diagnosis	Anxiety disorder, unspecified		
Diagnosis	Major depressive disorder, recurrent, unspecified		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	01 Feb 2017
Reason for Visit	f/u		
Encounter Date	04 Jan 2017 @ 1324	Clinic	Psychiatry Be
Provider	PAUL, SHERIN	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date	06 Jan 2017
Reason for Visit			
Encounter Date	04 Jan 2017 @ 0941	Clinic	Psychiatry Be
Provider	TOBAR, EDEN	Facility	WRNMMC

Daniel ANDERSON

CONFIDENTIAL

Page 36 of 67

Diagnosis	Generalized anxiety disorder	
Procedure	Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management	Procedure Date 04 Jan 2017
Reason for Visit	f/u	
Encounter Date	06 Dec 2016 @ 0854	Clinic Psychiatry Be
Provider	PAUL, SHERIN	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Procedure	Psychiatric Therapy Individual Approximately 60 Minutes	Procedure Date 08 Dec 2016
Reason for Visit		
Encounter Date	05 Dec 2016 @ 0920	Clinic Psychiatry Be
Provider	TOBAR, EDEN	Facility WRNMMC
Diagnosis	Major depressive disorder, recurrent, unspecified	
Procedure	Psych Ther Indiv Approx 60 Min W/ Medical Evaluation & Management	Procedure Date 05 Dec 2016
Reason for Visit	Notes Entered by: COPSEY, HELEN C 28 Nov 2016 1243 Pt email	
Encounter Date	28 Nov 2016 @ 1243	Clinic GI Clinic Bethesda
Provider	COPSEY, HELEN C	Facility WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea	
Reason for Visit	spec	
Encounter Date	15 Nov 2016 @ 1203	Clinic Psychiatry Be
Provider	PAUL, SHERIN	Facility WRNMMC
Diagnosis	Generalized anxiety disorder	
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Psychiatric Diagnostic Evaluation	Procedure Date 16 Nov 2016
Reason for Visit		
Encounter Date	24 Oct 2016 @ 0952	Clinic Psychiatry Be
Provider	TOBAR, EDEN	Facility WRNMMC
Diagnosis	Anxiety disorder, unspecified	
Procedure	Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management	Procedure Date 24 Oct 2016
Reason for Visit	Notes Entered by: COPSEY, HELEN C 11 Oct 2016 1145 Pt email	
Encounter Date	11 Oct 2016 @ 1145	Clinic GI Clinic Bethesda
Provider	COPSEY, HELEN C	Facility WRNMMC
Diagnosis	Irritable bowel syndrome with diarrhea	
Reason for Visit	F/U FOR Helicobacter pylori [H. pylori] as the cause of diseases cla	

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1193

Daniel ANDERSON

CONFIDENTIAL

Page 37 of 67

Encounter Date 04 Oct 2016 @ 1400
Provider COPSEY, HELEN C
Diagnosis Irritable bowel syndrome with diarrhea

Clinic GI Clinic Bethesda
Facility WRNMMC

Reason for Visit

Encounter Date 28 Sep 2016 @ 0919
Provider TOBAR, EDEN
Diagnosis Anxiety disorder, unspecified

Clinic Psychiatry Be
Facility WRNMMC

Procedure Psych Ther Indiv Approx 30 Min
W/ Medical Evaluation &
Management

Procedure Date 29 Sep 2016

Reason for Visit Notes Entered by: TOBAR,EDEN 08 Sep 2016 1517
prolonged non face-to-face services

Encounter Date 08 Sep 2016 @ 1517
Provider TOBAR, EDEN
Diagnosis Anxiety disorder, unspecified

Clinic Psychiatry Be
Facility WRNMMC

Reason for Visit

Encounter Date 06 Sep 2016 @ 0753
Provider TOBAR, EDEN
Diagnosis Anxiety disorder, unspecified

Clinic Psychiatry Be
Facility WRNMMC

Procedure Psych Ther Indiv Approx 60 Min
W/ Medical Evaluation &
Management

Procedure Date 08 Sep 2016

Reason for Visit

Encounter Date 25 Aug 2016 @ 1005
Provider JARRETT, ERICA M
Diagnosis Generalized anxiety disorder

Clinic Integrative Hlth & Well BE
Facility WRNMMC

Reason for Visit Notes Entered by: ATCHERSON,KATHY A 23 Jun 2016 1140
Emergency room follow up call.

Encounter Date 23 Jun 2016 @ 1144
Provider ATCHERSON, KATHY A
Diagnosis Encounter for other administrative examinations

Clinic Int Med CL C Medical Home BE
Facility WRNMMC

Reason for Visit

Encounter Date 22 Jun 2016 @ 1019
Provider KWOK, RYAN M
Diagnosis Other chest pain

Clinic GI Clinic Bethesda
Facility WRNMMC

Reason for Visit Notes Entered by: SHAH,NISHA A 15 Jun 2016 1621
Lab results

Encounter Date 15 Jun 2016 @ 1621
Provider SHAH, NISHA AMISH
Diagnosis Encounter for issue of other medical certificate

Clinic GI Clinic Bethesda
Facility WRNMMC

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1194

Daniel ANDERSON

CONFIDENTIAL

Page 38 of 67

Reason for Visit Unspecified disturbances of smell and taste

Encounter Date 07 Jun 2016 @ 1255

Provider XYDAKIS, MICHAEL S

Clinic Otolaryngology Clinic Bethesda

Facility WRNMMC

Diagnosis Unspecified disturbances of smell and taste

Diagnosis Glossitis

Diagnosis Gastro-esophageal reflux disease without esophagitis

Reason for Visit Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Encounter Date 11 May 2016 @ 0721

Provider LACZEK, JEFFREY T

Clinic GI Clinic Bethesda

Facility WRNMMC

Diagnosis Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Diagnosis Irritable bowel syndrome with diarrhea

Reason for Visit pha/navy

Encounter Date 22 Apr 2016 @ 0854

Provider TACKIE, DIANE A

Clinic Medical Readiness Clinic Bethesda

Facility WRNMMC

Diagnosis Counseling, unspecified

Procedure BMI is documented within normal parameters and no follow-up plan is required

Procedure Date 22 Apr 2016

Procedure Screening Test Of Visual Acuity, Quantitative, Bilateral

Procedure Date 22 Apr 2016

Reason for Visit

Encounter Date 18 Apr 2016 @ 1344

Provider THOMPSON, DAVID HERRON

Clinic Otolaryngology Clinic Bethesda

Facility WRNMMC

Diagnosis Parageusia

Reason for Visit

Encounter Date 12 Apr 2016 @ 1309

Provider THOMPSON, DAVID HERRON

Clinic Otolaryngology Clinic Bethesda

Facility WRNMMC

Diagnosis Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Reason for Visit change in taste

Encounter Date 11 Apr 2016 @ 0907

Provider THOMPSON, DAVID HERRON

Clinic Otolaryngology Clinic Bethesda

Facility WRNMMC

Diagnosis Unspecified disturbances of smell and taste

Procedure Fiberoptic Laryngoscopy Flexible (diagnostic)

Procedure Date 05 Apr 2016

Reason for Visit

Encounter Date 05 Apr 2016 @ 0835

Provider BAHR, ROBERT J

Clinic Phys Therapy CL BE

Facility WRNMMC

Diagnosis Pain in left ankle and joints of left foot

Procedure Physical Therapy Service Re-Evaluation

Procedure Date 05 Apr 2016

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1195

Daniel ANDERSON

CONFIDENTIAL

Page 39 of 67

Reason for Visit			Clinic	Phys Therapy CL BE
Encounter Date	07 Mar 2016 @ 0823		Facility	WRNMMC
Provider	BAHR, ROBERT J			
Diagnosis	Pain in left ankle and joints of left foot			
Procedure	Physical Therapy Service Re-Evaluation	Procedure Date	07 Mar 2016	
Procedure	Physical Therapy: ___ Session Segments, 15 Minutes Each	Procedure Date	07 Mar 2016	
Reason for Visit	Notes Entered by: CONRAD, ALLEN C 29 Feb 2016 0849			
	Call pt with test results			
Encounter Date	29 Feb 2016 @ 0850		Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R		Facility	WRNMMC
Diagnosis	Parageusia			
Reason for Visit	Sprain of other ligament of left ankle, subsequent encounter		Clinic	Dermatology Clinic Bethesda
Encounter Date	24 Feb 2016 @ 1324		Facility	WRNMMC
Provider	MARQUART, JASON DANIEL			
Diagnosis	Anogenital (venereal) warts			
Procedure	Destruction Of Benign Lesion By Cryosurgery	Procedure Date	24 Feb 2016	
Reason for Visit	Sprain of other ligament of left ankle, subsequent encounter		Clinic	Phys Therapy CL BE
Encounter Date	19 Feb 2016 @ 0703		Facility	WRNMMC
Provider	BAHR, ROBERT J			
Diagnosis	Acquired absence of right leg below knee			
Procedure	Physical Therapy: ___ Session Segments, 15 Minutes Each	Procedure Date	19 Feb 2016	
Procedure	Physical Therapy Service Evaluation	Procedure Date	19 Feb 2016	
Reason for Visit			Clinic	Psychiatry Be
Encounter Date	16 Feb 2016 @ 1438		Facility	WRNMMC
Provider	ZEMBRZUSKA, HANNA DOMINIKA			
Diagnosis	Encounter for issue of repeat prescription			
Reason for Visit	Ankle - Extreme pain from previous injury location		Clinic	Int Med CL C Medical Home BE
Encounter Date	16 Feb 2016 @ 0721		Facility	WRNMMC
Provider	WILSON, BRYAN J			
Diagnosis	Other skin changes			
Diagnosis	Sprain of other ligament of left ankle, subsequent encounter			
Diagnosis	Parageusia			
Reason for Visit	SARP/LABS		Clinic	Behavioral Health Qu
Encounter Date	05 Feb 2016 @ 1517		Facility	WRNMMC
Provider	AILOR, LYNNE P			

Daniel ANDERSON

CONFIDENTIAL

Page 40 of 67

Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	05 Feb 2016
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 02 Feb 2016 1208 CC GROUP/ CLOSE OUT		
Encounter Date	02 Feb 2016 @ 1209	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	02 Feb 2016
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	02 Feb 2016
Reason for Visit	Notes Entered by: BROWN, CYNTHIA E 19 Jan 2016 1208 CC Group/Individual		
Encounter Date	19 Jan 2016 @ 1208	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	19 Jan 2016
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date	19 Jan 2016
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	19 Jan 2016
Reason for Visit	SARP/LABS		
Encounter Date	13 Jan 2016 @ 1532	Clinic	Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	13 Jan 2016
Reason for Visit	SARP/LABS		
Encounter Date	08 Jan 2016 @ 0846	Clinic	Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	08 Jan 2016
Reason for Visit	SARP/LABS		
Encounter Date	06 Jan 2016 @ 0731	Clinic	Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	06 Jan 2016

Daniel ANDERSON

CONFIDENTIAL

Page 41 of 67

Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 05 Jan 2016 1230 CC GROUP	
Encounter Date	05 Jan 2016 @ 1230	Clinic Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Alcohol and/or drug services; case management	Procedure Date 05 Jan 2016
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 05 Jan 2016

Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 29 Dec 2015 1223 CC GROUP	
Encounter Date	29 Dec 2015 @ 1223	Clinic Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Alcohol and/or drug services; case management	Procedure Date 29 Dec 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 29 Dec 2015

Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 22 Dec 2015 1243 CC GROUP	
Encounter Date	22 Dec 2015 @ 1244	Clinic Substance Abuse NY
Provider	HILL, LARRY D	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Alcohol and/or drug services; case management	Procedure Date 22 Dec 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 22 Dec 2015

Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 15 Dec 2015 1223 CC GROUP	
Encounter Date	15 Dec 2015 @ 1223	Clinic Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Alcohol and/or drug services; case management	Procedure Date 15 Dec 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 15 Dec 2015

Reason for Visit	SARP/LABS	
Encounter Date	14 Dec 2015 @ 0726	Clinic Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility WRNMMC
Diagnosis	Alcohol dependence, uncomplicated	
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date 14 Dec 2015

Daniel ANDERSON

CONFIDENTIAL

Page 42 of 67

Reason for Visit	SARP/LABS	Clinic	Behavioral Health Qu
Encounter Date	08 Dec 2015 @ 1534	Facility	WRNMMC
Provider	AILOR, LYNNE P		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	08 Dec 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 08 Dec 2015 1155 CC GROUP		
Encounter Date	08 Dec 2015 @ 1155	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	08 Dec 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	08 Dec 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 01 Dec 2015 1226 CC GROUP		
Encounter Date	01 Dec 2015 @ 1228	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	01 Dec 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	01 Dec 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 24 Nov 2015 1218 CC GROUP		
Encounter Date	24 Nov 2015 @ 1219	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol abuse, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	24 Nov 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	24 Nov 2015
Reason for Visit	SARP/LABS	Clinic	Behavioral Health Qu
Encounter Date	20 Nov 2015 @ 1556	Facility	WRNMMC
Provider	AILOR, LYNNE P		
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	23 Nov 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 17 Nov 2015 1326 CC GROUP		

Daniel ANDERSON

CONFIDENTIAL

Page 43 of 67

Encounter Date	17 Nov 2015 @ 1327	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol abuse, uncomplicated		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	17 Nov 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	17 Nov 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 12 Nov 2015 0756 INDIVIDUAL SESSION		
Encounter Date	12 Nov 2015 @ 0756	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol abuse, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	12 Nov 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	12 Nov 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 10 Nov 2015 1300 CC GROUP		
Encounter Date	10 Nov 2015 @ 1300	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol abuse, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	10 Nov 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	10 Nov 2015
Reason for Visit	lost taste		
Encounter Date	09 Nov 2015 @ 1050	Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R	Facility	WRNMMC
Diagnosis	Parageusia		
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 03 Nov 2015 1226 CC GROUP		
Encounter Date	03 Nov 2015 @ 1227	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	03 Nov 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	03 Nov 2015
Reason for Visit	est		
Encounter Date	03 Nov 2015 @ 1033	Clinic	Psychiatry Be
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Facility	WRNMMC

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1200

Daniel ANDERSON

CONFIDENTIAL

Page 44 of 67

Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	03 Nov 2015
Reason for Visit	Notes Entered by: MAPLES, MICHAEL J 27 Oct 2015 1245 CC GROUP		
Encounter Date	27 Oct 2015 @ 1246	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	Alcohol dependence, uncomplicated		
Procedure	Alcohol and/or drug services; case management	Procedure Date	27 Oct 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	27 Oct 2015
Reason for Visit	follow-up		
Encounter Date	01 Oct 2015 @ 1305	Clinic	Psychiatry Be
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Facility	WRNMMC
Diagnosis	Generalized anxiety disorder		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	01 Oct 2015
Reason for Visit	Notes Entered by: CUNNINGHAM, RACHEL E 30 Sep 2015 1027 lab		
Encounter Date	30 Sep 2015 @ 1027	Clinic	Dermatology Clinic Bethesda
Provider	FALKNER, RACHEL E	Facility	WRNMMC
Diagnosis	visit for: administrative purpose		
Reason for Visit	SARP/LABS		
Encounter Date	29 Sep 2015 @ 1318	Clinic	Behavioral Health Qu
Provider	MANTANONALEE, CHRISTY LIA	Facility	WRNMMC
Diagnosis	Laboratory Studies		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	29 Sep 2015
Reason for Visit	MOLLUSCUM CONTAGIOSUM		
Encounter Date	29 Sep 2015 @ 0955	Clinic	Dermatology Clinic Bethesda
Provider	MARQUART, JASON DANIEL	Facility	WRNMMC
Diagnosis	SKIN NEOPLASM GROIN		
Diagnosis	FOLLICULITIS DECALVANS		
Reason for Visit	Followup, Genital Warts / Herpes and Bronchitis		
Encounter Date	28 Sep 2015 @ 1027	Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R	Facility	WRNMMC
Diagnosis	MOLLUSCUM CONTAGIOSUM		

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1201

Daniel ANDERSON

CONFIDENTIAL

Page 45 of 67

Diagnosis	CHRONIC BRONCHITIS		
Reason for Visit	Sleep Pathways II		
Encounter Date	23 Sep 2015 @ 1326		
Provider	JARRETT, ERICA M	Clinic	Integrative Hlth & Well BE
Diagnosis	sleep disturbances	Facility	WRNMMC
Procedure	Health And Behav Intervention, Each 15 Min Grp (2 Or More)	Procedure Date	23 Sep 2015
Reason for Visit	SARP/LABS		
Encounter Date	18 Sep 2015 @ 1212		
Provider	MANTANONALEE, CHRISTY LIA	Clinic	Behavioral Health Qu
Diagnosis	Laboratory Studies	Facility	WRNMMC
Diagnosis	PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	18 Sep 2015
Reason for Visit	sleep pathway I		
Encounter Date	17 Sep 2015 @ 0858		
Provider	CORSO, MEGHAN L	Clinic	Integrative Hlth & Well BE
Diagnosis	lack of adequate sleep	Facility	WRNMMC
Procedure	Health And Behav Intervention, Each 15 Min Grp (2 Or More)	Procedure Date	17 Sep 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 15 Sep 2015 1205 CC GROUP		
Encounter Date	15 Sep 2015 @ 1205		
Provider	BROWN, CYNTHIA E	Clinic	Substance Abuse NY
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)	Facility	WRNMMC
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	15 Sep 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	15 Sep 2015
Reason for Visit	Notes Entered by: HERNANDEZ,DARROCQUES D 08 Sep 2015 0724 fever, swollen knee		
Encounter Date	08 Sep 2015 @ 0727		
Provider	FIACCO, NICHOLAS RYAN	Clinic	Int Med Cons/Spec Care CI Be
Diagnosis	penile lesion	Facility	WRNMMC
Reason for Visit	Follow-up		
Encounter Date	27 Aug 2015 @ 1319		
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Clinic	Psychiatry Be
Diagnosis	GENERALIZED ANXIETY DISORDER	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		

Daniel ANDERSON

CONFIDENTIAL

Page 46 of 67

Diagnosis	Patient Education - Medication		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	27 Aug 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 25 Aug 2015 1218 CC GROUP		
Encounter Date	25 Aug 2015 @ 1218	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; case management	Procedure Date	25 Aug 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	25 Aug 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 18 Aug 2015 1224 CC GROUP		
Encounter Date	18 Aug 2015 @ 1225	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; case management	Procedure Date	18 Aug 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	18 Aug 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 11 Aug 2015 1232 CC GROUP		
Encounter Date	11 Aug 2015 @ 1232	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; case management	Procedure Date	12 Aug 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	12 Aug 2015
Reason for Visit	STD Screening/Possible Genetal Warts		
Encounter Date	11 Aug 2015 @ 1008	Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R	Facility	WRNMMC
Diagnosis	PENILE WARTS		
Diagnosis	MAJOR DEPRESSION RECURRENT MODERATE		
Diagnosis	ORGANIC SLEEP APNEA		
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 28 Jul 2015 1158 CC GROUP		
Encounter Date	28 Jul 2015 @ 1158	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	28 Jul 2015

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1203

Daniel ANDERSON

CONFIDENTIAL

Page 47 of 67

Procedure	Alcohol and/or drug services; case management	Procedure Date	28 Jul 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 21 Jul 2015 1219 CC GROUP		
Encounter Date	21 Jul 2015 @ 1219	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; case management	Procedure Date	21 Jul 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	21 Jul 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 15 Jul 2015 0711 CC GROUP		
Encounter Date	15 Jul 2015 @ 0711	Clinic	Substance Abuse NY
Provider	BROWN, CYNTHIA E	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	15 Jul 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	15 Jul 2015
Reason for Visit			
Encounter Date	08 Jul 2015 @ 1923	Clinic	Dermatology Clinic Bethesda
Provider	TAYLOR, BRADLEY MICHAEL	Facility	WRNMMC
Diagnosis	visit for: administrative purpose		
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 30 Jun 2015 1157 CC GROUP		
Encounter Date	30 Jun 2015 @ 1202	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	30 Jun 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	30 Jun 2015
Reason for Visit	Procedure - SARP LABS		
Encounter Date	26 Jun 2015 @ 1119	Clinic	Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Laboratory Studies		
Diagnosis	PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	26 Jun 2015
Reason for Visit	Procedure - SARP LABS		
Encounter Date	25 Jun 2015 @ 1024	Clinic	Behavioral Health Qu

Daniel ANDERSON

CONFIDENTIAL

Page 48 of 67

Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Laboratory Studies		
Diagnosis	PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	25 Jun 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 23 Jun 2015 1203 CC GROUP		
Encounter Date	23 Jun 2015 @ 1205	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	23 Jun 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	23 Jun 2015
Reason for Visit	alopecia areata		
Encounter Date	23 Jun 2015 @ 0722	Clinic	Dermatology Clinic Bethesda
Provider	STEARNS, LAUREL R	Facility	WRNMMC
Diagnosis	Alopecia		
Procedure	Biopsy Skin Each Additional Lesion	Procedure Date	23 Jun 2015
Procedure	Biopsy Skin	Procedure Date	23 Jun 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 16 Jun 2015 1202 CC GROUP		
Encounter Date	16 Jun 2015 @ 1203	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	16 Jun 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	16 Jun 2015
Reason for Visit	follow up		
Encounter Date	11 Jun 2015 @ 0902	Clinic	Psychiatry Be
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Facility	WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER		
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date	12 Jun 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 09 Jun 2015 1200 CC GROUP		
Encounter Date	09 Jun 2015 @ 1200	Clinic	Substance Abuse NY
Provider	HILL, LARRY D	Facility	WRNMMC

Daniel ANDERSON

CONFIDENTIAL

Page 49 of 67

Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	09 Jun 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date	09 Jun 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	09 Jun 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 02 Jun 2015 0935 CC INTAKE/CC GROUP		
Encounter Date	02 Jun 2015 @ 0936		
Provider	BROWN, CYNTHIA E	Clinic	Substance Abuse NY
		Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	02 Jun 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	02 Jun 2015
Procedure	Behavioral health screening to determine eligibility for admission to treatment program	Procedure Date	02 Jun 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 27 May 2015 0859 OP GROUP		
Encounter Date	27 May 2015 @ 0859		
Provider	GONZALEZZARAZUA, JORGE A	Clinic	Substance Abuse NY
		Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Alcohol and/or drug services; case management	Procedure Date	27 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	27 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 22 May 2015 0849 OP GROUP		
Encounter Date	22 May 2015 @ 0849		
Provider	REGIS, JAMES	Clinic	Substance Abuse NY
		Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; case management	Procedure Date	22 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	22 May 2015
Reason for Visit	Procedure - SARP LABS		
Encounter Date	21 May 2015 @ 0824		
Provider	AILOR, LYNNE P	Clinic	Behavioral Health Qu
		Facility	WRNMMC
Diagnosis	Laboratory Studies		
Diagnosis	PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	21 May 2015

Daniel ANDERSON

CONFIDENTIAL

Page 50 of 67

Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 20 May 2015 0804	
	OP GROUP/EST	
Encounter Date	20 May 2015 @ 0804	
Provider	REGIS, JAMES	Clinic Substance Abuse NY
		Facility WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; case management	Procedure Date 20 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 20 May 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date 20 May 2015
Reason for Visit	CBT-i	
Encounter Date	18 May 2015 @ 0820	
Provider	MELTON, APRIL M	Clinic Psychiatry Be
		Facility WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER	
Procedure	Psychiatric Therapy Group Interactive	Procedure Date 19 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 18 May 2015 0848	
	OP GROUP	
Encounter Date	18 May 2015 @ 0848	
Provider	REGIS, JAMES	Clinic Substance Abuse NY
		Facility WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; case management	Procedure Date 18 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 18 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 15 May 2015 0818	
	OP GROUP	
Encounter Date	15 May 2015 @ 0818	
Provider	REGIS, JAMES	Clinic Substance Abuse NY
		Facility WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; case management	Procedure Date 15 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 15 May 2015
Reason for Visit	est	
Encounter Date	14 May 2015 @ 0903	
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Clinic Psychiatry Be
		Facility WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER	
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)	
Procedure	Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management	Procedure Date 15 May 2015

Daniel ANDERSON

CONFIDENTIAL

Page 51 of 67

Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 13 May 2015 0800	
	OP GROUP/EST	
Encounter Date	13 May 2015 @ 0801	
Provider	REGIS, JAMES	Clinic Substance Abuse NY
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	Facility WRNMMC
Procedure	Alcohol and/or drug services; case management	Procedure Date 13 May 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date 13 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 13 May 2015
Reason for Visit	CBT-i	
Encounter Date	11 May 2015 @ 1134	
Provider	MELTON, APRIL M	Clinic Psychiatry Be
Diagnosis	GENERALIZED ANXIETY DISORDER	Facility WRNMMC
Procedure	Psychiatric Therapy Group Interactive	Procedure Date 12 May 2015
Reason for Visit	Notes Entered by: BROWN,CYNTHIA E 11 May 2015 1055	
	OP GROUP	
Encounter Date	11 May 2015 @ 1055	
Provider	REGIS, JAMES	Clinic Substance Abuse NY
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)	Facility WRNMMC
Procedure	Alcohol and/or drug services; case management	Procedure Date 11 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 11 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 08 May 2015 0853	
	OP GROUP	
Encounter Date	08 May 2015 @ 0855	
Provider	GONZALEZZARAZUA, JORGE A	Clinic Substance Abuse NY
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	Facility WRNMMC
Procedure	Alcohol and/or drug services; case management	Procedure Date 08 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 08 May 2015
Reason for Visit	Physical Exam (SARP Related - Navy Yard), Dermatology issue as well	
Encounter Date	07 May 2015 @ 1302	
Provider	ARGUINZONI, JUAN B.	Clinic Int Med CL C Medical Home BE
Diagnosis	ALCOHOL ABUSE - IN REMISSION	Facility WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER	
Diagnosis	ALOPECIA AREATA	
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 06 May 2015 0911	
	OP GROUP	

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1208

Daniel ANDERSON

CONFIDENTIAL

Page 52 of 67

Encounter Date	06 May 2015 @ 0911	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	06 May 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	06 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 06 May 2015 0808 EST		
Encounter Date	06 May 2015 @ 0808	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; case management	Procedure Date	06 May 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date	06 May 2015
Reason for Visit	PROCEDURE - SARP LABS		
Encounter Date	05 May 2015 @ 0841	Clinic	Behavioral Health Qu
Provider	AILOR, LYNNE P	Facility	WRNMMC
Diagnosis	Laboratory Studies		
Diagnosis	PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I		
Procedure	Psychiatric Diagnostic Evaluation Review of Records and Reports	Procedure Date	05 May 2015
Reason for Visit	CBT-i		
Encounter Date	04 May 2015 @ 1411	Clinic	Psychiatry Be
Provider	MELTON, APRIL M	Facility	WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER		
Procedure	Psychiatric Therapy Group Interactive	Procedure Date	05 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 04 May 2015 0846 OP GROUP		
Encounter Date	04 May 2015 @ 0846	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date	04 May 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	04 May 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 01 May 2015 0758 OP GROUP/EST		
Encounter Date	01 May 2015 @ 0759	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1209

Daniel ANDERSON

CONFIDENTIAL

Page 53 of 67

Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; case management	Procedure Date 01 May 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 01 May 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date 01 May 2015
Reason for Visit	CBT-I	
Encounter Date	30 Apr 2015 @ 1031	Clinic Psychiatry Be
Provider	MELTON, APRIL M	Facility WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER	
Procedure	Psychiatric Therapy Group Interactive	Procedure Date 30 Apr 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 29 Apr 2015 0854 OP GROUP	
Encounter Date	29 Apr 2015 @ 0854	Clinic Substance Abuse NY
Provider	REGIS, JAMES	Facility WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; case management	Procedure Date 29 Apr 2015
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 29 Apr 2015
Reason for Visit	pha/navy	
Encounter Date	28 Apr 2015 @ 0901	Clinic Medical Readiness Clinic Bethesda
Provider	PARSON, MARSHEA S	Facility WRNMMC
Diagnosis	visit for: military services physical	
Diagnosis	ASTHMA	
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Diagnosis	MAJOR DEPRESSION RECURRENT MODERATE	
Diagnosis	ANXIETY DISORDER NOS	
Diagnosis	ESSENTIAL HYPERTRIGLYCERIDEMIA	
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA	
Diagnosis	Patient Education	
Diagnosis	ROSACEA	
Procedure	Screening Test Of Visual Acuity, Quantitative, Bilateral	Procedure Date 28 Apr 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 27 Apr 2015 0824 OP GROUP	
Encounter Date	27 Apr 2015 @ 0824	Clinic Substance Abuse NY
Provider	REGIS, JAMES	Facility WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR	
Procedure	Alcohol and/or drug services; group counseling by a clinician	Procedure Date 27 Apr 2015

Daniel ANDERSON

CONFIDENTIAL

Page 54 of 67

Procedure	Alcohol and/or drug services; case management	Procedure Date	27 Apr 2015
Reason for Visit	Generalized Anxiety Disorder & Alcohol Use Disorder, Severe		
Encounter Date	23 Apr 2015 @ 0852	Clinic	Psychiatry Be
Provider	ZEMBRZUSKA, HANNA DOMINIKA	Facility	WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER		
Diagnosis	ALCOHOL DEPENDENCE (ALCOHOLISM)		
Procedure	Psychiatric Diagnostic Evaluation With Medical Evaluation And Management	Procedure Date	23 Apr 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 22 Apr 2015 1019 OP INTAKE		
Encounter Date	22 Apr 2015 @ 1022	Clinic	Substance Abuse NY
Provider	GONZALEZZARAZUA, JORGE A	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; case management	Procedure Date	22 Apr 2015
Procedure	Behavioral health screening to determine eligibility for admission to treatment program	Procedure Date	22 Apr 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 23 Mar 2015 0909 EST		
Encounter Date	23 Mar 2015 @ 0909	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date	23 Mar 2015
Procedure	Alcohol and/or drug services; case management	Procedure Date	23 Mar 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 20 Mar 2015 0737 EST		
Encounter Date	20 Mar 2015 @ 0737	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		
Procedure	Alcohol and/or drug services; case management	Procedure Date	20 Mar 2015
Procedure	Behavioral health counseling and therapy, per 15 minutes	Procedure Date	20 Mar 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 19 Mar 2015 0755 LIP APPOINTMENT		
Encounter Date	19 Mar 2015 @ 0755	Clinic	Substance Abuse NY
Provider	ARITA, ANTHONY A	Facility	WRNMMC
Diagnosis	ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR		

Daniel ANDERSON

CONFIDENTIAL

Page 55 of 67

Procedure	Psychiatric Diagnostic Evaluation	Procedure Date	19 Mar 2015
Reason for Visit	Notes Entered by: PATSOS,ASHLEY N 17 Mar 2015 0725 ASSESSMENT		
Encounter Date	17 Mar 2015 @ 0726	Clinic	Substance Abuse NY
Provider	REGIS, JAMES	Facility	WRNMMC
Diagnosis	visit for: screening exam alcoholism		
Procedure	Alcohol and/or drug assessment	Procedure Date	17 Mar 2015
Reason for Visit	est		
Encounter Date	30 Oct 2014 @ 0730	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	04 Nov 2014
Reason for Visit	est		
Encounter Date	23 Oct 2014 @ 0745	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	24 Oct 2014
Reason for Visit	Notes Entered by: JORDAN,TIMOTHY W 22 Oct 2014 0935 flu vaccine		
Encounter Date	22 Oct 2014 @ 0935	Clinic	FLU CI KI
Provider	JORDAN, TIMOTHY W	Facility	WRNMMC
Diagnosis	Vaccines Prophylactic Need Against Influenza		
Procedure	Influenza Virus Vaccine Live Intranasal Quadrivalent	Procedure Date	22 Oct 2014
Procedure	Immunization Admin By Intranasal / Oral Route One Vaccine	Procedure Date	22 Oct 2014
Reason for Visit	est		
Encounter Date	16 Oct 2014 @ 0709	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	16 Oct 2014
Reason for Visit	Notes Entered by: RINIS,DONNA L 07 Oct 2014 0938 MRI results		
Encounter Date	07 Oct 2014 @ 0938	Clinic	Int Med CL C Medical Home BE
Provider	RINIS, DONNA L	Facility	WRNMMC
Diagnosis	visit for: administrative purpose		

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1212

Daniel ANDERSON

CONFIDENTIAL

Page 56 of 67

Diagnosis	ANKLE SPRAIN LEFT		
Reason for Visit	Notes Entered by: AUSTIN, MARIE 01 Oct 2014 1834 Really health message		
Encounter Date	01 Oct 2014 @ 1834	Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R	Facility	WRNMMC
Diagnosis	foot pain (soft tissue)		
Reason for Visit	Left knee pain/ paper work		
Encounter Date	26 Sep 2014 @ 1246	Clinic	Int Med CL C Medical Home BE
Provider	AUSTIN, MARIE R	Facility	WRNMMC
Diagnosis	left ankle joint pain		
Reason for Visit	est		
Encounter Date	25 Sep 2014 @ 0706	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	25 Sep 2014
Reason for Visit			
Encounter Date	24 Sep 2014 @ 1506	Clinic	Phys Therapy CL BE
Provider	LAI, PHILOMENA C	Facility	WRNMMC
Diagnosis	left ankle joint pain		
Procedure	Physical Therapy Service Re- Evaluation	Procedure Date	24 Sep 2014
Reason for Visit	Notes Entered by: TIVEY-ANDERSON, MILAN D 24 Sep 2014 1201 ASO ankle brace		
Encounter Date	24 Sep 2014 @ 1202	Clinic	Orthotics & Prosthetics Srv Be
Provider	ANDERSON, PETER P	Facility	WRNMMC
Diagnosis	Brace		
Procedure	Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf	Procedure Date	25 Sep 2014
Procedure	Phys Ther Ed Checkout For Ortho/Prosth Use Estab Patient	Procedure Date	25 Sep 2014
Reason for Visit	est		
Encounter Date	18 Sep 2014 @ 0710	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	25 Sep 2014
Reason for Visit	est		
Encounter Date	11 Sep 2014 @ 0735	Clinic	Psychiatry Be

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1213

Daniel ANDERSON

CONFIDENTIAL

Page 57 of 67

Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Clinical Social Work Individual Outpatient Counseling 45 Minutes	Procedure Date	25 Sep 2014
Reason for Visit	Notes Entered by: AZARRAGA, ANN B 21 Aug 2014 0757 Pt wanted clarification if he is being seen weekly starting on the 28th at 0730.		
Encounter Date	21 Aug 2014 @ 0758	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	MAJOR DEPRESSION RECURRENT MODERATE		
Reason for Visit	Notes Entered by: NILSEN, LINDA M 21 Aug 2014 0756 N/S This writer called and left a message for patient at 7:45		
Encounter Date	21 Aug 2014 @ 0756	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	MAJOR DEPRESSION RECURRENT MODERATE		
Reason for Visit	est		
Encounter Date	08 Aug 2014 @ 0649	Clinic	Phys Therapy CL BE
Provider	LAI, PHILOMENA C	Facility	WRNMMC
Diagnosis	left ankle joint pain		
Procedure	Physical Therapy Service Re- Evaluation	Procedure Date	08 Aug 2014
Reason for Visit	Rout		
Encounter Date	04 Aug 2014 @ 0932	Clinic	Psychiatry Be
Provider	NILSEN, LINDA M	Facility	WRNMMC
Diagnosis	ANXIETY DISORDER NOS		
Procedure	Psychiatric Diagnostic Evaluation	Procedure Date	04 Aug 2014
Reason for Visit	F/u		
Encounter Date	27 Jun 2014 @ 0829	Clinic	Integrative Hlth & Well BE
Provider	YORK, CARLA M	Facility	WRNMMC
Diagnosis	anxiety		
Reason for Visit	ANKLE SPRAIN LEFT		
Encounter Date	27 Jun 2014 @ 0753	Clinic	Phys Therapy CL BE
Provider	LAI, PHILOMENA C	Facility	WRNMMC
Diagnosis	left ankle joint pain		
Procedure	Physical Therapy: ____ Session Segments, 15 Minutes Each	Procedure Date	27 Jun 2014
Procedure	Physical Therapy Service Evaluation	Procedure Date	27 Jun 2014
Reason for Visit	anxiety		
Encounter Date	16 Jun 2014 @ 1238	Clinic	Integrative Hlth & Well BE

Daniel ANDERSON

CONFIDENTIAL

Page 58 of 67

Provider	JARRETT, ERICA M	Facility	WRNMMC
Diagnosis	GENERALIZED ANXIETY DISORDER		
Diagnosis	NEUROTIC EXCORIATION		
Procedure	Psychiatric Therapy Individual Approximately 30 Minutes	Procedure Date	20 Jun 2014
Procedure	Psychiatric Diagnostic Evaluation	Procedure Date	19 Jun 2014
Procedure	Psychiatric Diagnostic Evaluation Initial	Procedure Date	16 Jun 2014
Reason for Visit	f/u after sprained ankle		
Encounter Date	16 Jun 2014 @ 0955	Clinic	Int Med CL A Medical Home BE
Provider	CLARK, THOMAS STEPHEN	Facility	WRNMMC
Diagnosis	ANKLE SPRAIN LEFT		
Reason for Visit	Notes Entered by: PEREZ,DULCE C 04 Jun 2014 0632 left ankle swelling		
Encounter Date	04 Jun 2014 @ 0633	Clinic	Int Med Cons/Spec Care Cl Be
Provider	DOUGHERTY, DIANA L	Facility	WRNMMC
Diagnosis	ANKLE SPRAIN LEFT		
Reason for Visit	Notes Entered by: ELLIS,KEISHA 30 May 2014 1141 REFERRAL		
Encounter Date	30 May 2014 @ 1141	Clinic	AMH M01A Red Ki
Provider	COLEMAN, AUDREY G	Facility	WRNMMC
Diagnosis	left ankle joint pain		
Reason for Visit	PHA/NAVY/NIOC		
Encounter Date	19 May 2014 @ 1141	Clinic	AMH M01A Red Ki
Provider	UDE, ASSUMPTA O	Facility	WRNMMC
Diagnosis	ESSENTIAL HYPERTRIGLYCERIDEMIA		
Diagnosis	visit for: military services physical		
Reason for Visit	UDE-F/U FROM ER		
Encounter Date	06 May 2014 @ 1408	Clinic	AMH M01A Red Ki
Provider	UDE, ASSUMPTA O	Facility	WRNMMC
Diagnosis	ARMED FORCES FITNESS FOR DUTY EXAM		
Diagnosis	ANKLE SPRAIN LEFT		
Diagnosis	visit for: exam following treatment		
Reason for Visit	Notes Entered by: COPSEY,HELEN C 30 Dec 2013 0802 Called pt		
Encounter Date	30 Dec 2013 @ 0802	Clinic	GI Clinic Bethesda
Provider	COPSEY, HELEN C	Facility	WRNMMC
Diagnosis	visit for: administrative purpose		

Daniel ANDERSON

CONFIDENTIAL

Page 59 of 67

Reason for Visit	TIO HIGH RISK MEDICAL SCREENING	
Encounter Date	07 Aug 2013 @ 1416	
Provider	SLOAN, DAWN M	Clinic AMH M01A Red Ki
Diagnosis	visit for: military services physical	Facility WRNMMC
Reason for Visit	Notes Entered by: RYAN,LINDSEY O 05 Aug 2013 0903 update imm	
Encounter Date	05 Aug 2013 @ 0903	
Provider	WRAY, KIM D	Clinic Immunization Kimbrough
Diagnosis	Vaccines Prophylactic Need Against Bacterial Diseases	Facility WRNMMC
Procedure	Meningococcal Oligosaccharide Diphtheria Toxoid Conjugate Vaccine	Procedure Date 05 Aug 2013
Procedure	Immunization Administration One Vaccine	Procedure Date 05 Aug 2013
Reason for Visit	navy pha	
Encounter Date	10 Apr 2013 @ 1058	
Provider	UDE, ASSUMPTA O	Clinic AMH M01B Blue Ki
Diagnosis	IMPAIRED FASTING GLUCOSE	Facility WRNMMC
Diagnosis	ESSENTIAL HYPERTRIGLYCERIDEMIA	
Diagnosis	visit for: military services physical	
Diagnosis	ANOMALIES OF SKIN	
Reason for Visit	Notes Entered by: RYAN,LINDSEY O 21 Mar 2013 0914 ppd check	
Encounter Date	21 Mar 2013 @ 0914	
Provider	MASON, HAZEL J	Clinic Immunization Kimbrough
Diagnosis	visit for: follow-up exam	Facility WRNMMC
Reason for Visit	Notes Entered by: PERRY,CHARLES 19 Mar 2013 1225 ANNAUL HEARING EXAM	
Encounter Date	19 Mar 2013 @ 1226	
Provider	PERRY, CHARLES	Clinic Hearing Conservation Kimbrough
Diagnosis	visit for: occupational health / fitness exam	Facility WRNMMC
Diagnosis	visit for: ears / hearing exam	
Procedure	Threshold Audiogram (Pure Tone)	Procedure Date 19 Mar 2013
Reason for Visit	Notes Entered by: WRAY,KIM D 19 Mar 2013 0852 imm update	
Encounter Date	19 Mar 2013 @ 0852	
Provider	WRAY, KIM D	Clinic Immunization Kimbrough
Diagnosis	Need For Vaccination Typhoid	Facility WRNMMC
Diagnosis	Need For Vaccination DTP + TAB	
Diagnosis	visit for: screening exam pulmonary tuberculosis	

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1216

Daniel ANDERSON

CONFIDENTIAL

Page 60 of 67

Procedure	Immunization Administration One Vaccine	Procedure Date	19 Mar 2013
Procedure	Immunization Administration Each Additional Vaccine	Procedure Date	19 Mar 2013
Procedure	Skin Test Anergy Tuberculin Intradermal	Procedure Date	19 Mar 2013
Procedure	Typhoid Vaccine Vi Capsular Polysaccharide, For Intramus Use	Procedure Date	19 Mar 2013
Procedure	Tdap Vaccine	Procedure Date	19 Mar 2013
Reason for Visit	Ude Personal	Clinic	AMH M01B Blue Ki
Encounter Date	28 Jan 2013 @ 1012	Facility	WRNMMC
Provider	UDE, ASSUMPTA O		
Diagnosis	Guidance: Concerns About Unsafe Sexual Practices		
Diagnosis	visit for: screening exam STD		
Reason for Visit	UDE: ACNE	Clinic	AMH M01B Blue Ki
Encounter Date	30 Nov 2012 @ 0826	Facility	WRNMMC
Provider	UDE, ASSUMPTA O		
Diagnosis	FOLLICULITIS		
Reason for Visit	Ude Discuss Vasectomy	Clinic	AMH M01B Blue Ki
Encounter Date	05 Nov 2012 @ 0835	Facility	WRNMMC
Provider	DING, YIMING		
Diagnosis	Need For Prophylactic Measure		
Reason for Visit	FLU MIST	Clinic	FLU CI Ki
Encounter Date	24 Oct 2012 @ 0849	Facility	WRNMMC
Provider	JACOBS, MILLASENT J.		
Diagnosis	Vaccines Prophylactic Need Against Influenza		
Procedure	Immunization Admin By Intranasal / Oral Route One Vaccine	Procedure Date	24 Oct 2012
Procedure	Influenza Virus Vaccine Live Intranasal	Procedure Date	24 Oct 2012
Procedure	Immunization Administration One Vaccine	Procedure Date	24 Oct 2012
Reason for Visit	IBD vs mass	Clinic	GI Inflam Bowel Dis Be
Encounter Date	23 Oct 2012 @ 0738	Facility	WRNMMC
Provider	COPSEY, HELEN C		
Diagnosis	Imaging Studies Nonspecific Abnormal Findings		
Diagnosis	abdominal pain		
Reason for Visit	Notes Entered by: AGOSTO, ROBERT 12 Oct 2012 0805		
	Admission screening for CM services		
Encounter Date	12 Oct 2012 @ 0806	Clinic	Wounded Warrior GWOT
Provider	AGOSTO, ROBERT	Facility	WRNMMC

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1217

Daniel ANDERSON

CONFIDENTIAL

Page 61 of 67

Diagnosis	CONDITIONS INFLUENCING HEALTH STATUS		
Procedure	Case Management, each 15 minutes	Procedure Date	12 Oct 2012
Procedure	Coordinated care fee, maintenance rate	Procedure Date	12 Oct 2012
Reason for Visit	cough/fever		
Encounter Date	14 May 2012 @ 0846	Clinic	Corry MHP
Provider	BRADLEY, RACHAEL NAOMI	Facility	NH Pensacola, FL
Diagnosis	VIRAL SYNDROME		
Reason for Visit	chronic fever feelings		
Encounter Date	10 May 2012 @ 1220	Clinic	Corry MHP
Provider	GUNTER, ROGER WILLIAM	Facility	NH Pensacola, FL
Diagnosis	VIRAL SYNDROME		
Reason for Visit	PHA PART II / VA		
Encounter Date	06 Mar 2012 @ 1328	Clinic	Readiness Center
Provider	TREVEN, LAUREN A	Facility	NH Pensacola, FL
Diagnosis	visit for: occupational health / fitness exam		
Reason for Visit	flu SHOT		
Encounter Date	02 Nov 2011 @ 1101	Clinic	Corry MHP
Provider	GRIMM, CHRISTOPHER T	Facility	NH Pensacola, FL
Diagnosis	Vaccines Prophylactic Need Against Influenza		
Procedure	Immunization Administration One Vaccine	Procedure Date	02 Nov 2011
Procedure	Influenza Split Virus Vaccine 0.5mL Dosage Intramuscular Preservative Free	Procedure Date	02 Nov 2011
Reason for Visit	6 mo f/u		
Encounter Date	07 Oct 2011 @ 0750	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA		
Diagnosis	Aftercare Following Surgery Of Sense Organs		
Procedure	Determination Of Refractive State	Procedure Date	07 Oct 2011
Procedure	Ophthalmological Prior Patient Start Comprehensive Care	Procedure Date	07 Oct 2011
Reason for Visit	f/u skin check		
Encounter Date	27 Jul 2011 @ 0826	Clinic	Dermatology Clinic
Provider	BRUMWELL, ERIC P	Facility	NH Pensacola, FL
Diagnosis	FOLLICULITIS		
Reason for Visit	PULM/LAB RESULTS/MEDS/20MIN		
Encounter Date	26 Jul 2011 @ 1054	Clinic	Pulmonary Disease Clinic

Daniel ANDERSON

CONFIDENTIAL

Page 62 of 67

Provider	LEWIS, CHRISTOPHER T	Facility	NH Pensacola, FL
Diagnosis	ASTHMA		
Reason for Visit	prk f/u		
Encounter Date	06 Jun 2011 @ 0822	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA		
Diagnosis	Aftercare Following Surgery Of Sense Organs		
Procedure	Postoperative Visit, Without Charge	Procedure Date	06 Jun 2011
Reason for Visit	1 month PRK F/u		
Encounter Date	06 Jun 2011 @ 0758	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA		
Diagnosis	Aftercare Following Surgery Of Sense Organs		
Procedure	Postoperative Visit, Without Charge	Procedure Date	06 Jun 2011
Reason for Visit	prk f/u		
Encounter Date	04 May 2011 @ 0818	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	SUPERFICIAL INJURY - ABRASION OF CORNEA		
Procedure	Ophthalmological Prior Patient Start Comprehensive Care	Procedure Date	04 May 2011
Reason for Visit	1 WEEK PRK F/U		
Encounter Date	26 Apr 2011 @ 0756	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	Aftercare Following Surgery Of Sense Organs		
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA		
Procedure	Postoperative Visit, Without Charge	Procedure Date	26 Apr 2011
Reason for Visit	1 DAY PRK F/U		
Encounter Date	22 Apr 2011 @ 0733	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	POSTSURGICAL STATE OF EYE AND ADNEXA		
Diagnosis	Aftercare Following Surgery Of Sense Organs		
Procedure	Postoperative Visit, Without Charge	Procedure Date	22 Apr 2011
Reason for Visit	PRK Sx		
Encounter Date	21 Apr 2011 @ 0928	Clinic	Refractive Surgery
Provider	ROPP, CORBY D	Facility	81st Medical Group
Diagnosis	REFRACTIVE ERROR - MYOPIA		

Daniel ANDERSON

CONFIDENTIAL

Page 63 of 67

Procedure	Photorefractive keratectomy (PRK)	Procedure Date	21 Apr 2011
Reason for Visit	PRK Screen		
Encounter Date	29 Mar 2011 @ 1219	Clinic	Ophthalmology Clinic
Provider	ROPP, CORBY D	Facility	NH Pensacola, FL
Diagnosis	REFRACTIVE ERROR - MYOPIA		
Diagnosis	visit for: preoperative exam		
Procedure	Computerized Corneal Topography	Procedure Date	29 Mar 2011
Procedure	Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral	Procedure Date	29 Mar 2011
Procedure	Corneal Pachymetry Both Eyes	Procedure Date	29 Mar 2011
Procedure	Determination Of Refractive State	Procedure Date	29 Mar 2011
Procedure	Ophthalmological New Patient Start Comprehensive Care	Procedure Date	29 Mar 2011
Reason for Visit	difficulty breathing (dyspnea)		
Encounter Date	17 Mar 2011 @ 1300	Clinic	Pulmonary Function Lab
Provider	LEWIS, CHRISTOPHER T	Facility	NH Pensacola, FL
Diagnosis	difficulty breathing (dyspnea)		
Procedure	Pulmonary Function Carbon Monoxide Diffusion % (DLCO)	Procedure Date	24 Mar 2011
Procedure	Bronchial Challenge With Methacholine	Procedure Date	24 Mar 2011
Procedure	Spirometry Pre-bronchodilator	Procedure Date	24 Mar 2011
Procedure	Spirometry Post-bronchodilator	Procedure Date	24 Mar 2011
Procedure	Special Dr. Services Analysis Of Computerized Data	Procedure Date	24 Mar 2011
Procedure	Pulse Oximetry	Procedure Date	24 Mar 2011
Procedure	Pulmonary Function MVV	Procedure Date	24 Mar 2011
Procedure	Pulmonary Function FRC (% Predicted Normal)	Procedure Date	24 Mar 2011
Reason for Visit	NASP/EVAL PRK/NO CONTACTS 30 DAYS/20/UNIF/MED LIST		
Encounter Date	16 Mar 2011 @ 0851	Clinic	NASP Optometry
Provider	ZENT, JOHN W	Facility	NH Pensacola, FL
Diagnosis	PERIPHERAL RETINAL DEGENERATION - LATTICE		
Diagnosis	REFRACTIVE ERROR - MYOPIA		
Procedure	Determination Of Refractive State	Procedure Date	16 Mar 2011
Procedure	Ophthalmological Prior Patient Start Intermediate Level Care	Procedure Date	16 Mar 2011
Reason for Visit	NASP 3600/ROUT EYE EXAM/ME DLIST/CTD/20/REC/UOD		
Encounter Date	17 Feb 2011 @ 0946	Clinic	NASP Optometry
Provider	ZENT, JOHN W	Facility	NH Pensacola, FL
Diagnosis	REFRACTIVE ERROR - MYOPIA		

Personal Data - Privacy Act of 1974 (PL 93-579)

AR 1220

Daniel ANDERSON

CONFIDENTIAL

Page 64 of 67

Procedure	Corneal Pachymetry Both Eyes	Procedure Date	17 Feb 2011
Procedure	Ophthalmological Prior Patient Start Comprehensive Care	Procedure Date	17 Feb 2011
Reason for Visit	ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN		
Encounter Date	16 Feb 2011 @ 0755	Clinic	Pulmonary Disease Clinic
Provider	LEWIS, CHRISTOPHER T	Facility	NH Pensacola, FL
Diagnosis	difficulty breathing (dyspnea)		
Reason for Visit	pha/jacc/15 min/rec/rx/ct		
Encounter Date	08 Feb 2011 @ 0824	Clinic	Readiness Center
Provider	BROWN, TRAVIS S	Facility	NH Pensacola, FL
Diagnosis	visit for: occupational health / fitness exam		
Diagnosis	ASTHMA EXTRINSIC		
Reason for Visit	MED REFILL		
Encounter Date	24 Jan 2011 @ 1244	Clinic	Corry Prime Care
Provider	WIEDL, ERICA KITCHELL	Facility	NH Pensacola, FL
Diagnosis	ALLERGIC RHINITIS		
Reason for Visit	f/u skin check		
Encounter Date	24 Nov 2010 @ 0814	Clinic	Dermatology Clinic
Provider	BRUMWELL, ERIC P	Facility	NH Pensacola, FL
Diagnosis	SKIN NEOPLASM UNCERTAIN BEHAVIOR		
Diagnosis	visit for: screening exam malignant neoplasm skin		
Procedure	Biopsy Skin	Procedure Date	24 Nov 2010
Reason for Visit	flumist		
Encounter Date	15 Nov 2010 @ 1337	Clinic	Corry Prime Care
Provider	WILLIAMS, TREVOR MICHAEL	Facility	NH Pensacola, FL
Diagnosis	Vaccines Prophylactic Need Against Influenza		
Diagnosis	Parent Education: Immunizations		
Procedure	Immunization Administration One Vaccine	Procedure Date	15 Nov 2010
Procedure	Influenza Virus Vaccine Live Intranasal	Procedure Date	15 Nov 2010
Reason for Visit	F/u biopsy		
Encounter Date	13 Oct 2010 @ 0837	Clinic	Dermatology Clinic
Provider	BRUMWELL, ERIC P	Facility	NH Pensacola, FL
Diagnosis	FOLLICULITIS		
Reason for Visit	Suture Removal		
Encounter Date	04 Oct 2010 @ 0756	Clinic	Dermatology Clinic
Provider	BRUMWELL, ERIC P	Facility	NH Pensacola, FL
Diagnosis	Removal Of Sutures		

Daniel ANDERSON

CONFIDENTIAL

Page 65 of 67

Reason for Visit	f/u skin check	Clinic	Dermatology Clinic
Encounter Date	28 Sep 2010 @ 0748	Facility	NH Pensacola, FL
Provider	BRUMWELL, ERIC P		
Diagnosis	FOLLICULITIS		
Procedure	Biopsy Skin	Procedure Date	28 Sep 2010
Procedure	Biopsy Skin Each Additional Lesion	Procedure Date	28 Sep 2010
Reason for Visit	poss. allergic reaction	Clinic	Corry Prime Care
Encounter Date	01 Sep 2010 @ 0824	Facility	NH Pensacola, FL
Provider	GUNTER, ROGER WILLIAM		
Diagnosis	ASTHMA EXTRINSIC		
Reason for Visit	f/u skin check	Clinic	Dermatology Clinic
Encounter Date	25 Aug 2010 @ 0824	Facility	NH Pensacola, FL
Provider	SMITH, ERIC P		
Diagnosis	FOLLICULITIS		
Reason for Visit	ROSACEA/DERM-NHP/MED LIST/CTD/20/RECORDS/UNIFORM	Clinic	Dermatology Clinic
Encounter Date	20 Jul 2010 @ 0916	Facility	NH Pensacola, FL
Provider	SMITH, ERIC P		
Diagnosis	FOLLICULITIS		
Reason for Visit	allergic reaction	Clinic	Corry Prime Care
Encounter Date	14 Jun 2010 @ 0932	Facility	NH Pensacola, FL
Provider	GUNTER, ROGER WILLIAM		
Diagnosis	ROSACEA		
Reason for Visit	EYE EXAM-CONSULT FOR PRK/BLD 3600/UOD/REC/MEDS/GLASSES/CDT/20MINS	Clinic	NASP Optometry
Encounter Date	21 Apr 2010 @ 0755	Facility	NH Pensacola, FL
Provider	ZENT, JOHN W		
Diagnosis	REFRACTIVE ERROR - MYOPIA		
Diagnosis	PERIPHERAL RETINAL DEGENERATION - LATTICE		
Procedure	Determination Of Refractive State	Procedure Date	23 Apr 2010
Procedure	Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia)	Procedure Date	23 Apr 2010
Procedure	Spectacles Services Fitting Monofocals (Not For Aphakia)	Procedure Date	23 Apr 2010
Procedure	Ophthalmological New Patient Start Comprehensive Care	Procedure Date	23 Apr 2010
Reason for Visit	PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD	Clinic	Readiness Center
Encounter Date	17 Mar 2010 @ 0727	Facility	NH Pensacola, FL
Provider	BROWN, TRAVIS S		
Diagnosis	visit for: occupational health / fitness exam		
Diagnosis	ALLERGIC RHINITIS		

Daniel ANDERSON

CONFIDENTIAL

Page 66 of 67

Reason for Visit	Anthrax Vaccine		
Encounter Date	09 Mar 2010 @ 0824	Clinic	Corry Prime Care
Provider	THOMAS, JOSHUA L	Facility	NH Pensacola, FL
Diagnosis	Vaccines Prophylactic Need Against Bacterial Diseases		
Procedure	Anthrax Vaccine, For Subcutaneous Use	Procedure Date	09 Mar 2010
Reason for Visit	H1N1		
Encounter Date	22 Dec 2009 @ 1100	Clinic	Corry Prime Care
Provider	GUNTER, ROGER WILLIAM	Facility	NH Pensacola, FL
Diagnosis	Parent Education: Immunizations		
Procedure	Influenza Virus Vaccine Pandemic Formulation	Procedure Date	22 Dec 2009
Procedure	Immunization Administration One Vaccine	Procedure Date	22 Dec 2009
Reason for Visit	influenza		
Encounter Date	23 Sep 2009 @ 1440	Clinic	Corry Prime Care
Provider	GUNTER, ROGER WILLIAM	Facility	NH Pensacola, FL
Diagnosis	Vaccines Prophylactic Need Against Influenza		
Diagnosis	Parent Education: Immunizations		
Procedure	Immunization Administration One Vaccine	Procedure Date	23 Sep 2009
Procedure	Influenza Virus Vaccine Live Intranasal	Procedure Date	23 Sep 2009
Reason for Visit	re-enlistment Phy		
Encounter Date	16 Sep 2009 @ 0805	Clinic	Corry Phys Exams
Provider	GUNTER, ROGER WILLIAM	Facility	NH Pensacola, FL
Diagnosis	visit for: military services physical		
Reason for Visit	REQUEST FOR LABS/JACC/20/MED LIST/CTD		
Encounter Date	20 Aug 2009 @ 0915	Clinic	Corry Prime Care
Provider	HEDARIA, ELIZABETH A	Facility	NH Pensacola, FL
Diagnosis	exposure to STD		
Reason for Visit	indoc		
Encounter Date	07 May 2009 @ 1355	Clinic	Corry Health Promotion And Wel
Provider	LINVILLE, TREVOR S	Facility	NH Pensacola, FL
Diagnosis	Patient Education - HIV		
Diagnosis	Guidance: Concerns About Unsafe Sexual Practices		
Diagnosis	visit for: administrative purpose		
Diagnosis	Inquiry And Counseling: Contraceptive Practices		
Reason for Visit	abdominal pain		
Encounter Date	06 Mar 2006 @ 0759	Clinic	NATTC MHP

Daniel ANDERSON

CONFIDENTIAL

Page 67 of 67

Provider	MAYNARD, PENELOPE A	Facility	NH Pensacola, FL
Diagnosis	feared medical condition not demonstrated		
Diagnosis	visit for: issue medical certificate fitness		

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Subject: Medical Board - Request for Formal Board

Summary of medical symptoms how they effect my work and why I have been promotable and advanced even through the severity. This is from my perspective and on the fly my doctors may have more conclusive evidence. I have such chronic pain that the GI clinic cannot treat it while in the military. The pain is so bad that I have been granted a Maryland Medicinal Certification to relieve my chronic pain. The military says I am ok because I have advanced and served. I cannot put up with the pain for another 4 years.


IBS with Diarrhea:

- Symptoms: Pain (6-10 on the pain scale), Spasms, Urgency, Soiling of Pants
- Frequency: 2-10 episodes daily 5-30 minutes in length each
- Causes: Anxiety, Stress, Intestinal Pressure (Uniforms, Gas, Food), Physical Training, Specific Scents and Specific Foods/Derivatives.
- Other: Due to traffic; long drives to Fort Meade and Walter Reed soiling of pants has occurred. In some occurrences, soiling at work has occurred due to emergency urgency and being unable to remove my uniform in time or stuck on watch without a fast-enough relief. (At home this isn't an issue as I wear sweats and easily removable clothing). The pain has been treated in many ways but as of the last Gastroenterology appointment no military approved method has worked to treat my daily pain. I have advanced and been successful because of fear and my mental health conditions and because of being worried about life outside of the military. I may have done well so far but I am tired of forcing myself through extra pain and embarrassment from this condition which makes me suicidal on a regular basis.

Mental Health (Depression, Anxiety and Trauma):

- Symptoms: Inability to get along with coworkers and family, Seclusion, Under or Over exertion of task.
- Frequency: Daily
- Causes: Security Clearance, Military Life, Childhood Trauma which resulted in wrong career path choices and not being compatible with the military, IBS-D
- Other: These mental health conditions are what have made me successful but at the expense of my health. In attempt to over compensate and to earn peoples praise I have only led my life in a way to be praised for being successful, I.E. Promotions and working well. I do not have my own identity or normalization of relationships from friendships to even family; this has required heavy therapy to try and bring some sense of normalization to my thought patterns as well as to prevent suicidal ideation which I find would be my way out of the insurmountable overexertion that I find necessary to live and because of military life which has prevented me from moving on and healing as a person.

Respectfully,
Daniel Anderson

 01/25/18



**Walter Reed
National Military
Medical Center**

Sherin Paul Psy.D.

Clinical Psychologist

Adult Behavioral Health Clinic - Outpatient

Walter Reed National Military Medical Center
(WRNMMC)

8901 Wisconsin Ave., Bethesda, MD 20889-5600

19 February 2018

TO: CTN2 Anderson, Daniel Dennis (REDACTED)

THRU: Lieutenant Commander Bryan Pyle, Chief Adult Behavioral Health Clinic- Outpatient Service, WRNMMC (BP)

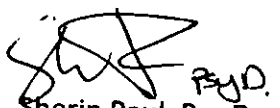
SUBJECT: Unfitting Conditions for CTN2 Daniel Anderson

1. The purpose of this memorandum is to provide the Physical Evaluation Board (PEB) with information concerning the fitness of CTN2 Daniel Anderson to continue to serve as a Cryptologic Networking Technician (CNT) from a behavioral health perspective.
2. CTN2 Anderson has received behavioral health services at the Adult Outpatient Behavioral Health Clinic at Walter Reed National Military Medical Center since 04 August 2014 and consistently on a weekly basis with this provider since 15 November 2016. CTN2 Anderson was initially treated in 2014 for a diagnosis of Anxiety Disorder Not Other Wise Specified which was then revised to a diagnosis of Generalized Anxiety Disorder (GAD) in 2015. CTN2 Anderson also has a concurrent diagnosis of Major Depressive Disorder (MDD). Additionally, per available records, CTN2 Anderson also completed a 28-day inpatient program in March 2015 for a diagnosis of Alcohol Use Disorder and has maintained follow up outpatient treatment on this issue.
3. Despite long term compliance with treatment recommendations CTN2 Anderson's GAD and MDD diagnoses cause him various symptoms that limit his ability to serve in the military, including but not limited to the following: 1) consistent anxiety or depression affecting the ability to function independently, appropriately and effectively; 2) difficulty in adapting to stressful circumstances, including work or a work-like setting; and 3) and difficulty developing healthy coping skills to manage life stressors.
4. The above limitations prevent CTN2 Anderson from performing either his basic military duties or the duties of his rating. As a CNT, CTN2 Anderson works daily in a stressful position that requires him to maintain complex Information Technology (IT) networks containing secure, classified information. CTN2 Anderson's continued service would place at risk not only his mental health but also his sensitive work product, as his symptoms will likely continue to negatively interfere with his ability to efficiently, effectively, and accurately perform his duties.
5. In my professional medical opinion, CTN2 Anderson's GAD and MDD diagnoses, individually and when taken together, leave him unable to safely and reliably perform the duties required of a Cryptologic Networking Technician.



Walter Reed
National Military
Medical Center

6. Questions regarding this memo can be directed to the undersigned at (301) 295-0500 and/or sherin.paul.ctr@mail.mil.


Sherin Paul, Psy.D.
Clinical Psychologist
WRNMMC

LATHAM & WATKINS^{LLP}

MEMORANDUM

Date: February 12, 2017

From: Tae Hee (Tamara) Kim, Esq. and Eugene Elrod, Esq., of Latham & Watkins LLP, on behalf of CTN2 Daniel Anderson

To: President, Department of Navy Physical Evaluation Board (PEB)
Attention: Ms. Ton Jua Howard (TDRL)
720 Kennon Street
BLDG 36 STE 309
Washington Navy Yard, DC 20374-5023

Subj: CTN2 Daniel Anderson's Request for Informal Reconsideration

Ref: (a) SECNAVINST 1850.4E
(b) DoDI 1332.18

Encl: Abbreviated Medical Evaluation Board Report dated June 13, 2017 (Exhibit A)
Abbreviated Medical Evaluation Board Report dated December 6, 2017 (Exhibit B)
Consolidated NARSUM (Exhibit C)
Compensation and Pension Exam Report for DBQ PSYCH Mental disorders Exam dated October 26, 2017 (Exhibit D)
Non-Medical Assessment (NMA) dated October 27, 2017 (Exhibit E)
Medical Record created October 30, 2017 at WRNMMC (Exhibit F)
Personal Health Information created on January 24, 2018 from the Military Electronic Health Record (Exhibit G)
Personal Summary of Medical Symptoms by Daniel Anderson (Exhibit H)

February 12, 2018
Page 2

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1. The purpose of this memorandum is to file the non-concurrence of CTN2 Daniel Anderson (hereafter, "Anderson") with the findings of the Informal Physical Evaluation Board (IPEB) and to request that the IPEB find his Irritable Bowel Syndrome (IBS), Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) to be unfitting conditions.

2. Pursuant to SECNAVINST 1850.4E, the military disability retirement system is based on fitness for duty. Under SECNAVINST 1850.4E §3304, a member may be determined Unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found Unfit because of physical disability. Under §3306, if a preponderance (more than 50 percent) of the evidence indicates unfitness, a finding must be made to that effect. Under SECNAVINST 1850.4E §3306, each case is considered by relating the nature and degree of physical disability of the member to the requirements and duties that member may reasonably be expected to perform in his or her office, grade, rank or rating.

3. Under Appendix 2 of DoDI 1332.18, a Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable reasonably to perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation. A Service member may also be considered unfit when the evidence establishes that: 1) the Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or 2) the Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

4. On October 27, 2017, the Commanding Officer of the Cyber Strike Activity Sixty Three completed a Non-Medical Assessment (NMA) in Anderson's case, confirming the following facts: 1) considering Anderson's current physical condition, he is not worldwide assignable; and 2) he does not have good potential for continued service in his present physical and mental condition. Exhibit E, at 2-3. The NMA is the Commanding Officer's unbiased and accurate comments describing how the medical condition impacts the service member's ability to function within his/her rank and MOS/rating. *Id.*, at 1.

5. On November 6, 2017, the Medical Evaluation Board (MEB) at Walter Reed National Military Medical Center released a consolidated NARSUM finding the following diagnoses to fail the medical retention standards of the Navy: MDD, GAD, and IBS with Diarrhea. Exhibit C.

6. On December 6, 2017, after the IPEB found Anderson fit for duty, medical officers proposed in the Abbreviated Medical Evaluation Board Report that Anderson should continue on limited duty for his GAD, MDD and IBS.. Exhibit B. The clinical information provided by the medical officers stated: 1) that Anderson has anxiety, depression, and co-morbid medical condition that have significantly negatively impacted his ability to function at home and in his social environment; and 2) that the GI confirmed the IBS-D/P to be of such severity that it interferes with military activities of daily living (ADLs). *Id.*

7. In light of these facts, Anderson respectfully requests the PEB find him unfit for duty based on the following conditions:

February 12, 2018
Page 3

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I. Irritable Bowel Syndrome (IBS), Fecal Urgency and Fecal Smearing

8. Anderson requests that his IBS be found unfitting because it causes pain, spasms, fecal urgency, fecal leaking, fecal smearing, and soiling of pants. Exhibit H.

9. Anderson has reported a long history of GI symptoms dating back to childhood, but symptoms have been more frequent and disruptive over the past few years. Exhibit C. In 2016, Anderson was repeatedly diagnosed with “IBS with Diarrhea” on May 11, October 4, October 11 and November 28. Exhibit G. In 2017, Anderson continued to be diagnosed with “IBS with Diarrhea” at every one of the following doctor’s appointments: on March 16, April 13, May 17, June 1, July 12, June 27, August 7, 2017, September 19, September 29, October 17, November 2, and December 6. *Id.* Similarly, Anderson was diagnosed with “Mixed Irritable Bowel Syndrome” on June 12, 2017, and with “Irritable Bowel Syndrome” (IBS) on July 13, 2017. *Id.* Finally, Anderson was diagnosed with Fecal Urgency and Soiling on September 19, 2017, and with Fecal Urgency and Fecal Smearing on September 29, 2017. Exhibit F.

10. On June 14, 2017, Anderson was placed on Limited Duty due to his IBS being of such “severity that it daily interferes with military Activities of Daily Living (ADLs).” Exhibit A. As part of Anderson’s placement on limited duty, the military was required to allow him to be in “close proximity” to the bathroom at all times. Anderson’s Limited Duty was extended on December 6, 2017. Exhibit B.

11. On November 6, 2017, the Medical Evaluation Board determined that Anderson’s IBS failed medical retention standards due to his experiencing “generalized sharp, crampy abdominal pain about every 1-2 days that peaks prior to defecation,” which is “triggered by physical activity, anxiety, and stress.” Exhibit C. The MEB also based its decision on the fact that Anderson’s IBS precluded both his deployment to an austere environment and his return to full duty in the next 12 months.

12. Anderson’s IBS is incompatible with military service, permanently duty limiting, and thus unfitting for duty. Anderson’s IBS, which is exacerbated by “physical activity and with increased anxiety/stress,” is incompatible with general Navy life. Exhibit C. Anderson is unable to take a basic Navy physical fitness assessment, work in a deployed environment, or work in a high-stress, fast-paced unit without worsening his condition. Moreover, Anderson’s fecal urgency and soiling is incompatible with his rating of Cryptologic Networking Technician (CNT). As a CNT, working in a secured facility, Anderson has soiled his pants on more than one occasion due to fecal urgency that left him unable to get to bathroom and remove his uniform in a timely fashion. Exhibit H.

II. Generalized anxiety disorder (GAD) and Major depressive disorder (MDD)

13. Anderson requests that his GAD and MDD, individually and when taken together, be found unfitting because the symptoms prevent him from performing, safely and reliably, the duties of his rating or even his basic military duties.

February 12, 2018
Page 4

LATHAM & WATKINS LLP

14. Anderson has been in mental health treatment regularly, with weekly visits to his psychiatrist since August of 2012. Exhibit D, at 5. Anderson was hospitalized in 2015 for 30 days at Fort Belvoir for inpatient treatment. *Id.*

15. Despite being in treatment for several years and on Limited Duty for over 6 months, Anderson's MDD and GAD continue to cause significant symptoms and limitations as illustrated by his NARSUM and VA DBQ PSYCH Mental disorders Exam (Psych DBQ) dated September 25, 2017. Exhibit D. Specifically, Anderson's NARSUM notes that his MDD results in sad mood, feelings of helplessness, feelings of hopelessness, low energy, anhedonia, and chronic suicidal ideation and that his GAD manifests in worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. Exhibit C.

16. Anderson's GAD and MDD create numerous symptoms that directly limit his ability to serve in the military and to function in the larger world. For example, Anderson's Psych DBQ states that he has "near-continuous panic or depression affecting the ability to function independently, appropriately and effectively," "difficulty in adapting to stressful circumstances, including work or a worklike setting," and "obsessional rituals which interfere with routine activities." Exhibit D.

17. Anderson's limitations not only prevent him from performing his basic military duties and the duties of his rating, but also place an undue risk and burden on both himself and the military. As a CNT, Anderson works daily in a stressful job that requires him to maintain complex Information Technology (IT) networks containing secure, classified information. Therefore, should the PEB find Anderson fit and Anderson were to continue service, the Navy would be placing at risk not only his mental health, but also its own secure documentation and information systems. This is because Anderson's continued work is likely to cause difficulty adapting, panic and depression, thereby resulting in mistakes, poor judgment, and limited functioning on his part.

18. Anderson's command believes that his medical conditions render him unfit for military service and prevent his further service. His commander personally endorsed the suspension of Anderson's access to TTS/SCI materials and facilities, and states that his mental health condition "has prompted a review by Department of the Navy Central Adjudication Facility to see if the member can retain his current level of security clearance," preventing him from completing regular CNT duties. Exhibit E, at 3-4. Moreover, since Anderson's condition, according to his NARSUM, is not likely to improve in the next 12 to 36 months, it appears that he will be disqualified from obtaining the security clearance required to do his job for an indefinite period. Exhibit C.

19. Perhaps the best evidence of Anderson's lack of fitness for duty in light of his MDD and GAD is his most recent Abbreviated MEB. In sharp contrast to the IPEB's finding that Anderson is fit for duty, the most recent Abbreviated MED placed him on his second period of limited duty. Exhibit B. From a mental health perspective, Anderson's second period of limited duty is even more limiting than was his first period of limited duty. The second period requires him to remain at Walter Reed for "extensive medical care," removing him indefinitely from his work as a CNT. In addition, Anderson's second period of limited duty precludes his participation in "late

February 12, 2018
Page 5

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night or overnight duty,” excluding him from shift work that is common for a sailor serving as a CNT. *Id.* Moreover, Anderson’s second period of limited duty prevents him from living on a boat, deploying, and from firing and carrying a weapon. *Id.*

V. Conclusion

20. Contrary to what the PEB claimed in its IPEB response, all evidence in Anderson’s medical records illustrate that his IBS, GAD and MDD limit his continued military service. There is no indication that Anderson is limited in his duties simply because his command does not trust him. In fact, as illustrated by his commander’s NMA, his command documents that his medical conditions cause him to miss 30 hours of work per week and caused him to lose the clearance required to do his job as a CNT.

21. For the reasons set forth above and evidence enclosed herewith, Anderson respectfully requests that the PEB find his IBS, GAD, and MDD, individually and when taken together, render him unfit for continued military service.

/s/ Tamara Kim
Tae Hee (Tamara) Kim, Esq.

/s/ Gene Elrod
Eugene Elrod, Esq.

This work card is a space for PEB members to make notes and does not reflect their thoughts or analysis of the case.
The rationale alone represents their judgments.

IDES FIT FPEB REQUEST

ANDERSON, DANIEL [REDACTED]

FORMAL HEARING DENIAL COMMENTS

PRESIDING OFFICER:

2nd LINE OFFICER:

MEDICAL OFFICER:

FORMAL BOARD DENIED

REVIEWED

By John Reeser, President PEB at 1:33 pm, Feb 22, 2018

1. WAS NEW INFORMATION RECEIVED? ☒ Yes ☐ No
2. CHANGE TO UNFIT (revote in JDETS)? ☐ Yes ☒ No

NOTES:

Member's inability to perform is due to conduct not medical.
No change from informal findings.
Formal Board not recommended.

REVIEWED

By CAPT David McLean, MC, USN at 7:02 am, Feb 20, 2018

Reviewed, concur w/MO. No change to IPEB, Fit. Do not recommend formal board.

REVIEWED

By Col William Berris, USMC at 7:33 am, Feb 20, 2018

Reviewed, concur w/ IPEB findings. Formal board not recommended.

REVIEWED

By CDR Diana Tersak, USN at 10:11 am, Feb 20, 2018

This work card is a space for PEB members to make notes and does not reflect their thoughts or analysis of the case.
The rationale alone represents their judgments.

that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent, or as permitted by law, is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made."

See below:



DEPARTMENT OF THE NAVY
SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
720 KENNON STREET SE STE 309
WASHINGTON NAVY YARD DC 20374-5023

IN REPLY REFER TO
1850
CORB:003
9 Jul 15

From: Director, Secretary of the Navy Council of Review Boards
To: President, Physical Evaluation Board

Subj: DELEGATION OF AUTHORITY

Ref: (a) SECNAVINST 1850.4E

1. Pursuant to reference (a), § 4109, You are hereby delegated authority to deny requests for formal hearings from service members found fit for continued naval service by the Informal Physical Evaluation Board.



J. A. RIEHL

Copy to:
Counsel

On 27 Jul 2015, DES Counsel PM informed CORB counsel that the attorneys would continue to press the issue (see attached email). S:\WNYD\JAG\JAG 16\DES DROP\A NEW DES DRIVE\DES PROCESS\Authority to Deny Formal Request after FIT finding\RE Formal requests post FIT finding.msg

Thanks for the heads-up. As an aside, I subscribe to that principle of administrative law that states powers can be delegated unless specifically prohibited by law. No such language is in the SECNAVINST. However, we will clarify in the instruction's revision and consider a fix in the interim.

RC

1. Duty Station (If different from home station, list here)					2. Duty Station (If different from home station, list here)		3. Date		4. SSN	
5. Promotion Status					6. Date Reported		7. Physical Readiness		8. Billet Subcategory (if any)	
GARRISON SUPPORT-8					16SEP15		W		NA	
9. From: 17JUL21					15. To: 18MAR15					
10. Physical Readiness					20. Physical Readiness		21. Billet Subcategory (if any)		22. UIC	
W					W		NA		37700	
23. SSN					24. UIC		25. Title		26. SSN	
000-00-0000					1810		CO		000-00-0000	
<p>27. Primary duty abbreviation in box.)</p> <p>28. GARRISON SUPPORT-8. Provides personnel support to Cryptologic Operations in support of U.S. Cyber Command (USCYBERCOM) and the Cyber Defense of the Nation (DTN) missions.</p> <p>29. TEMADD: 17AUG29-17SEP26. WATCH: OFFICER OF THE DECK-8. PFA:</p>										
30. Date Counseled					31. Counselor		32. Signature of Individual Counseled			
17OCT06					JORDAN, S C					
<p>33. Standards not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.</p>										
1.0 Below Standards		2.0 Progressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards		
<p>34. Knowledge of rating, specialty and ability to apply knowledge to solve problems.</p> <p>35. Meets advancement/PQS requirements.</p>		<p>36. Needs little supervision. Produces quality work. Few errors and resulting rework. Uses resources efficiently.</p>		<p>37. Strong working knowledge of rating, specialty and job. Reliably applies knowledge to accomplish tasks. Meets advancement/PQS requirements on time.</p>		<p>38. Recognized expert, sought out by all for technical knowledge. Uses knowledge to solve complex technical problems. Meets advancement/PQS requirements early with distinction.</p>		<p>39. Needs excessive supervision. Frequently needs rework. Wastes resources.</p>		
<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
<p>40. Active member to Navy's retention/retention goals. Active in decreasing attrition. Actions adequately encourage/support subordinates' personal/professional growth.</p> <p>41. Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.</p>		<p>42. Needs no supervision. Always produces exceptional work. No rework required. Maximizes resources.</p>		<p>43. Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. Actions adequately encourage/support subordinates' personal/professional growth. Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.</p>		<p>44. Measurably contributes to Navy's increased retention and reduced attrition objectives. Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. The model of achievement. Develops unit cohesion by valuing differences as strengths.</p>		<p>45. Needs excessive supervision. Frequently needs rework. Wastes resources.</p>		
<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
<p>46. Excellent personal appearance. Excellent conduct conscientiously complies with regulations. Complies with physical readiness program. Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.</p>		<p>47. Exemplary personal appearance. Model of conduct, on and off duty. A leader in physical readiness. Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.</p>		<p>48. Excellent personal appearance. Excellent conduct conscientiously complies with regulations. Complies with physical readiness program. Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.</p>		<p>49. Exemplary personal appearance. Model of conduct, on and off duty. A leader in physical readiness. Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.</p>		<p>50. Needs excessive supervision. Frequently needs rework. Wastes resources.</p>		
<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
<p>51. Productive and motivated. Completes tasks and qualifications fully and on time. Plans/prioritizes effectively. Reliable, dependable, willingly accepts responsibility.</p>		<p>52. Energetic self-starter. Completes tasks on qualifications early, far better than expected. Plans/prioritizes wisely and with exceptional foresight. Seeks extra responsibility and takes on the hardest jobs.</p>		<p>53. Productive and motivated. Completes tasks and qualifications fully and on time. Plans/prioritizes effectively. Reliable, dependable, willingly accepts responsibility.</p>		<p>54. Energetic self-starter. Completes tasks on qualifications early, far better than expected. Plans/prioritizes wisely and with exceptional foresight. Seeks extra responsibility and takes on the hardest jobs.</p>		<p>55. Needs excessive supervision. Frequently needs rework. Wastes resources.</p>		
<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		

Assigned this individual for (maximum of two): Assignment in Rating
Programs, Shore Special Programs, Commissioning Programs,
Other Programs, Rating Instructor Duty, Other. (Be specific)


SPRAGUE, T L, ISC Date: 16-4-2018

TRAINING. Provided 18 hours of EIWS training to 15 personnel to include four First Class Petty Officers, three Second Class Petty Officers and eight junior Sailors that were completing EIWS Books 1 and 2.

SUPPORTER. Assisted in the completion of a Standard Operating Procedure for the 15th Garrison Division, which assisted leadership establishing overall processes and procedures for the 15th Garrison Division.

Anderson is not recommended for retention or advancement.

IMPROVEMENTS - Education, awards, community involvement, etc., during this period

	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47 Retention Not Recommended <input checked="" type="checkbox"/> Recommended <input type="checkbox"/>
		X				48 Reporting Senior Address COMMANDING OFFICER CYBERSTRKACT 63 9800 SAVAGE RD, SUITE 6135 FT MEADE, MD 20755-6585
	0	1	0	1	0	

Comments: I have reviewed the evaluation of this member
and support explanation to support the marks of 1.0 and 5.0.

Date: 16 MAR 1988

50 Signature of Reporting Senior

30 Signature of reporting
Deo Yasho

Date. 11 MAR 18

Summary Group Average

3.50

Summary Group Average:	3.50
and signature of Regular Reporting Senior on Concurrent Report	

...I have seen this report, been apprised of my
...right to submit a statement."

☐ I do not intend to submit a statement.

Date: 2 MAR 1968

Date _____

LATHAM & WATKINS LLP

Code 16
02 04 2018

MEMORANDUM THRU Physical Evaluation Board Liaison Office, NMC Portsmouth, VA

FOR Mr. Jeffrey Riehl, Director, SECNAVCORB, 720 Kennon Street SE, Suite 309,
Washington Navy Yard, Washington DC, 20734-5106

SUBJECT: SECNAVCORB Petition for Relief for CTN2 Daniel Anderson

1. Our client, CTN2 Daniel Anderson (hereafter "Anderson"), is a Sailor undergoing evaluation in IDES. On 02 04 18, PEB President J.D. Reeser denied Anderson's request for a Formal Physical Evaluation Board (FPEB) Hearing.
2. **Request for Relief:**
 - a. Undersigned counsel for Anderson ("Counsel") submit that it was improper for the PEB President to deny Anderson's request for a Formal PEB Hearing. Counsel respectfully request that you revisit this decision.
 - b. Counsel further submit that Anderson is unfit to continue on active duty. Accordingly, Counsel respectfully request that a Formal Hearing be scheduled with personal appearance and Counsel to present this matter for consideration on the merits.
3. **Regarding the Authority to Deny a Formal Hearing:**
 - a. SECNAVINST 1850.4E, Encl. 4 § 4109 clearly dictates the role of the PEB in the Formal Hearing process:
 - i. "The President, PEB, may grant a request for a hearing before a Formal PEB or recommend to the DIRNCPB, that the request be denied. The DIRNCPB, upon review of the case may grant the request for a hearing or deny it. The decision of the Director in any case will not be subject to appeal."
 - b. SECNAV explicitly withheld from the PEB President authority to deny a Formal Hearing, specifying instead the PEB President may only "recommend" a denial. This bifurcated appeal process ensures that the member receives due process, rather than appealing to the same entity whose proposed findings are in dispute.
 - c. SECNAVCORBINST 5216.1G, as illustrated by its title ("Authority to Sign...") and sub-headings ("Signatory Authority"), merely delegates clerical authority to "sign" correspondence. It does not delegate decision-making authority.

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- i. The same is true of SECNAVINST M-5216.5 CORRESPONDENCE MANUAL (Jun 2015), superseding SECNAVINST 5216.50 (Aug 1996), which some cite to support the position that that an officer may sub-delegate authority delegated to him or her, unless the delegation restricts sub-delegation. This also applies only to signatory authority (see § 2- 2(5)(b)(1) and title, "Delegation of Signature Authority").
- d. Furthermore, SECNAVCORBINST 5216.1G fails to meet the specificity requirement of SECNAV M-5216.5:
 - i. Per SECNAV M-5216.5 §2-2(5)(b)(1): "For each individual that the delegation of authority applies, a letter so delegating that authority to the individual, by name, will be prepared."
 - ii. SECNAVCORBINST 5216.1G fails to specify Mr. Reeser by name, listing instead "President or Executive Secretary PED (own title)."
- e. With respect to the SECNAVCORB delegation memorandum, Counsel respectfully submit that it is improper for SECNAVCORB to re-delegate this authority.
 - i. The Secretary explicitly made his wishes clear in SECNAVINST 1850.4E, Encl. 4 § 4109. The PEB President may "recommend to the DIRNCPB, that the request [for a Formal Hearing] be denied."
 - ii. It is not logically sound that the PEB President would "recommend to [DIRSECNAVCORB] that the request be denied" if the PEB President were making the decision himself.
 - iii. Nor does it follow that the Secretary would direct the PEB President to recommend to a third party that a Formal Hearing be denied, if the Secretary intended for the PEB President have authority to deny a Formal Hearing.
 - iv. DIRSECNAVCORB's delegation counteracts the expressed intent of the Secretary. SECNAVINST § 4109 established a process which allows the PEB President to grant and reconsider his own decision, but requires *another* authority to review and ultimately deny (without further appeal) the PEB President's proposal. Because the Secretary required the CORB to review the decisions of the PEB, it is illogical that CORB, without approval from the Secretary of the Navy, would delegate power to the PEB President to uphold his own decision without an avenue for appeal.
- f. Even if DIRSECNAVCORB believed that it were appropriate to re-delegate authority originally delegated to him by SECNAV, he may not re-delegate such authority to the PEB President.

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- i. The Secretary was explicit in his intentions that the PEB may only "recommend" denial, and a third party must review and implement.
 - ii. Because the Secretary explicitly limited the PEB President to recommending a course of action, delegation of ultimate authority to the PEB President without appeal is contrary to SECNAVINST 1850.4E, Encl. 4 § 4109.
 - g. Finally, even if DIRSECNAV CORB believed that it were appropriate to re-delegate the authority to deny a Formal Hearing, he would remain responsible for ensuring that any such denial was proper.
 - i. US Navy Regulations § 1022 (1990), Delegations of Authority, states that:
 - 1. "The delegation of authority and the issuance of orders and instructions by a person in the naval service shall not relieve such person from any responsibility imposed upon him or her. He or she shall ensure that the delegated authority is properly exercised and that his or her orders and instructions are properly executed."
 - h. In filing this appeal, Counsel respectfully request that DIRSECNAV CORB "ensure that the delegated authority [was] properly exercised" in the denial of my Formal Hearing request.
4. Regarding the Informal (FIT/UNFIT) Findings of the PEB:
- a. For the aforementioned reasons, Counsel respectfully request that a Formal Hearing be scheduled with personal appearance and assigned Counsel to present this matter for a Formal Hearing on the merits.
 - b. POC is Michael S. Yedinak, DES Counsel, NMC Portsmouth, VA 23708, 757-953-5877, michael.s.yedinak.mil@mail.mil.

Respectfully submitted,

Tae Hee (Tamara) Kim and Eugene Elrod
Latham & Watkins
555 11th St NW Suite 1000
Washington DC 20004

Counsel for CTN2 Daniel Anderson



DEPARTMENT OF THE NAVY
SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
720 KENNON STREET SE STE 309
WASHINGTON NAVY YARD DC 20374-5023

IN REPLY REFER TO

1850
PEB Index N21800148
08 Mar 2018

From: President, Physical Evaluation Board

To: Chief of Naval Personnel

Subj: NOTIFICATION OF DECISION

Ref: (a) SECNAVINST 1850.4E

1. Per reference (a), the President, Physical Evaluation Board acting for the Secretary of the Navy has considered the physical condition of the following members of the Naval Service as referred by a medical board to determine each individual's fitness for duty.

2. FINDING. In each instance the member is found **FIT** to perform the duties of his/her office, grade, or rank on active duty

3. DISPOSITION. You are requested to take appropriate action to **CONTINUE THESE SERVICE MEMBERS ON ACTIVE DUTY** until such active duty is terminated under other provisions of law or regulation.

Member

SSN

CTN2 Daniel D ANDERSON, USN

[REDACTED]

/s/B. B. Fortney
PEB Enbloc Department
By direction

See attachments for signed
FB Denial Letter

IDES FIT FPEB REQUEST



FORMAL HEARING DENIAL COMMENTS

PRESIDING OFFICER:

2nd LINE OFFICER:

MEDICAL OFFICER:

1. WAS NEW INFORMATION RECEIVED? ☒ Yes ☐ No

2. CHANGE TO UNFIT (revote in JDETS)? ☐ Yes ☒ No

NOTES:

Member's inability to perform is due to conduct not medical.
No change from informal findings.
Formal Board not recommended.

Reviewed, concur w/MO. No change to IPEB, Fit. Do not recommend formal board.

Reviewed, concur w/ IPEB findings. Formal board not recommended.



Integrated Disability Evaluation System (IDES)
IPEB Election of Options (EOO)

1/24/18

Date

From **Daniel Anderson E-5** [REDACTED] **WRNMMC**
 Rank/Name Last 4 Hospital

To: President, Physical Evaluation Board

Subj: **IDES ELECTION OF OPTIONS**

Ref: (a) OUSD Directive-Type Memoranda (DTM) dtd 19 Dec 2011
 (b) SECNAVINST 1850.4E

1. I acknowledge receipt of my Physical Evaluation Board (PEB) findings and appropriate counseling regarding my IDES Election of Options. I understand my PEB Findings and options, and choose the following option(s) in accordance with references (a) and (b). I understand the PEB will finalize my case (as *Presumed Acceptance*) if I do not choose an option within ten (10) calendar days from the day I received my findings.

2. Right to legal counsel. I understand my right to consult with an attorney prior to completing this form. Upon my request, a government lawyer (at no charge) will be assigned to represent me. I also have the right to be represented by private counsel, but at my sole expense.

Note: I understand my right to consult with an attorney does not delay my ten (10) day period to decide my option(s).

3. eBenefits – I am aware of the eBenefit web portal; a veteran and family gateway web portal to benefit information. eBenefits provides a central location for veterans, service members, and their families to research, find, access, manage benefits and personal information. I may access eBenefits web portal at <https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal>.

4. Compensation and Benefits Handbook – I am aware of the *TurboTap* Transition Assistant Program and the Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces web portal at: <http://turbotap.org/register.tpp>.

5. “Quick Series” Guide – I have received my *Quick Series: Guide to the IDES* to ensure that I understand the basic components of the IDES and where to go for help.

6. VA Vocational Rehabilitation and Employment (VRE) – I am aware of the VA Vocational Rehabilitation and Employment web portal that provides a central location for service members & their families to research, & gather information on VA VRE benefits. I may access the VRE portal at <http://www.vba.va.gov/bln/vre/>.

7. Service obligation for Military Officers. I understand that Service Headquarters will determine my obligated service requirements.

To ensure my choice is accurately understood, I will initial the bottom of each page and the appropriate sections:

DA
 Initials

INFORMAL PEB FINDINGS

I. DA I accept / do not accept (initial and circle your decision) the Informal PEB's fitness determination:

- If accepting, proceed to section II.
- If contesting, proceed to section III.

SECTION II (Accept)

II. I ACCEPT the Informal PEB's finding(s). I do not request a Formal PEB hearing, waive my right to submit new and/or additional information, and (Select the Following):

- Note: Options A and B are not available for members enrolled in PLD.

A. _____ I request to remain on active duty in a Permanent Limited Duty (PLD) status until _____. I understand I am responsible for sending my PLD Request (with justification and Command endorsement) within fifteen (15) calendar days from today's counseling date, to COMNAVPERSCOM (PERS-4821) or CMC (MMSR-4) with concurrent notification to the PEB. I understand the PEB does not approve my PLD.

B. _____ (For UNFIT Navy members only) I request my separation/retirement date be on _____. Requested date must be no less than 30 days, but not more than 60 days from the day, I received notice of my PEB findings. I understand the PEB does not determine my separation/retirement date.

C. _____ Request the Department of Veterans Affairs (VA) reconsider my disability rating percentage(s).

Note: I understand that:

1. The VA will ONLY reconsider the disability rating(s) for the condition(s) the PEB determined were Unfitting.
2. The request for a VA disability rating reconsideration *must* include new medical evidence or sufficient justification of an error to warrant reconsideration.
3. I understand the PEB will finalize my case (without forwarding for a VA Reconsideration) if I fail to submit new medical evidence or sufficient justification of an error to warrant reconsideration within ten (10) calendar days from the day I received my findings.
4. Upon receipt of the VA Reconsideration, the PEB will immediately finalize my case, notify my service headquarters, and send me the VA's Reconsideration.
5. Although I am permitted only a one-time VA disability rating reconsideration while in the DES, upon my separation/retirement I may appeal my disability ratings directly to the VA per 38 CFR Part 3. Additionally, I understand I have the opportunity to be represented before the VA by a VA-accredited attorney, agent, or representative of a VA-recognized Service organization.

DA
Initials

_____ The following list contain the condition(s), together with the supporting documentation, I desire the PEB to forward to the VA for reconsideration on my disability rating percentage(s).

_____ Provided documentation: ☐ Yes: ☐ No

_____ Provided documentation: ☐ Yes: ☐ No

_____ Provided documentation: ☐ Yes: ☐ No

_____ Provided documentation: ☐ Yes: ☐ No

Please explain and/or provide statement:

Note: Attachment including medical and/or non-medical documentation justifying an error warranting reconsideration must be included together with this EOO.

DA

Initials

SECTION III (Contest)**III. I DO NOT ACCEPT and CONTEST the Informal PEB's finding(s), and:**

DA I request a Formal PEB hearing to contest only my fitness determination.
 (For a VA Reconsideration refer to paragraph II (C))

Note: I understand that:

1. The PEB will ONLY consider the fitness determination (Fit or Unfit), and will not consider the disability rating percentage(s); Rating percentage(s) will be determined by the VA. (Not applicable for TDRL)
2. Because a Formal Hearing is a "de novo" proceeding, my previous PEB findings can change.
3. I am entitled and strongly encouraged to submit a statement clearly indicating the reason(s) for contesting the Informal PEB's fitness determination. This statement should include the final PEB result I desire.
4. This formal hearing will be a full and fair hearing, and I will be appointed a government lawyer (at no charge) to represent me. I also have the right to be represented by private counsel, but at my sole expense.

Select and initial as applicable:

DA Per SECNAVINST 1850.4E §§ 3202, 3302, I request that the PEB determine the following diagnosis(es) as unfitting:

<u>MAJOR DEPRESSIVE DISORDER</u>	Provided documentation: <input checked="" type="checkbox"/> Yes: <input type="checkbox"/> No
<u>GENERALIZED ANXIETY DISORDER</u>	Provided documentation: <input checked="" type="checkbox"/> Yes: <input type="checkbox"/> No
<u>IRRITABLE BOWEL SYNDROME w/ DIARRHEA</u>	Provided documentation: <input checked="" type="checkbox"/> Yes: <input type="checkbox"/> No
_____	Provided documentation: <input type="checkbox"/> Yes: <input type="checkbox"/> No
_____	Provided documentation: <input type="checkbox"/> Yes: <input type="checkbox"/> No

Please explain and/or provide statement:

Note: Attachment including medical and/or non-medical documentation justifying an error warranting reconsideration may be included together with this EOO.

DA
 Initials

Member's local mailing address/telephone number:

Address where service member will be flying from

ADDRESS:

GCEW BURNIE MD

AIRPORT NAME:

DATE OF BIRTH:

05

PHONE #s:

HOME

WORK: ()

CELL: ()

FAX: ()

EMAIL ADDRESS:

GMAIL.COM

Admin/PSD address: (Complete Address Required) COMMANDING OFFICER CSA63

9800 SAVAGE ROAD

FORT GEORGE G MEADE MD 20755

DANIEL ANDERSON

Member's name (Printed)

[Signature]

Signature

2-13-18

Date

PEBLO CERTIFICATION/SIGNATURE

I certify upon the penalty of perjury that I fulfilled the counseling requirements in accordance with references (a) through (b), and that I forwarded the Member's election of options to the Physical Evaluation Board.

Lakeisha Brower

PEBLO NAME

[Signature]

Signature

1/24/18

Date

DA

Initials

LATHAM & WATKINS LLP

MEMORANDUM

Date: February 12, 2017

From: Tae Hee (Tamara) Kim, Esq. and Eugene Elrod, Esq., of Latham & Watkins LLP, on behalf of CTN2 Daniel Anderson

To: President, Department of Navy Physical Evaluation Board (PEB)
Attention: Ms. Ton Jua Howard (TDRL)
720 Kennon Street
BLDG 36 STE 309
Washington Navy Yard, DC 20374-5023

Subj: CTN2 Daniel Anderson's Request for Informal Reconsideration

Ref: (a) SECNAVINST 1850.4E

(b) DoDI 1332.18

Encl: Abbreviated Medical Evaluation Board Report dated June 13, 2017 (Exhibit A)

Abbreviated Medical Evaluation Board Report dated December 6, 2017 (Exhibit B)

Consolidated NARSUM (Exhibit C)

Compensation and Pension Exam Report for DBQ PSYCH Mental disorders Exam dated October 26, 2017 (Exhibit D)

Non-Medical Assessment (NMA) dated October 27, 2017 (Exhibit E)

Medical Record created October 30, 2017 at WRNMMC (Exhibit F)

Personal Health Information created on January 24, 2018 from the Military Electronic Health Record (Exhibit G)

Personal Summary of Medical Symptoms by Daniel Anderson (Exhibit H)

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1. The purpose of this memorandum is to file the non-concurrence of CTN2 Daniel Anderson (hereafter, "Anderson") with the findings of the Informal Physical Evaluation Board (IPEB) and to request that the IPEB find his Irritable Bowel Syndrome (IBS), Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) to be unfitting conditions.
2. Pursuant to SECNAVINST 1850.4E, the military disability retirement system is based on fitness for duty. Under SECNAVINST 1850.4E §3304, a member may be determined Unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found Unfit because of physical disability. Under §3306, if a preponderance (more than 50 percent) of the evidence indicates unfitness, a finding must be made to that effect. Under SECNAVINST 1850.4E §3306, each case is considered by relating the nature and degree of physical disability of the member to the requirements and duties that member may reasonably be expected to perform in his or her office, grade, rank or rating.
3. Under Appendix 2 of DoDI 1332.18, a Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable reasonably to perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation. A Service member may also be considered unfit when the evidence establishes that:
1) the Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or 2) the Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.
4. On October 27, 2017, the Commanding Officer of the Cyber Strike Activity Sixty Three completed a Non-Medical Assessment (NMA) in Anderson's case, confirming the following facts: 1) considering Anderson's current physical condition, he is not worldwide assignable; and 2) he does not have good potential for continued service in his present physical and mental condition. Exhibit E, at 2-3. The NMA is the Commanding Officer's unbiased and accurate comments describing how the medical condition impacts the service member's ability to function within his/her rank and MOS/rating. *Id.*, at 1.
5. On November 6, 2017, the Medical Evaluation Board (MEB) at Walter Reed National Military Medical Center released a consolidated NARSUM finding the following diagnoses to fail the medical retention standards of the Navy: MDD, GAD, and IBS with Diarrhea. Exhibit C.
6. On December 6, 2017, after the IPEB found Anderson fit for duty, medical officers proposed in the Abbreviated Medical Evaluation Board Report that Anderson should continue on limited duty for his GAD, MDD and IBS.. Exhibit B. The clinical information provided by the medical officers stated: 1) that Anderson has anxiety, depression, and co-morbid medical condition that have significantly negatively impacted his ability to function at home and in his social environment; and 2) that the GI confirmed the IBS-D/P to be of such severity that it interferes with military activities of daily living (ADLs). *Id.*
7. In light of these facts, Anderson respectfully requests the PEB find him unfit for duty based on the following conditions:

I. Irritable Bowel Syndrome (IBS), Fecal Urgency and Fecal Smearing

8. Anderson requests that his IBS be found unfitting because it causes pain, spasms, fecal urgency, fecal leaking, fecal smearing, and soiling of pants. Exhibit H.

9. Anderson has reported a long history of GI symptoms dating back to childhood, but symptoms have been more frequent and disruptive over the past few years. Exhibit C. In 2016, Anderson was repeatedly diagnosed with “IBS with Diarrhea” on May 11, October 4, October 11 and November 28. Exhibit G. In 2017, Anderson continued to be diagnosed with “IBS with Diarrhea” at every one of the following doctor’s appointments: on March 16, April 13, May 17, June 1, July 12, June 27, August 7, 2017, September 19, September 29, October 17, November 2, and December 6. *Id.* Similarly, Anderson was diagnosed with “Mixed Irritable Bowel Syndrome” on June 12, 2017, and with “Irritable Bowel Syndrome” (IBS) on July 13, 2017. *Id.* Finally, Anderson was diagnosed with Fecal Urgency and Soiling on September 19, 2017, and with Fecal Urgency and Fecal Smearing on September 29, 2017. Exhibit F.

10. On June 14, 2017, Anderson was placed on Limited Duty due to his IBS being of such “severity that it daily interferes with military Activities of Daily Living (ADLs).” Exhibit A. As part of Anderson’s placement on limited duty, the military was required to allow him to be in “close proximity” to the bathroom at all times. Anderson’s Limited Duty was extended on December 6, 2017. Exhibit B.

11. On November 6, 2017, the Medical Evaluation Board determined that Anderson’s IBS failed medical retention standards due to his experiencing “generalized sharp, crampy abdominal pain about every 1-2 days that peaks prior to defecation,” which is “triggered by physical activity, anxiety, and stress.” Exhibit C. The MEB also based its decision on the fact that Anderson’s IBS precluded both his deployment to an austere environment and his return to full duty in the next 12 months.

12. Anderson’s IBS is incompatible with military service, permanently duty limiting, and thus unfitting for duty. Anderson’s IBS, which is exacerbated by “physical activity and with increased anxiety/stress,” is incompatible with general Navy life. Exhibit C. Anderson is unable to take a basic Navy physical fitness assessment, work in a deployed environment, or work in a high-stress, fast-paced unit without worsening his condition. Moreover, Anderson’s fecal urgency and soiling is incompatible with his rating of Cryptologic Networking Technician (CNT). As a CNT, working in a secured facility, Anderson has soiled his pants on more than one occasion due to fecal urgency that left him unable to get to bathroom and remove his uniform in a timely fashion. Exhibit H.

II. Generalized anxiety disorder (GAD) and Major depressive disorder (MDD)

13. Anderson requests that his GAD and MDD, individually and when taken together, be found unfitting because the symptoms prevent him from performing, safely and reliably, the duties of his rating or even his basic military duties.

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14. Anderson has been in mental health treatment regularly, with weekly visits to his psychiatrist since August of 2012. Exhibit D, at 5. Anderson was hospitalized in 2015 for 30 days at Fort Belvoir for inpatient treatment. *Id.*

15. Despite being in treatment for several years and on Limited Duty for over 6 months, Anderson's MDD and GAD continue to cause significant symptoms and limitations as illustrated by his NARSUM and VA DBQ PSYCH Mental disorders Exam (Psych DBQ) dated September 25, 2017. Exhibit D. Specifically, Anderson's NARSUM notes that his MDD results in sad mood, feelings of helplessness, feelings of hopelessness, low energy, anhedonia, and chronic suicidal ideation and that his GAD manifests in worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. Exhibit C.

16. Anderson's GAD and MDD create numerous symptoms that directly limit his ability to serve in the military and to function in the larger world. For example, Anderson's Psych DBQ states that he has "near-continuous panic or depression affecting the ability to function independently, appropriately and effectively," "difficulty in adapting to stressful circumstances, including work or a worklike setting," and "obsessional rituals which interfere with routine activities." Exhibit D.

17. Anderson's limitations not only prevent him from performing his basic military duties and the duties of his rating, but also place an undue risk and burden on both himself and the military. As a CNT, Anderson works daily in a stressful job that requires him to maintain complex Information Technology (IT) networks containing secure, classified information. Therefore, should the PEB find Anderson fit and Anderson were to continue service, the Navy would be placing at risk not only his mental health, but also its own secure documentation and information systems. This is because Anderson's continued work is likely to cause difficulty adapting, panic and depression, thereby resulting in mistakes, poor judgment, and limited functioning on his part.

18. Anderson's command believes that his medical conditions render him unfit for military service and prevent his further service. His commander personally endorsed the suspension of Anderson's access to TTS/SCI materials and facilities, and states that his mental health condition "has prompted a review by Department of the Navy Central Adjudication Facility to see if the member can retain his current level of security clearance," preventing him from completing regular CNT duties. Exhibit E, at 3-4. Moreover, since Anderson's condition, according to his NARSUM, is not likely to improve in the next 12 to 36 months, it appears that he will be disqualified from obtaining the security clearance required to do his job for an indefinite period. Exhibit C.

19. Perhaps the best evidence of Anderson's lack of fitness for duty in light of his MDD and GAD is his most recent Abbreviated MEB. In sharp contrast to the IPEB's finding that Anderson is fit for duty, the most recent Abbreviated MED placed him on his second period of limited duty. Exhibit B. From a mental health perspective, Anderson's second period of limited duty is even more limiting than was his first period of limited duty. The second period requires him to remain at Walter Reed for "extensive medical care," removing him indefinitely from his work as a CNT. In addition, Anderson's second period of limited duty precludes his participation in "late

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night or overnight duty,” excluding him from shift work that is common for a sailor serving as a CNT. *Id.* Moreover, Anderson’s second period of limited duty prevents him from living on a boat, deploying, and from firing and carrying a weapon. *Id.*

V. Conclusion

20. Contrary to what the PEB claimed in its IPEB response, all evidence in Anderson’s medical records illustrate that his IBS, GAD and MDD limit his continued military service. There is no indication that Anderson is limited in his duties simply because his command does not trust him. In fact, as illustrated by his commander’s NMA, his command documents that his medical conditions cause him to miss 30 hours of work per week and caused him to lose the clearance required to do his job as a CNT.

21. For the reasons set forth above and evidence enclosed herewith, Anderson respectfully requests that the PEB find his IBS, GAD, and MDD, individually and when taken together, render him unfit for continued military service.

/s/ Tamara Kim
Tae Hee (Tamara) Kim, Esq.

/s/ Gene Elrod
Eugene Elrod, Esq.

PRIVACY ACT WAIVER

In order to waive my rights under the Privacy Act, 5 U.S.C. 552a(b), and under any other federal or state law or regulation which controls access to my records, I give my prior written consent to the U.S. Department of Veterans Affairs (VA); U.S. Departments of Defense, Army, Navy, Marine Corps, and Air Force; and any other public or private custodian of (including, but not limited to, hospitals, clinics, and current and former treating physicians), or agency that possesses or controls, my military personnel, military medical, VA claims file, VA medical, mental health, drug or alcohol treatment, Discharge Review Board, Board for Correction of Military or Naval Records, or Physical Disability Board of Review records and files, to disclose fully and promptly to National Veterans Legal Services Program employees **Daniella Furey, Dorrie Popovski, and/or attorneys Ronald B. Abrams, Rochelle Bobroff, Patrick Berkshire, Katy Clemens, Christine Cote, Jill Davenport, Jenna A. Goldberg, Alexis Ivory, Ray Kim, Esther N. Leibfarth, Erin Mee, Caitlin Milo, Thomas A. Moore, Amy F. Odom, Paul Schwen, David Sonenshine, Richard V. Spataro, Barton F. Stichman, Stacy Tromble, and Bernadette Valdellon**, and any agents, attorneys, legal interns or law clerks working under their supervision or any other person or law firm designated by any of the attorneys named above, any and all records, documents, or files that pertain to me which they may request.

If these records include information protected under 38 U.S.C. § 7332 about drug abuse, infection with human immunodeficiency virus (HIV), alcoholism or alcohol abuse or sickle cell anemia, I specifically consent to that disclosure as well.


Name: Anderson, Daniel D

(Last, First, Middle Initial)

Date of Birth: 1985-01-01 Last 4 Digits of Social Security #: 1234

VA Claims File # (if known): _____

Address: [REDACTED] Glen Burnie, MD [REDACTED]
(Street, City, State and Zip Code)

Signature:  Today's Date: 20180125
(Please provide a handwritten signature) (YYYYMMDD)

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRees at <http://www.archives.gov/veterans/military-service-records/>.
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible.)

1. NAME USED DURING SERVICE (last, first, full middle) Anderson, Daniel Dennis	2. SOCIAL SECURITY # [REDACTED]	3. DATE OF BIRTH [REDACTED] 1985	4. PLACE OF BIRTH Riverside, California
--	---	--	---

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	USN-US Navy	01NOV05		<input type="checkbox"/>	<input checked="" type="checkbox"/>	DOD# 1286180538
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>	

6. IS THIS PERSON DECEASED? ☒ NO ☐ YES - *MUST* provide Date of Death if veteran is deceased: _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☒ NO ☐ YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED**1. CHECK THE ITEM(S) YOU ARE REQUESTING:**

☒ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____
This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. An **UNDELETED DD214** is ordinarily required to determine eligibility for benefits. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An **UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY** by checking this box: ☐ I want a **DELETED** copy.

☒ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. *IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:* _____

☒ **Other (Specify):** Please include ALL documents in my OMPF; do NOT send an extract.

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary**; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☒ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: benefits claim assistance

SECTION III - RETURN ADDRESS AND SIGNATURE**1. REQUESTER NAME:** Anderson, Daniel Dennis

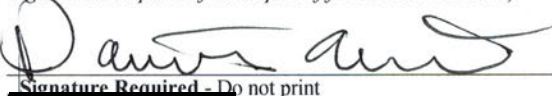
2. ☒ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above. ☐ I am the VETERAN'S LEGAL GUARDIAN (*MUST submit copy of Court Appointment*) or AUTHORIZED REPRESENTATIVE (*MUST submit copy of Authorization Letter or Power of Attorney*) ☐ OTHER _____
(Relationship to deceased veteran) (Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

National Veterans Legal Services Program

Name
1600 K Street NW, Suite 500
Street Apt.
Washington DC 20006
City State Zip Code

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)

 25JAN18
Signature Required - Do not print Date

* This form is available at <http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf> on the National Archives and Records Administration (NARA) web site. *

Daytime phone _____ Fax Number _____
Email address _____@gmail.com

INFORMAL	Findings of the Physical Evaluation Board Proceedings	Ref. # F217nm13426
Date Printed 17 Jan 2018		Page 1


PERSONNEL DATA					
1. Name ANDERSON, Daniel D	2 [REDACTED]	3. Rate/Rank CTN2	4. Service USN	5. Desig.	6. LOS 12 yrs. 0 mos.

PHYSICAL EVALUATION BOARD	
7. The Board convened at: NCPB, Washington DC, 17 Jan 2018 to consider the MedBoard originated at: Bethesda, MD	
Board Membership Consisted of: CAPT, USN, Medical Officer CAPT, USNR, Line Officer N/A, N/A, Third Officer	

FINDINGS		
8. Finding Fit	9. Recommended Disposition Fit to Continue on Active Duty	10. Combined Disability Rating

S. D. Hull
By direction

INFORMAL	Findings of the Physical Evaluation Board Proceedings	Ref. # F217nm13426
Date Printed 17 Jan 2018		Page 2

<i>PERSONNEL DATA</i>					
1. Name ANDERSON, Daniel D	2. 	3. Rate/Rank CTN2	4. Service USN	5. Desig.	6. LOS 12 yrs. 0 mos.

AUTHENTICATION

PHYSICAL EVALUATION BOARD MEMBERSHIP

Medical Officer: E. X. Ferrara, CAPT, USN, Medical Officer

Presiding Officer: S. D. Hull, CAPT, USNR, Line Officer

Third Officer: Third Member Vote, N/A, N/A, Third Officer

FINDINGS COMMENTS

MedicalOfer

2018-01-16 13:39:41 exf

The member has a diagnosis of OSA, IBS, anxiety, and depression based on medical documentation. Based on the evidence contained within the case file, specifically the medical notes that document adequate treatment of his OSA with CPAP and a long standing history of IBS, depression, and anxiety that in spite of, the member has successfully served in rate and promoted. His inability to work in rate at this time is due to loss of confidence by his command for violations of the UCMJ, not because of his diagnoses such that the Informal Board has determined that the member's condition does not preclude him from the reasonable performance of his duties. Therefore, the Board finds that the member is fit to continue naval service and that he is reasonably able to perform the duties of his rating.

The Department of the Navy considered the combined effect of all conditions when making its fitness determination and applied this to the final adjudication.

PresidingOfer

2018-01-17 06:31:13 sdh

The evidence establishes that the member is able to reasonably perform duties of his office, grade, rank, or rating.


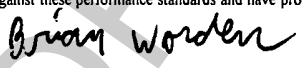
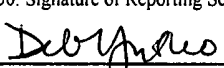
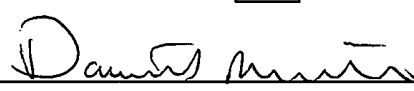
EVALUATION REPORT & COUNSELING RECORD (EI-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ 265		6. UIC 37700		7. Ship/Station CYBERSTRKACT 63			8. Promotion Status REGULAR		9. Date Reported 16SEP15	
Occasion for Report 10. Periodic <input type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input checked="" type="checkbox"/>				Period of Report 14. From: 16NOV16 15. To: 17JUL20						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness P		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title CO		26. UIC 37700	
							27. SSN [REDACTED]			
28. Command employment and command achievements. Provide and deploy trained personnel, expertise, and equipment to conduct Offensive and Defensive Cyberspace Operations in support of U.S. Cyber Command (USCYBERCOM) and the Cyber National Mission Force (CNMF) Defend the Nation missions.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) NWCP NETWORK WARFARE CYBER PLANNER-10. Creates and submits detailed cyber plans in support of 02 National Mission Team (02 NMT) and Cyber National Mission Force (CNMF) objectives. COLL: DEPT CAREER COUNSELOR-7; FULL SPEED AHEAD FACILITATOR-3. PFA: 17-1.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 17MAY15		31. Counselor FISHER, C M		32. Signature of Individual Counseled [Signature]		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]			
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>		-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well. <input checked="" type="checkbox"/>		<input type="checkbox"/>		-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction. <input type="checkbox"/>		<input type="checkbox"/>		-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction. <input type="checkbox"/>	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices. <input checked="" type="checkbox"/>		<input type="checkbox"/>		-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment. <input type="checkbox"/>		<input type="checkbox"/>		-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others. <input type="checkbox"/>	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="1.86"/>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) NONE				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  FISHER, C M, CTNC (IW/AW) Date: 1 AUG 17					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Submitted upon member's reduction in rate to E-5. - Member found guilty at Commanding Officer's Nonjudicial Punishment held on 20 July 2017 for violation of UCMJ Article 92 (Violation of a Lawful General Regulation, two specifications). Concluding date: 27 July 2017. - Member relieved of all positions of leadership and trust, to include Department Career Counselor and Full Speed Ahead collaterals.											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input checked="" type="checkbox"/> Recommended <input type="checkbox"/>				
45. INDIVIDUAL		X					48. Reporting Senior Address COMMANDING OFFICER CYBERSTRKACT 63 9800 SAVAGE RD FT MEADE, MD 20755-6585				
46. SUMMARY	<input checked="" type="checkbox"/>	1	0	0	0	0					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  WORDEN, B P, LCDR Date: 1 AUG 17						50. Signature of Reporting Senior  Date: 28 JUL 17 Summary Group Average: 1.86					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 02 AUG 17						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

Page 1 of 1

JDETS Findings and Recommended Disposition Work Card

Review: Informal

Printed: 11/28/2017

Date of board action:

Name ANDERSON, Daniel D		SSN [REDACTED]	Service USN	Rate/Rank CTN2	Grade E6	MOS/Desig.	PFit Eligible <input type="checkbox"/>	Eligible Reservist <input type="checkbox"/>
Hospital Bethesda, MD		LOS 12 yrs. 0 mos.	EAOS 2021.10.31		Age 33	DOB 1985 [REDACTED]	Gender M	Expedite <input type="checkbox"/> DEATH IMMINENT
Date to PEB 2017.11.14	MEB Date 2017.09.08	Current Location Screening Ready (Digi Files)			People/Finding Keys P217nm05114 F217nm13426		Spec. Interest <input type="checkbox"/> Trainee <input type="checkbox"/> CongIn <input type="checkbox"/> PastEAOS 208806	

Degree of Impairment	Limited Duty	Recommended Disposition		Combat Related Instrument of War War/NatEmergency Armed Conflict Hazardous Service Period of War/Nat'l Emergency
Competent	Proximate Result	LOS Voids EPTE	Disability Rating	
Unemployable	Incurred since 9/15/78	Minority Opinion	Fit	

RNR	Br. #	Cat	ICD9	Description	%	VASRD Codes	Pct.	NC	EP -	Adj Pct	BF	Left / Right	Major / Minor
		3		irritable bowel syndrome w/diarrhea	n/a								
		3		generalized anxiety d/o	n/a								
		3		major depressive d/o, recurrent, moderate	n/a								
		3		obstructive sleep apnea	n/a								

This work card is a space for PEB members to make notes and does not reflect their thoughts or analysis of the case.
The rationale alone represents their judgments.

Medical Officer

SM:

MEBR		NMA	
33 year old CT with 12 years TIS ref: IBS, anx, MDD, OSA MBR: 11/6/17 h/o childhood trauma suicide attempt by OD at age 17 PTS h/o anxious mood, IBS, and attention probs since age 14 anx while on ship 2006-09, trying to be perfect trichotillomania increased drinking MH care 6-10/2014 then d/c'd self referred to SARP 3/2015, level 1 then residential tx 3-4/2015 meds start stop start SI harassment allegation against him, lost rank addiction treatment 7/17 TMS 10/17 stressors are financial, lack of social support, legal stressors (misconduct) reactive attachment disorder borderline personality traits IBS since childhood ext w/u neg for organic dx low FODMAP diet helps effexor helps abd cramps OSA CPAP rec		<div> <input checked="" type="radio"/> Out of Rate <input type="radio"/> In Rate </div> <div> <input checked="" type="radio"/> Unable <input type="radio"/> Able </div> <div> <input checked="" type="radio"/> NOT WWA <input type="radio"/> WWA </div> <div> <input checked="" type="radio"/> No Potential <input type="radio"/> Has Potential </div> <div> <input checked="" type="radio"/> No Desire <input type="radio"/> Desires to Stay </div> <div> Hours missing work / week <input type="text" value="30"/> </div> <div> Date of last PFA <input type="text" value="3/17"/> </div> <div> <input type="radio"/> NO CO <input type="radio"/> YES CO </div> <div> no PLD no OEF/OIF TS/SCI clearance suspended following NJP and LIMDU eval 7/17 SP relieved from positions of leadership and trust per 7/17 eval not due to medical condition LIMDU 7/13/17 </div> <div> <input checked="" type="checkbox"/> C & P Exam Reviewed </div>	
Overall Ruling	Stability	PEB PLD Endorsement	Adjudicator Stamp
FIT			

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The rationale alone represents their judgments.

Presiding Officer

SM:



FIT	
Overall Ruling <small>(FIT/UNFIT/PFIT; PQ/NPQ; EPTS-SA/EPTS-NR)</small>	Combat Conditions <small>CR/NCR; CZ/NCZ</small>
MEBR: MEB WRNMC: "Discussion: The VA DBQ examiner did not establish a diagnosis related to the following claims, and there is no evidence of impact on duty in available medical records: left wrist condition, anal fissure, and anal spasms. The SM claimed mental health condition to include schizoid effect. Per an AHLTA Psychology Assessment Be note dated 08 February 2017, PO2 Anderson underwent psychological testing which yielded the impression that he had a pattern consistent with Schizoid personality traits but did not formally diagnoses the SM with a personality disorder. Personality traits do not constitute a ratable condition. The SM claimed sleep disturbance to include insomnia which is subsumed under the diagnosis of Major Depressive Disorder, Recurrent, Moderate as diagnosed by the VA and supported by the medical record. Diagnoses: 1. Major Depressive Disorder (MDD), Recurrent, Moderate (ICD10: F33.1) 2. Generalized Anxiety Disorder (GAD) (ICD 10: F41.1) 3. Irritable bowel syndrome with diarrhea (ICD10 Code: K58.0) 4. Obstructive sleep apnea (ICD10 Code: G47.33)"	
NMA: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Working in Rate? <input type="radio"/> ↑ <input checked="" type="radio"/> ↓ <input type="radio"/> ↔</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Able or Not? <input type="radio"/> ↑ <input checked="" type="radio"/> ↓ <input type="radio"/> ↔</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>PFT/PRT/CFT?; last taken <input type="radio"/> ↑ <input checked="" type="radio"/> ↓ <input type="radio"/> ↔</div> <div style="border: 1px solid black; width: 150px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Within HT/WT standards <input checked="" type="radio"/> ↑ <input type="radio"/> ↓</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div># Hours away from work / wk</div> <div style="border: 1px solid black; width: 200px; text-align: center;">30</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Worldwide assignable? <input type="radio"/> ↑ <input checked="" type="radio"/> ↓ <input type="radio"/> ↔</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Potential? <input type="radio"/> ↑ <input checked="" type="radio"/> ↓ <input type="radio"/> ↔</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Service Member Desire</div> <div><input type="radio"/> Remain <input checked="" type="radio"/> Separate</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>PLD? <input type="radio"/> ↑ <input checked="" type="radio"/> ↓</div> </div>	
Additional Comments: NMA: "Upon receipt of CTN2 Anderson's LIMDU paperwork and July 2017 NJP, assigned Special Security Officer (SSO) recommended and I endorsed service member's TS/SCI classified access and classified facility access badge be suspended, Security Access Eligibility Report (SAER) released, and process initiated for DoD Clearance Adjudication Facility (CAF) to determine if he should maintain a clearance. Final outcome of this decision is pending."	

Adjudicator Stamp:

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The rationale alone represents their judgments.

Third Officer

SM:



Overall Ruling

(FIT/UNFIT/PFIT; PQ/NPQ; EPTS-SA/EPTS-NR)

Combat Conditions

CR/NCR; CZ/NCZ

MEBR:

NMA:

Working in Rate? ☐ ↑ ☐ ↓ ☐ ↔

Able or Not? ☐ ↑ ☐ ↓ ☐ ↔

PFT/PRT/CFT?; last taken ☐ ↑ ☐ ↓ ☐ ↔

Within HT/WT standards ☐ ↑ ☐ ↓

Hours away from work / wk

Worldwide assignable? ☐ ↑ ☐ ↓ ☐ ↔

Potential? ☐ ↑ ☐ ↓ ☐ ↔

Service Member Desire ☐ Remain ☐ Separate

PLD? ☐ ↑ ☐ ↓

Additional Comments:

Adjudicator Stamp:



DEPARTMENT OF THE NAVY
SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
720 KENNON STREET SE STE 309
WASHINGTON NAVY YARD DC 20374-5023

IN REPLY REFER TO

Dear TDRL Periodic Re-examiner,

A medically retired Sailor or Marine has been assigned to your clinic for a Temporary Disability Retired List (TDRL) re-evaluation exam. The Physical Evaluation Board (PEB) is required to rate the service member based on the VA Schedule for Rating Disabilities. Although the required information for rating may not be consistent with how you would typically review an interim history or conduct a physical, please be aware that the information requested in the paragraph below is required by Title 10, U. S. Code so that the PEB can adequately assess and assign a rating to the service member.

If the required information below is not received by the PEB, the service member may have to return for repeated examinations. Please recognize that this delays the process and may even lead to some members losing benefits while their service headquarters reissue Temporary Additional Duty orders. Thank you for your time and attention in helping this Sailor or Marine.

Very Respectfully,

For the Physical Evaluation
Board

Orthopedic Conditions (Codes 5000-5500)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Arthritis (Codes 5002 & 5025)

Evaluator: Rheumatology

- Discuss number of flares in the past 12 months.
- Discuss response to therapy.
- Discuss limitation of motion of individual joints.

Prosthetic Implants and Amputations (Codes 5051-5199)

Evaluator: Orthopedics

- Date of Surgery.
- Document level of amputation.
- Document fitting of prosthesis (if applicable).
- Discuss current symptoms and function.

Examination of Joints: (Codes 5200-5299)

Evaluator: Orthopedics or Sports Medicine, Physical Therapy may document ranges of motion

For rating purposes, the Veterans Administration REQUIRES that ranges of motion in all planes be repeated three times and measured with a goniometer. **All three measurements MUST be recorded in your note and the statement that they were measured with a goniometer must be included.**

- Address ankylosis (if present) and document angle of ankylosis.
- Address instability.
- If there is impairment due to direct bony defect, address defect.
- If there is a deformity, address the deformity.
- Document pain with ranges of motion and where pain begins.

Examination of Muscle Groups (Codes 5300-5399)

Evaluator: Orthopedics or Sports Medicine

- Address motor strength.
- Address atrophy and measure muscle circumference, if possible.

Organs of Special Sense (Codes 6000-6299)

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Eyes

Evaluator: Ophthalmology

- Anatomic loss of either or both eyes.
- Visual acuity in both eyes.
- Visual fields assessment using 8 points (every 45 degrees).
- Incapacitating episodes – periods of time in which the patient was prescribed bed rest by a physician. Be specific with time in days or weeks over the past 12 months.

Ears

Evaluator: Otolaryngology (ENT) and Audiology

- Audiogram with frequencies 1000, 2000, 3000, 4000 Hz.
- Speech Discrimination %.
- Episodes of dizziness.

Smell

Evaluator: Otolaryngology (ENT)

- Document substances used to assess.
- Document pathologic or anatomic basis for loss.

Taste

Evaluator: Otolaryngology (ENT)

- Document substances used to assess.
- Document pathologic or anatomic basis for loss.

Infectious Diseases and Immune Disorders (Codes 6300-6360)

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Chronic Fatigue Syndrome

Evaluator: Rheumatology

- What is the decrease in activity level as a percentage of pre-illness level of function?
- Do the symptoms wax and wane?
- Are the symptoms constant?

Infectious Diseases

Evaluator: Infectious Disease

- Is the disease active?
- What are the current signs/symptoms of the active disease?
- Are there any residual impacts of the disease?
- What is the current treatment?

Respiratory System (Codes 6500-6900)

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Evaluator: Pulmonology

Diseases of the Lungs

- Patient needs a current Pulmonary Function Test.
- Has the patient had any incapacitating episodes in which a physician has prescribed bed rest?
- What medications is the patient actually taking?
- How often does the patient use a rescue inhaler?

Pulmonary Vascular Disease

- Does the patient have pulmonary hypertension?
- Does the patient require constant uses of anticoagulants (not aspirin)?

Cardiovascular System (Codes 7000-7199)

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Evaluator: Cardiology

Diseases of the Heart

- An evaluation that characterizes the patient's workload in METs.
- If a stress test is contraindicated, a targeted level of activity questions will suffice:
 - How far can the patient walk before sitting down?
 - Can the patient carry grocery bags?
 - Can the patient mow the lawn?
 - Can the patient climb a flight of stairs (and how many)?
 - Other questions as needed.
- For arrhythmias an ECG is required.
- Cardiomyopathies must be documented with an ECHO, ECG or Chest X-ray. (one will suffice)
- ECHO – needed if diastolic dysfunction is known or suspected.
- Has the patient had episodes of heart failure?

Digestive System (Codes 7200-7400)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Gastroenterology

- Frequency of flares.
- Duration of flares.
- Health between flares.
- GI bleeding.
- Incontinence to stool.
- Weight and weight loss/gain.
- Endoscopy as appropriate.

Nephrology Conditions (Codes 7500-7599)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Nephrology

For renal dysfunction

- Is the member on dialysis?
- When did they start dialysis?
- Are they pending a transplant?
- Has the member had a transplant?
- When was the transplant done? If not on dialysis, what is their stage of CKD?
- What is their BUN?
- What is their creatinine?
- What is their blood pressure trend?
- Do they have weight loss or gain?
- Do they have lethargy, weakness, anorexia?
- Do they have edema? How often?
- Do they have proteinuria (please quantitate based on first morning urine pro/crea ratio or 24 hour urine collection, confirmed adequacy by creatinine excretion)?
- What does their urine sediment contain?

For voiding dysfunction or obstructive uropathy

- Do they have a ureterostomy or vesicostomy?
- If on a cathing regimen, how often do they cath and are they compliant?
- If they have incontinence, how often must they change the absorbent materials per day?
- If appropriate, what is their post void residual in mLs?
- If appropriate, what is their peak flow rate measured in mLs/sec?
- Do they have culture confirmed infections? How often and what organisms?
- Are they on prophylaxis and are they compliant with this treatment?
- Do they have a stricture disease that requires dilatation? How often?

For kidney stones

- How often do they get stones?
- What types of intervention are needed for treatment?
- What is their recommended therapy for stone prevention?
- Are they compliant with therapy?
- Do they have hydronephrosis? If so, have they had pyonephrosis or attacks of colic with infection?

For hydronephrosis and urinary tract infections

- Please include current imaging results to describe degree of hydronephrosis.
- Do they require drainage intervention?
- Do they have culture confirmed urinary tract infections? How often, what organisms?
- Do they require oral or intravenous antibiotic treatment?
- Do they require hospitalization? How frequently per year?

or post surgical renal or urologic conditions

- Describe what surgery was done and what residual organs or portions thereof remain.
- If there is associated functional limitation due to urologic surgery, please describe.

Gynecologic and Breast Disorders (Codes 7600-7699)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Gynecology

- Any surgically removed organs?
- Discuss laparoscopic findings, if performed (particularly for endometriosis).

Hemic and Lymphatic Systems (Codes 7700-7799)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Hematology and Oncology

Issues to discuss:

- CBC.
- Bone marrow biopsy (if done).
- Bone marrow transplant.

- For cancers:
 - Surgical interventions.
 - Radiation.
 - Chemotherapy.
 - Current staging.
 - Prognosis.

The Skin (Codes 7800-7899)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Dermatology

Issues to discuss:

- Area of body surface affected, as a percentage.
- Area of exposed body surface affected, as a percentage.
- Use of steroids (oral and topical).
- Other immunosuppressive medications.
- Phototherapy.
- Duration of flares (days, weeks, months).

The Endocrine System (Codes 7900-7999)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Endocrinology

Issues to address:

- For thyroid disorders:
 - TSH.
 - Weight.
 - Cardiac involvement (if any).
 - Symptoms of fatigue, constipation, mental dysfunction, weakness.
- For diabetics:
 - Hemoglobin A1C.
 - Insulin.
 - Hypoglycemic episodes.
 - DKA.
 - Exercise patterns and level of activities.
 - Specific restrictions that the patient absolutely CANNOT do.
 - Inpatient admissions.
 - ER visits.

Neurologic Conditions (Codes 8000-8999)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

Evaluator: Neurology

General Neurologic Conditions

- Frequency of flares.
- Residual deficits as a result of the neurologic condition.

Traumatic Brain Injury

- | | |
|---|---|
| <ul style="list-style-type: none"> • Memory, subjective and objective findings. • Judgment. • Social Interaction. • Orientation. • Motor Activity. | <ul style="list-style-type: none"> • Visual Spatial Orientation. • Subjective Symptoms. • Neurobehavioral Effects. • Communication. |
|---|---|

Migraines

- | | |
|---|--|
| <ul style="list-style-type: none"> • Frequency of headaches. | <ul style="list-style-type: none"> • Prostrating headaches. |
|---|--|

Peripheral Nerves

- | | |
|--|--|
| <ul style="list-style-type: none"> • Motor strength. • Sensory deficits. | <ul style="list-style-type: none"> • Pain levels. |
|--|--|

Seizure Disorders

- | | |
|---|---|
| <ul style="list-style-type: none"> • Frequency of seizures. • Major vs. Minor seizures. • Driving. | <ul style="list-style-type: none"> • Antiepileptic Medication Levels (if appropriate). |
|---|---|

Mental Health Conditions (Codes 9200-9599)

Evaluator: Mental Health (must be Psychiatrist or PhD level Psychologist)

By law, the PEB uses the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) to review and adjust, if warranted, percentages for unfitting conditions for Sailors and Marines on the Temporary Disability Retired List. To assess conditions, the VASRD has specific areas that must be addressed to obtain a proper rating. Evaluations should contain the initial history, specific interventions or treatments for the condition, and any medications for the specific condition. There should be an interval history from the time of retirement and a statement of current condition.

For rating purposes, the Veterans Administration **REQUIRES** an objective assessment of social and occupational functioning. For mental health conditions, please summarize the original incident leading to the mental health injury (if there is one), confirmed by primary source documents (i.e. PDHA, PDHRA, the initial mental health assessment), a history of mental health interventions tried to date, compliance with treatment, and a history of the medications trialed to date with a review of the prescription profile refills (please print from AHLTA or VISTA, which will include even civilian pharmacy fills if paid for by the DoD; scan into AddNote at the end of your assessment).

Since being placed on TDRL, has the service member been employed in or out of the home (this includes being self-employed or being a home-maker)? How long did they hold each job? Why did they leave or are they still employed in that field? Have they gone to school? Did they obtain a degree or technical training?

Since being placed on TDRL, has the service member dated, been engaged, gotten married, broken up or gotten divorced? Have they had any children? Do they have friends that they talk to on the phone or see in person?

What do they do in their downtime? Are they able to do activities of daily living (dress, feed themselves, maintain their personal hygiene, pay bills)?

If the answer is yes to any of the below questions, please provide concrete examples of support

- Do they have any gross impairment in thought processes or communication?
- Do they have persistent delusions or hallucinations?
- Do they have any grossly inappropriate behavior that has led to self-harm or injury to others?
- Are they disoriented to their own name, location, or time?
- Do they have obsessional rituals?
- Do they have obsessional rituals which interfere with routine activities?
- Is their speech intermittently illogical, obscure, or irrelevant?
- Do they have panic or depression affecting the ability to function independently, appropriately and effectively? How often does this occur?
- Do they have impaired impulse control?
- Are they able to understand complex commands?
- Do they have sleep impairment? Please describe.

Mental Health Conditions (cont.) (Codes 9200-9599)

- Do they have objective evidence of short term or long-term memory deficiencies? If there is concern, please refer the member for neuropsychiatric testing.
- Please describe their affect, speech, judgment, abstract thinking, motivation, mood, ability to have a conversation with you.
- Is the member competent to handle finances?
- If the member is working, do they have any special requirements (weapons handling, security of information, etc.) which could be a danger to self or public?
- What specific medications is the member prescribed?
- If the member suffers from a TBI, headaches, or has had a previously abnormal NPE how many days are lost from work or school? Please include an updated NPE within the last 12 months.

IDES CASE

ID#: N-208806

LAST NAME: ANDERSON
(FORMERLY MERWIN)

LAST 4:



PEB Receive Date

Lakeisha Brower

11/13/17

Integrated Disability Evaluation System Package Checklist

Instructions: Please use this form to confirm all necessary contents are submitted with the case to the physical evaluation board. Please fill out and attach this form to the submitted case file.

Daniel Anderson (formerly Merwin)	E5/USN	LAST 4 SSN [REDACTED]	DOB: [REDACTED] 1985
MTF WRNMMC	RESERVES NO	IDES NUMBER 208806	
PEBLO/CASE MANGER NAME LAKEISHA M. BROWER		EAOS 20211031	MOS/DESIGNATOR CTN
PEBLO/CASE MANAGER PHONE 301-400-0059		LAKEISHA.M.BROWER.CTR@MAIL.MIL	
PEBLO/CASE MANAGER SIGNATURE <i>Lakeisha Brower</i>		CURRENT DATE 11/13/2017	
Place Case in this Order: (Initial Yes/No Box)	Yes	No	Remarks
1. IDES Package Checklist (This Form)	X		
2. IDES Legal consultation and IDES Enrollment Request (DES Counsel form)	X		
3. NAVMED 1850/1 Legacy disability Evaluation System Enrollment Request		X	
4. NAVMED 1850/2 Initial Entry Training Legacy Disability evaluation System Enrollment		X	
5. VA Pilot Referral Sheet		X	
6. VA 21-0819	X		
7. NAVMED 6100/ 1 (Cover Sheet): 2 MD Signatures & Date, CA Signature & Date, P Signature if indicated	X		
8. MEBR/NARSUM: Name & Last 4 SSN Match, MD Signature (PA/NP must have MD co-sign), Referred diagnosis listed clearly - Must be dated within 6 months	X		
9. NAVMED 6100/2 (for MEBR/NARSUM): Circle intent, date, & initial, SNM signature, memo (if no SNM signature)	X		
10. Rebuttal (as required): Sign & Date		X	
11. Surrebuttal (as required): Sign & Date, Address each item of the rebuttal		X	
12. Addendum(s): Name & Last 4 SSN Match, MD Signature (PA/NP must have MD co-sign), Referred diagnosis listed clearly - Must be dated within 6 months		X	
13. NAVMED 6100/2 for Addendum(s): Circle intent, date, & initial, SNM signature, memo (if no SNM signature)		X	
14. Non Medical Assessment: Name & Last 4 SSN, OIF/OEF, EAOS, Rate, Designator, CO signature & comments, LIMDU papers, ADSD - Must be dated within 6 months	X		
15. Fitness Reports/EVALs: Previous 2 years only	X		
16. Statement (by Member if desired)		X	
17. LODI & LODD (Line of Duty Determination): SF600 signed by CO & MO or LODI & LODD w/ Gen court martial CA signature		X	
18. C&P Exam: Name matches on each page, all pages & one sided - Must be dated within 12 months	X		
19. LODB (Line of Duty Benefits for Reservists): MCMEDs (Marines) or Line of Duty Benefits letter or Active Duty orders covering period of injury		X	
20. Credentials (2100 Medical Corps only)		X	AR 1278

21. All Medical Treatment Records: AHLTA records of radiology, medical encounters, prescriptions, inpatient stay records, all AHLTA and civilian medical notes	X	Altha print, entrance exam, all medical records.
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Disability Evaluation System Counsel Program IDES and LDES Fact Sheet

You have been referred into the Disability Evaluation System (DES) so that the Physical Evaluation Board (PEB) may evaluate your fitness for continued military service. The DES determines: 1) fitness for continued military service, and 2) appropriate benefits for service members who are medically separated or retired because of a compensable disability.

There are two Disability Evaluation System processes your case may proceed through: the Integrated Disability Evaluation System (IDES), and the Legacy Disability Evaluation System (LDES). Each process has its pros and its cons, however the primary decisions (fitness and stability of the condition(s) if determined to be unfit) for both IDES and LDES cases are decided by the same Physical Evaluation Board, and afford Service members the same due process rights (i.e., legal counsel, impartial review, rebuttal, formal board). You are automatically enrolled in IDES unless you waive your right to IDES and request LDES.

Integrated (IDES): Congress mandated the creation of IDES to increase transparency, eliminate redundancies and discrepancies between service disability evaluations and VA disability claims, and to decrease the time between separation and the start of VA disability benefits. IDES is the default enrollment option. You are automatically enrolled in IDES unless you waive your right to IDES and request LDES. **Certain members considered to be in initial entry training may be directed into LDES by their commanding officer on a case-by-case basis, even if they desire to remain in IDES.**

- **Pros:** The VA disability rating determination is integrated into the process, and you will receive VA Compensation and Pension (C&P) Examinations. You will be assigned a VA Medical Service Coordinator (MSC), who is a VA employee assigned to serve as your liaison throughout the VA disability evaluation and claims process. The VA will examine all of your claimed conditions before you leave active duty, even ones the Service does not consider unfitting. If the PEB finds you to be medically unfit because of any compensable condition(s), the VA will rate all your all of your conditions and the PEB must accept the ratings assigned by the VA for your unfitting condition(s). You will also have the right to request a one-time VA rating reconsideration for your unfitting condition(s) if you disagree with the ratings assigned to those conditions by the VA. If you are separated/retired due to your disability, both your DoD and VA disability ratings will have already been assigned, and receipt of your VA compensation benefits should not be delayed.

Cons: If you desire to leave active service quickly, IDES cases may take longer to process than Legacy cases.

Legacy (LDES): You may waive your right to IDES, and request to be enrolled in LDES if you do so within 10 days of your referral date. This request must be approved by your Commanding Officer.

- **Pros:** If you desire to leave active service quickly, LDES cases may take less time to process than IDES cases.
- **Cons:** Your VA disability rating and compensation benefits are not calculated in LDES, so you will not receive VA benefits or compensation automatically for all conditions if you are found Unfit. You will be advised about available VA benefits; but you will have to file your own VA claims, either within 180 days of an approved separation date or after attaining veteran status and signing your DD214. Electing LDES may delay receipt of VA compensation benefits. The only rating you receive during LDES will be a rating calculated by the PEB for the condition(s) they determine to be unfitting and you will not receive a rating for any additional conditions. The PEB rating for your unfitting condition(s) may be different from the rating the VA ultimately provides for the same condition(s). A primary reason Congress mandated IDES was because many Service members were rated 20% or less by DoD for conditions that the VA then rated 30% or higher, forcing those veterans to file appeals for correction of military records to seek medical retirement, often years after discharge. IDES was created to eliminate the discrepancy between PEB and VA rating percentages.

PRINTED NAME: DANIEL MERRIN

DATE: 11 AUG 17

Daniel Merrin
MEMBER'S SIGNATURE

IDES Legal Consultation and IDES Enrollment or IDES Waiver and LDES Enrollment RequestDATE: 11 Aug 17

Ref: (a) Assistant Secretary of the Navy (Manpower and Reserve Affairs) memo dated March 3, 2016.
 (b) Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) memo dated May 16, 2016.
 Encl: (1) DES Counsel IDES and LDES Facts Sheet

1. I have been referred into the Disability Evaluation System (DES) so that the Physical Evaluation Board may evaluate my fitness for continued military service. The DES determines: 1) fitness for continued military service, and 2) appropriate benefits for service members who are medically separated or retired because of a compensable disability. There are two Disability Evaluation System processes: the Integrated Disability Evaluation System (IDES), and the Legacy Disability Evaluation System (LDES).

2. Pursuant to reference (a), if requested by a Service member, the Service member's Commanding Officer (CO) can authorize the Service member's request to waive IDES processing and enroll in the Legacy Disability Evaluation System (LDES). I understand that if I do not waive IDES processing and elect LDES within 10 days of referral, I will remain in IDES to receive comprehensive disability evaluation of all my claimed condition(s), to include findings of service connection and assignment of appropriate VA benefits, before I leave active service. I understand that if I do request LDES, I need to inform my Commanding Officer of my request and ensure that my PEBLO receives my request within 10 days of referral. Once administratively enrolled in either IDES or LDES, I understand that I will not be allowed to switch options if I am later dissatisfied. I have also been advised that certain members considered to be in initial entry training may be directed into LDES by their commanding officer on a case-by-case basis, even if they desire to remain in IDES.

3. Per reference (b), I have consulted with legal counsel regarding the substantive and procedural differences between the Integrated and Legacy Disability Evaluation System options. I have been provided with a copy of enclosure (1) and a DES Counsel attorney has explained it to me. I am fully satisfied with the legal consultation provided and I understand the differences in my rights and potential benefits due to the procedural and substantive differences between IDES and LDES.

4. By my initial in the appropriate box and signature below, I am indicating my desire to remain enrolled into IDES or my desire to waive IDES and be enrolled in LDES. I also understand that if I am considered to be in initial entry training status, even if I desire to remain in IDES, my Commanding Officer may, on a case-by-case basis, direct me into LDES.

I elect to remain in IDES:

☒

I waive IDES and request LDES:

☐

5. If I waived IDES and have requested LDES, my command-endorsed LDES request must be returned to my PEBLO no later than _____ (10 business days from DES referral). I understand that by entering LDES I am waiving all my rights to be processed by the DoD and VA Integrated Disability Evaluation System (IDES) and am requesting instead to have my case processed through the DoD-only Legacy Disability Evaluation System (LDES). This request must be approved by my Commanding Officer (CO); once my CO has approved my request, it is not reversible.


6. I understand that I am ultimately responsible for delivering this document to my PEBLO, but by my signature below, I authorize the DES Counsel Program Office, which assisted me in this legal consultation, to transfer this signed and completed document to my PEBLO.

Daniel Merwin
 MEMBERS SIGNATURE
 PRINTED NAME: DANIEL MERWIN

Stephen M. Lyons
 LEGAL COUNSEL SIGNATURE
 PRINTED NAME: Stephen M. Lyons
 Member received required legal counseling

VA # 208606

NOREG372
WRNMMC BETHESDA
IDES & TRANSITIONOMB Approved No. 2900-0704
Respondent Burden: 30 minutes
Expiration Date: 7/31/2019

 Department of Veterans Affairs		VA DATE STAMP 2017 AUG 22 AM 11:59 WRITE IN THIS SPACE)	
VA/DOD JOINT DISABILITY EVALUATION BOARD CLAIM			
IMPORTANT - Please read the Privacy Act and Respondent Burden on the back before completing the form.			
Section I: To be completed by Military Treatment Facility referring Service member to Disability Evaluation System (DES)			
SERVICE MEMBER NAME (First, middle, last) DANIEL ANDERSON		GRADE CTN1/E-6	
COMPONENT US NAVY ACTIVE		UNIT ADDRESS NIOC MARYLAND FT. MEADE	
SOCIAL SECURITY NUMBER [REDACTED]		DATE OF BIRTH (MM,DD,YYYY) [REDACTED] 1985	
SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER (PEBLO) (First, MI, Last) (Include Area Code) LAKEISHA BROWER 301-400-0059		NAME OF REFERRING MILITARY TREATMENT FACILITY (MTF) WRNMMC	
		DATE OF REFERRAL TO MEDICAL EVALUATION BOARD (MEB) (MM,DD,YYYY) 08/14/2017	
MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION (List only conditions referred by physician): IBS D/P K58.0 GENERALIZED ANXIETY DISORDER 300.02 MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE 296.32			
PREPARED BY MARIO F. GOLLE, JR., MD, Director of IDES		DATE PREPARED 21 Aug 2017	
Section II: Tell us about yourself. Please provide a contact name and address. If you are on Temporary Duty, please indicate that on the VA Form 21-4138, Statement in Support of Claim available on the internet at www.va.gov/vaforms			
1. WHAT IS YOUR ADDRESS? Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country		2. WHAT ARE YOUR TELEPHONE NUMBERS? (Include Area Code) Daytime _____ Evening _____ Cell phone _____	
3. WHAT IS YOUR E-MAIL ADDRESS (If applicable)			
4. HAVE YOU EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide file number) _____ (VA File Number)		5. POINT OF CONTACT NAME AND ADDRESS	
6A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," go to Item 6b) <input type="checkbox"/> NO (If "No," go to Item 7)		6B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER	
7. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON		8. PLACE OF ENTRY	
Section III: Tell us about your military service. Enter complete information for your service. Tell us about your reserve duty or National Guard Duty			
9. ARE YOU CURRENTLY ASSIGNED TO AN ACTIVE RESERVE UNIT OR NATIONAL GUARD UNIT? <input type="checkbox"/> YES (If "Yes," provide date of activation below) _____ <input type="checkbox"/> NO		10A. WHAT IS THE NAME AND MAILING ADDRESS OF YOUR CURRENT UNIT?	
		10B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code)	

Associated with 21-52662 Reviewed 8-30-17



Department of Veterans Affairs

**APPLICATION FOR DISABILITY COMPENSATION
AND RELATED COMPENSATION BENEFITS**VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

2017 AUG 30 PM 12:29

WRITTEN
IDES

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

1. VETERAN/SERVICE MEMBER NAME (First, Middle Initial, Last)

D A N I E L A N D E R S O N

2. VETERAN'S SOCIAL SECURITY NUMBER

[REDACTED]

3. HAVE YOU EVER FILED A CLAIM WITH VA?

☐ YES ☒ NO (If "Yes," provide your file number in Item 4)

4. VA FILE NUMBER

[REDACTED]

5. DATE OF BIRTH (MM,DD,YYYY)

Month [REDACTED] Day [REDACTED] Year 1 9 8 5

6. SEX

☒ MALE ☐ FEMALE

7. VETERAN'S SERVICE NUMBER (If applicable)

[REDACTED]

8A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

☐ YES ☒ NO (If "Yes," complete Items 8B & 8C)

8B. POINT OF CONTACT (Name of person that VA can contact in order to get in touch with you)

8C. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

[REDACTED] - [REDACTED] - [REDACTED]

9A. SERVICE (Check all that apply)

☐ ARMY ☒ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ COAST GUARD

9B. COMPONENT (Check all that apply)

☒ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

10A. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

[REDACTED]

Apt./Unit Number

[REDACTED]

City

G L E N B U R N I E

State/Province

M D

Country

[REDACTED]

ZIP Code/Postal Code

[REDACTED]

10B. FORWARDING ADDRESS AND EFFECTIVE DATE (Provide the date you will be living at this address)

No. & Street [REDACTED]

Apt./Unit Number

[REDACTED]

City

[REDACTED]

State/Province

[REDACTED]

Country

[REDACTED]

ZIP Code/Postal Code

[REDACTED]

EFFECTIVE DATE:

Month

Day

Year

[REDACTED] - [REDACTED] - [REDACTED]

11. PREFERRED TELEPHONE NUMBER

[REDACTED]

12A. PREFERRED E-MAIL ADDRESS (If applicable)

[REDACTED]@GMAIL.COM

12B. ALTERNATE E-MAIL ADDRESS (If applicable)

Associated with 21-0519 Received 8-22-17

VETERANS SOCIAL SECURITY NO.

6 1 5 - 1 2 - 2 4 8 9

13. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES	
1.	S E E A T T A C H E D V A F O R M 2 1 - 4 1 3 8
2.	F O R C L A I M E D C O N D I T I O N S
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

14. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION	B. DATE(S) OF TREATMENT



Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (Type or print)

DANIEL ANDERSON

SOCIAL SECURITY NO.

VA FILE NO.

C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:
CONTINUATION OF VA FORM 21-526EZ PAGE 8

1. IBS D/P
2. GENERALIZED ANXIETY DISORDER
3. MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
4. HAIR LOSS
5. MENTAL HEALTH CONDITION TO INCLUDE SCHIZOID EFFECT, SLEEP DISTURBACNE TO INCLUDE INSOMNIA
6. ASTHMA
7. ALERGIC TO CATS
8. HEMMORHOIDS, ANAL FISURES, ANUS SPASMS
9. HAND CONDITION RIGHT HAND NUCKEL CONDITION
10. ANKLE CONDITION LEFT
11. SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD
12. DRY EYE SYNDROME
13. DENTAL CONDITION S/P SURGERY IN MOUTH AND JAW
14. WRIST CONDITION BILATERAL
15. SKIN CONDITION TO INCLUDE SCROTAL CYST, INGROWN TOE NAIL LEFT FOOT
16. GERD
17. SLEEP PARALISYS (SLEEP STUDY DATES 10/02/2017)
18. HEADACHES /MIGRAINES

2017 AUG 30 PM 12:29

1. I HAVE NO LEAVE OR SURGERIES FOR THE NEXT 60 DAYS.I HAVE A SLEEP STUDY SCHEDULED 10/02/2017 PLEASE DO NOT SCHEDULE ME THAT DAY OR THE DAY AFTER.
2. I HAVE PROVIDED ALL MEDICAL RECORDS IN MY POSSESSION TO MY PEBLO.
3. I HAVE BEEN ADVISED THAT IF I MISS, OR ARE LATE TO A VA EXAMINATION I MUST CONTACT MY MSC AND PEBLO PRIOR TO THE EXAM, WITH AN EXPLANATION WHY I MISSED MY EXAM. IF THE MSC HAS NOT BEEN CONTACTED THE EXAM MAY NOT BE RESCHEDULED. IF EXAMS NEED TO BE RESCHEDULED, THE VAMC CAN REQUIRE A MILITARY ESCORT.
4. I HAVE BEEN ADVISED THAT ANY CONDITION CLAIMED AFTER TODAY WILL BE WORKED AFTER I LEAVE SERVICE AND WILL NOT BE INCLUDED IN THE MEB\PEB PROCESS.

I WILL TURN IN A COPY OF MY DENAL RECORDS WITHIN THE NEXT 15 DAY.

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE

DATE SIGNED

30 AUG 17

ADDRESS

GLEN BURNIE MD

TELEPHONE NUMBERS (Include Area Code)

DAYTIME

EVENING

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

VETERANS SOCIAL SECURITY NO. [REDACTED]

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW
(VA forms are available at www.va.gov/vaforms).

For:	Required Form(s):
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specialty Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION II: SERVICE INFORMATION

15A. DID YOU SERVE UNDER ANOTHER NAME? <input checked="" type="checkbox"/> YES (If "Yes," complete Item 15B) <input type="checkbox"/> NO (If "No," skip to Item 16A)		15B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER: DANIEL DENNIS MERWIN	
16A. MOST RECENT ACTIVE SERVICE ENTRY DATE (MM,DD,YYYY) Month Day Year 11 - 01 - 2005		16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY) Month Day Year - - -	
16C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		16D. PLACE OF LAST OR ANTICIPATED SEPARATION	
17A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 17B thru 17F) (If "No," skip to Item 18A)		17B. COMPONENT <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVES	17C. OBLIGATION TERM OF SERVICE From: Month Day Year - - - To: Month Day Year - - -
17D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:		17E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code) ()	17F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO
18A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 18B & 18C)	18B. DATE OF ACTIVATION: (MM,DD,YYYY) Month Day Year - - -	18C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY) Month Day Year - - -	
19A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Item 19B)	19B. DATES OF CONFINEMENT (MM,DD,YYYY) From: Month Day Year To: Month Day Year - - - - - - - -		

SECTION III: SERVICE PAY

20A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 20B and 20C)	20B. LIST AMOUNT (If known) \$	20C. LIST TYPE (If known)
---	--	----------------------------------

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you *do not* want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 21**. Please note that if you check the box in **Item 21**, you *will not* receive VA compensation, if granted.

☐ **21. I want military retired pay instead of VA compensation**

IMPORTANT: You may elect to keep the training pay for inactive duty training days you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 22**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

☐ **22. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.**

VETERANS SOCIAL SECURITY NO. [REDACTED]

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 23, 24 and 25 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

23. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)

☒ CHECKING☐ SAVINGS☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: [REDACTED]

Account No.: [REDACTED]

24. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

25. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled, *Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits*.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; OR, I have no information or evidence to give VA to support my claim; OR, I have checked the box in Item 26, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify that I am a court-appointed representative; OR, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; OR, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; OR, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; OR, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; OR, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

26. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY** if you **DO NOT** want your claim considered for rapid processing under the FDC Program because you plan on submitting further evidence in support of your claim.

☒ I DO NOT want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.

27A. VETERAN/SERVICE MEMBER/ALTERNATE SIGNER SIGNATURE (REQUIRED)

27B. DATE SIGNED

08/30/2017

SECTION VI: WITNESSES TO SIGNATURE

28A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

28B. PRINTED NAME AND ADDRESS OF WITNESS

29A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

29B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

I certify that the claimant has authorized the undersigned representative to file this supplemental claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

30A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE

30B. DATE SIGNED

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

NAME: ANDERSON, DANIEL

DUTY STATION: WRNMMC

SSN: [REDACTED]

RACE: UNKNOWN

LENGTH OF SERVICE: YR 12 MON 0 GRADE/RANK: CTN1-E-6 SERVICE: NAVY

DOB: [REDACTED] 1985

RPT UIC: [REDACTED]

DUTY UIC: 0068

PSD UIC:

MTO: 0000

EAOS: 20211031

CAUSE OF INJURY: ILLNESS

ICD-10-CM	DIAGNOSIS	EPTE (ORIGIN)
1: F33.1	Major Depressive Disorder (MDD), Recurrent, Moderate	NONE
2: F41.1	Generalized Anxiety Disorder	NONE
3: K58.0	Irritable bowel syndrome with diarrhea	NONE
4: G47.33	Obstructive sleep apnea	NONE
5:		
6:		
7:		
8:		
9:		

ENTRANCE PHYSICAL EXAMINATIONS:

ADMITTED TO SICK LIST

DATE OF DISPOSITION:

LOD: YES ☐ NO ☒

BOARD DATE: 20170908

DISCIPLINARY ACTION

PENDING: ☐

D/R/M: _____

More than 10 Diagnosis ☐ _____

Indicated Disposition: REFER TO PEB

Limited Duty Expires on: _____

Board Members

Signature

Senior Member: Huma Chaudhery, MD

CHAUDHERY.HUMA
JAHAN.1379738385

Junior Member: Sharon K. Moore, MD (P)

MOORE.SHARON.K.15
22132450

Alternate Member:

ENCLOSURES:

- ☒ SIGNED NAVMED 6100/2
☐ 6100/2- ADDENDA
☐ SIGNED NAVMED 6100/3
☐ SIGNED NAVMED 6100/4
☐ SIGNED NAVMED 6100/5
☐ MEMBER'S REBUTTAL
☐ MEMBER'S SUR-REBUTTAL
☒ COPY OF HEALTH RECORD
☒ PHYSICAL EXAMINATION
☐ INCAPACITATION BOARD

- ☐ NOTICE OF ELIGIBILITY (NOE)
☐ LOD INVESTIGATION
☐ CLINICAL INPATIENT RECORD
☒ NON MEDICAL ASSESSMENT
☐ HIV TEST

Additional Enclosures: _____

Approved

Administrative Involuntary Separation Pending: _____

Date: 08 NOV 2017

Convening Authority Signature: Mario F. Golle, Jr., MD DIRECTOR IDES GOLLE.MARIO.FLO
RES.JR.1183828343 Digitally signed by
GOLLE MARIO FLORES JR 1183828343
DN: cn=US, o=U.S. Government, ou=DoD, ou=PR
ou=DNA, cn=GOLLE MARIO FLORES JR 1183828343
Date: 2017.11.08 08:59:27 -0500

MEMO ENDORSEMENT UPON REEVALUATION: MEMBER EXAMINED THIS DATE _____
 THE RESULTS AND FINDINGS ARE:

Member counseled this date of the finding:

DATE	Signature	Grade/Corps/Service
------	-----------	---------------------

Exam Physician: _____

Member: _____

Head of Department: _____

MEMBER AWAITING ACTION AT: _____



**DEFENSE HEALTH AGENCY
WALTER REED NATIONAL MILITARY MEDICAL CENTER
WRNMMC CONSOLIDATED NARSUM**

This consolidated NARSUM incorporates specialty consults and review of VA medical records, precluding the need for specialty addenda, and is an Administrative Document, *not* to be used as source documentation for medical decisions.

NAME: ANDERSON, DANIEL DENNIS
SSN/DOB: [REDACTED] 1985
STATUS: PO2/USN
DATE: 06 November 2017

Identification: PO2 Anderson is a 32 y/o USN with 12 years length of service. MOS is CTN. He was referred to the IDES on 21 August 2017 for Irritable bowel syndrome, Generalized anxiety disorder and Major depressive disorder recurrent moderate.

History of Present Illness: Per review of medical records available in AHLTA, ESSENTRIS, and JLV, the following diagnoses are referred to the Navy Central Physical Evaluation Board as duty limiting:

Diagnoses 1-3

1. **Diagnosis 1: Major Depressive Disorder (MDD), Recurrent, Moderate (ICD10: F33.1)**
Diagnosis 2: Generalized Anxiety Disorder (GAD) (ICD 10: F41.1)
Diagnosis 3: Alcohol Use Disorder, Moderate, in early remission (not ratable)

2. **Diagnostic Reasoning:** Per the VA DBQ PSYCH Mental disorders Exam dated 25 September 2017, PO2 Anderson had a history of childhood trauma, had attempted suicide at age 17 which he did not disclose at the time by taking a bottle of aspirin (detail AHLTA Psychiatry Be note dated 04 August 2014), but no history of behavioral health diagnosis or treatment prior to entry into military service in 2005. Per an AHLTA Integrative Health & Wellness Be note dated 16 June 2014, he had anxious mood, irritable bowel, attentional difficulties, nail biting, irritability and insomnia since around age 14. He noted anxiety had also been a problem when he was stationed on a ship in Japan from 2006 to 2009, where he had little down time, worked 12 hour shifts and tried to be the "perfect" worker and he began picking out circular patches of hair in his scalp. In 2014, he was selected for a new job with increased responsibility including leadership and management duties while he noted that he would prefer to do computer work in isolation. He reported at that time that he drank up to 3 drinks, one to two times per week, and would binge, 6 or more drinks once per month or less frequently, but had tried to cut down (AHLTA Psychiatry Be note dated 16 October 2014). He had concerns about his inability to resist daily drinking to manage his, insomnia, anxious ruminations and obsessions despite his growing lack of motivation, worsening mood, and (AHLTA Substance Abuse NY notes dated 17 and 19 March 2015). He had persistent dysphoric mood, intermittent suicidal ideation, irritability, apathy and continued anxiety (AHLAT PSYCHIATRY BE note dated 23 April 2015). He had some benefit to his mood from medication and noted he was more focused and productive but still had anxiety (AHLTA Psychiatry Be note dated 14 May 2015). However, his medication caused excessive sleepiness when the dose was increased and he asked to be tapered off. During times of increased stress, he had anxiety including physical tension, increased heart rate and nausea, and mood swings with suicidal ideation and on one occasion thought about jumping off of a roof related to juggling multiple work responsibilities (AHLTA Psychiatry Be note dated 06 September 2016). In addition, guilt about how he functioned in interpersonal relationships led him to feel suicidal. Though he drank less during active alcohol dependence treatment, he resumed regular drinking of 3to 4 drinks three to four times per week with binge drinking when he was not working (AHLTA Psychiatry Be note dated 04 January 2017). He stopped taking medication after a change in medication left him feeling flat, but later resumed. However, he noted that his anxiety overwhelmed him and was negatively impacting his ability to be a Sailor (AHLTA Psychiatry Be T-Con note dated 08 June 2017). He had a Command directed safety evaluation after voicing suicidal thoughts and researching methods of suicide on-line, in response to the aftermath of a harassment allegation against him (AHLTA Psychiatry Consult Liaison Be note dated 06 July 2017) which resulted in a loss of rank. When his personal and career circumstances were discussed without his knowledge in front of 150 Service members in an all hands meeting, furthering his

estrangement from Command, he noted increased anxiety and depression with suicidal thoughts of jumping off of a roof (AHLTA Psychiatry Be note dated 06 September 2017). At his most recent follow up, he noted no significant improvement in dysphoric mood, no drinking, and he had continued medication side effects (AHLTA Psychiatry Be note dated 01 November 2017).

3. Treatment History: PO2 Anderson was evaluated for anxiety at Walter Reed National Military Medical Center (WRNMMC) and participated in therapy June to October 2014 but discontinued due to limited impact of visits (AHLTA Substance Abuse at NY note dated 19 March 2015). He self-referred to Substance Abuse Recovery Program Washington Navy Yard in March 2015 for problematic drinking and participated in Level 1 and Continuing Care group therapy until February 2016. He was referred to the Ft. Belvoir Community Residential Treatment Center from 25 March 2015 to 23 April 2015. He was referred to medication management at WRNMMC and Cognitive Behavioral Group therapy for insomnia beginning in 2015. He began Addiction Treatment Services (ATS) at WRNMMC in July 2017 and continued with outpatient individual and group therapy through ATS. He attended the WRNMMC Intensive Outpatient Program from 31 August 2017 to 22 September 2017. He had Transcranial Magnetic Stimulation seven sessions as of 10 October 2017. He continued in behavioral health treatment modalities of individual and occupational therapy and medication management. Medication trials included Escitalopram, Sertraline, and Venlafaxine ER for mood, Melatonin and Ramelteon for insomnia, and Naltrexone for alcohol dependence. Most recent medication included Duloxetine 60mg daily for mood and Eszopiclone 2 mg nightly for insomnia.

4. Symptomatology and Objective Findings: Per the VA DBQ PSYCH Mental disorders Exam dated 25 September 2017, PO2 Anderson had the following symptoms consistent with MDD which included sad mood, feelings of helplessness, feelings of hopelessness, low energy, anhedonia, and chronic suicidal ideation. He had symptoms consistent with GAD which included worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. His symptoms of Alcohol Use Disorder included a maladaptive pattern of alcohol use, excessive use and tolerance, and of interpersonal or occupational problems occurring as a result of use. His most recent mental status was notable for dysphoric mood, full affect, circumstantial thought processes and no suicidal ideation intent or plan (AHLTA Psychiatry Be note dated 01 November 2017).

5. Limitations and Prognosis: The NMA dated 27 October 2017 stated, "The conditions listed in his LIMDU paperwork and the extensive range of medical appointments CTN2 Anderson's medical practitioners have recommended/assigned for his treatment prevent him from conducting his assigned mission for his MOS/Rate."

PO2 Anderson requires ongoing behavioral health treatment at a fixed MTF. He cannot deploy nor carry and fire a weapon from a behavioral health perspective. The prognosis is guarded. It is not likely that the SM will significantly improve sufficiently to be returned to fully duty in the next 12 to 36 months. The above condition is likely to remain stable over the next 12 months.

6. VA DBQ Findings: C&P exams have been reviewed.

Diagnoses 4

1. Diagnosis: Irritable bowel syndrome with diarrhea (ICD10 Code: K58.0)

2. Diagnostic Reasoning: 32 y/o AD male was diagnosed with IBS manifested by chronic intermittent abdominal pain in 2012. He has reported a long history of GI symptoms dating back to childhood, but symptoms have been more disruptive over the past few years. In 2012 he underwent a CT abdomen/pelvis, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was normal. In Sept 2017 anorectal manometry was normal. He has had frequent follow up with GI since 2016. Symptoms include generalized sharp, crampy abdominal pain about every 1-2 days that peaks prior to defecation and is relieved after bowel movements. He typically has 1-2 soft or liquid stools per day, infrequently with urgency. Abdominal pain is worse with intake of insoluble fibers; however, insoluble

PO2 Anderson, Daniel D.

06 November 2017

Page 2

AR 1291

fibers resolve his liquid stools. Abdominal pain is also worse during physical activity and with increased anxiety/stress. Low FODMAP diet has provided partial relief in frequency of pain and fecal urgency. GI evaluation dated 19Sept17 noted "IBS-D predominant symptoms complicated fecal urgency/soiling, with some element of FODMAP associated osmotic diarrhea. Comprehensive evaluation has otherwise been unremarkable."

3. **Treatment History:** dietary modification as noted, including low FODMAP and low fructose, peppermint oil 200mg daily for his abdominal cramping, Citrucel, Effexor
4. **Symptomatology and Objective Findings:** Stools have become more formed over the past few months since starting Effexor and continuing a low FODMAP diet. However, he has ongoing abdominal cramps, which continue to be triggered by physical activity, anxiety, and stress.
5. **Limitations and Prognosis:** Limited in ability to deploy to austere environment. NMA unavailable at this time.
Continued treatment is unlikely to return Soldier to full duty in 12 months. Condition is stable over 12-36 months. Will require ongoing GI and PCM follow-up and support.
6. **VA DBQ Findings:** Reviewed and concur.

Diagnoses 5

1. **Diagnosis: Obstructive sleep apnea (ICD10 Code: G47.33)**
2. **Diagnostic Reasoning:** Polysomnogram was performed on 04Oct17 at WRNMMC. SM was diagnosed with mild obstructive sleep apnea with AHI of 6/hr. CPAP was recommended.
3. **Treatment History:** CPAP
4. **Symptomatology and Objective Findings:** Apnea hypopnea index (AHI) of 7/hr.
5. **Limitations and Prognosis:** Limited in ability to deploy to austere environment due to need for electricity and fresh water. SM should not engage in any hazardous activities (such as driving) if excessively sleepy. While this condition does not limit his ability to perform his MOS, continued treatment is unlikely to return Soldier to full duty in 12 months. Condition is stable over 12-36 months. SM requires treatment with CPAP.
6. **VA DBQ Findings:** Reviewed and concur.

Conditions evaluated at the VA DBQ Exam that are not duty limiting, alone or in combination with the SM's other conditions:

3. **Subjective tinnitus**, with normal hearing bilaterally.
4. **Disturbance in sensation, cranial nerve V2**, residual OIF orthognathic surgery, improving and not duty limiting.
5. **Epidermal cysts of the scrotum**, s/p excision.
6. **Left neck folliculitis**, inactive, no residual scar per VA DBQ examiner.
7. **Scarring alopecia**, not duty limiting.
8. **Dry eye syndrome**, not duty limiting.
9. **Left ankle sprain**, resolved with no residual per VA DBQ examiner.
10. **Paronychia left hallux**, not duty limiting.
11. **Right wrist tendinitis**, VA diagnosis, with normal Rom on exam, not duty limiting.
12. **Right hand 5th proximal phalanx fracture 2008**, well healed without residual per VA DBQ examiner, no pathology found.
13. **Hemorrhoids**, not duty limiting.

PO2 Anderson, Daniel D.

06 November 2017

Page 3

AR 1292

14. **GERD**, managed with PPI.
15. **Migraine headaches**, onset 2008, treated with Alleve or Excedrin.
16. **Allergic rhinitis**, not duty limiting.
17. **Asthma**, not listed as a diagnosis by the VA DBQ examiner, diagnosis confirmed in the medical record. Pulmonary function tests were performed on 17Mar11 and revealed normal spirometry, very mild decrease in TLC, and a normal DLCO. Following the administration of methacholine there was a significant decrease in FEV1 consistent with a positive methacholine challenge. Pulmonary noted "symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. His symptoms are confined to allergen exposure, particularly to cats. Given the mild intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS." Albuterol was last refilled 18May17.

Competency Statement: SM is deemed mentally competent for pay purposes and is capable of cooperating in and understanding the nature of PEB proceedings.

Past Medical History, Social History, Family History and Review of Systems:

Discussed above, otherwise not pertinent.

Discussion: The VA DBQ examiner did not establish a diagnosis related to the following claims, and there is no evidence of impact on duty in available medical records: left wrist condition, anal fissure, and anal spasms. The SM claimed mental health condition to include schizoid effect. Per an AHLTA Psychology Assessment Be note dated 08 February 2017, PO2 Anderson underwent psychological testing which yielded the impression that he had a pattern consistent with Schizoid personality traits but did not formally diagnoses the SM with a personality disorder. Personality traits do not constitute a ratable condition. The SM claimed sleep disturbance to include insomnia which is subsumed under the diagnosis of Major Depressive Disorder, Recurrent, Moderate as diagnosed by the VA and supported by the medical record.

Diagnoses:

1. **Major Depressive Disorder (MDD), Recurrent, Moderate (ICD10: F33.1)**
2. **Generalized Anxiety Disorder (GAD) (ICD 10: F41.1)**
3. **Irritable bowel syndrome with diarrhea (ICD10 Code: K58.0)**
4. **Obstructive sleep apnea (ICD10 Code: G47.33)**

Recommendations:

The Medical Board recommends that case be referred to the Central Physical Evaluation Board for the above diagnoses. Conditions did not exist prior to entry into the service. This Service Member has received maximum benefit of military medical treatment.

CHAUDHERY.HU
MA.JAHAN.13797
38385

Huma Chaudhery, MD
Internist, MEB Division
WRNMMC

MOORE.SHARON.K.1522132450
N.K.1522132450

Sharon Moore, MD
Psychiatrist, MEB Division
WRNMMC

PO2 Anderson, Daniel D.

06 November 2017

Page 4

AR 1293

For Official Use Only – Privacy Act Protected

PO2 Anderson, Daniel D.

06 November 2017

Page 5

AR 1294

MEDICAL BOARD STATEMENT OF PATIENT
NAV MED 6100/2 (AUTOMATED VERSION) (1-91)

WRNMMC BETHESDA, MD

STATEMENT OF PATIENT
CONCERNING THE FINDINGS OF A MEDICAL BOARD

I have been informed that it is the recommendation of the Medical Board of National Naval Medical Center Bethesda, MD (00168) that: my case be referred to the Director, Secretary of the Navy Council of Review Boards.

LIMITATIONS ARE:

Having been informed of the contents, opinion(s) and recommendation(s) of the Medical Board I DO/DO NOT desire to submit a statement in rebuttal. I understand that this Medical Board report with my rebuttal, if any, will become part of my official military records. I further understand that the opinion(s) expressed by the Medical Board are not binding upon the military, and that my case may be subjected to review and final disposition by higher authority.

Signed:

Daniel Anderson
Anderson, Daniel
XXX-XX-XXXX

CURRENT ADDRESS

709 Millhouse Drive
Glen Burnie, MD 21060

I CERTIFY THAT I AM AM NOT PROCESSING FOR SEPARATION / RETIREMENT

Witnessed:

Lakeisha Brewer

Date:

11/13/17

NAV MED 6100/2 (AUTOMATED VERSION) (REVISED 1-91)



DEPARTMENT OF THE NAVY
CYBER STRIKE ACTIVITY SIXTY THREE
FORT GEORGE G MEADE MARYLAND 20755-6585

1850
Ser N00/017
27 Oct 17

From: Commanding Officer, Cyber Strike Activity SIXTY THREE
To: President, Physical Evaluation Board

Subj: NON-MEDICAL ASSESSMENT (NMA) IN THE CASE OF CTN2 ANDERSON,
DANIEL, XXX-XX- [REDACTED] USN/ACTIVE DUTY

Ref: (a) SECNAVINST 1850.4E, "Department of the Navy (DON) Disability Evaluation Manual," April 30, 2002

1. PURPOSE: The Non-Medical Assessment (NMA) is vital to the timely, fair, and transparent determination of whether a Marine or Sailor is Fit (or Unfit) for continued Naval service. The NMA is not a Fitness Report highlighting military character, but is the Commanding Officer's unbiased and accurate comments describing how the medical condition impacts the service member's ability to function within his/her rank and MOS/rating.

a. Part I, the "Questionnaire," collects required facts regarding the service member.

b. Part II, the "Commanding Officer's Comments," is where the PEB relies on the Commanding Officer's comments to explain how the member performs the duties of his/her MOS/Rate with their underlying medical condition(s). The NMA must be signed by the Commanding Officer or acting by direction.

2. PART I - QUESTIONNAIRE: The following assessment to assist the PEB in their determination of Fitness/Unfitness in the case of SNM: PO2 ANDERSON, DANIEL, XXX-XX- [REDACTED] USN/ACTIVE DUTY.

a. Service member's MOS/Primary Specialty; Rate/NEC: CTN/0000.

b. Member's current position or assignment: Non-working patient.

c. Is the member currently working outside of his/her specialty because of the medical condition? (Yes ☒ No ☐). If the member is working outside of his/her specialty, could the member perform in his/her rating? (Yes ☐ No ☒).

d. When did the member last pass a "full" PRT/PFT/CFT: March / 2017.

e. Did the member take the most recent PRT/PFT/CFT? (Yes ☐ No ☒ Partial ☐).

- If "No," why didn't the member take the PRT/PFT/CFT? Member's LIMITED DUTY paperwork is being considered for a waiver from PRT.

- If "Partial PRT/PFT/CFT," what events were waived and why? Pending CWG-6 medical waiver review.

f. Member's height and weight: 72in 189lbs. If not within weight standards, what is the member's body fat percentage? N/A.

g. Is the member within weight and body fat standards? (Yes ☒ No ☐). If "No," is the member on an official weight control program? (Yes ☐ No ☐ NA ☒.

h. To your knowledge, is the member fully attending all appointments and complying with all recommended treatments? (Yes ☒ No ☐.

- Has the member complied in the past? (Yes ☒ No ☐.
- If non-compliant, did the appropriate authority advise the member in writing of the medically proper course of treatment, therapy, medication, or restriction? (Yes ☐ No ☐.
- If the member is non-compliant, please explain why. N/A

i. What is the average number of work hours per week that the member's condition required the member to be away from his/her current duties for treatment, evaluation, and/or recuperation? 30 hours.

j. Is the member being processed for separation due to misconduct at a court-martial or administrative separation board proceeding? (Yes ☐ No ☒). [If "Yes," do not submit the case to the PEB until all misconduct proceedings are complete per ref (a) 3203(f)(6) because separation due to misconduct supersedes disability processing. If "No" proceed to paragraph k.]

- If "Yes" to the above, please identify the type of proceeding: ☐ Administrative Separation Board; ☐ Board of Inquiry; ☐ Summary Court-Martial; ☐ Special Court-Martial; or ☐ General Court-Martial and state the expected completion date: _____).
- Has the Commanding Officer notified PERS/MMSR-4 this member is being processed for separation due to misconduct? (Yes ☐ No ☐ NA ☒.
- Does PERS/MMSR-4 request disability processing for this member concurrent to the misconduct proceedings? (Yes ☐ No ☐ NA ☒). (Concurrent Processing requires submission to the ASN (M&RA) for ultimate disposition in accordance with ref (a) 3403(c))

k. What is the member's current length of service and date of entry into active/reserve

- LOS: 11 years / 11 months; ADSD/AFADBD: November / 2005.
- EAOS/EAS: October / 2021.
- Active Duty Years: 11 years / 11 months.
- Reserve Satisfactory Years: N/A.
- Reserve Retirement Eligible (Yes ☐ No ☒.
- Approved Retirement Date (if applicable): N/A.

l. Considering the member's current physical condition, is he/she worldwide assignable? (Yes ☐ No ☒.

m. Does the member have good potential for continued service in his/her present physical and mental condition? (Yes ☐ No ☒). If "No," please explain why not.

Member's medical condition has prompted a review by Department of the Navy Central Adjudication Facility to see if the member can retain his currently level of security clearance, which prevents him from performing the regular duties as a Cryptologic Technician Networks (CTN). Also, the member's current schedule of appointments and required treatment does not allow enough time in the normal course of a week to execute the requirements of his assigned duties.

n. Does the member desire to continue his/her military service; the PEB will not judge the member's request to separate (or remain) as a negative reflection of his/her dedication to serve in the naval service? (Yes ☐ No ☒). (Please personally obtain the member's express desire). The member desires to discontinue his military service.

o. Regarding Permanent Limited Duty (PLD) of active duty members, would you recommend that Naval Personnel Command/Headquarters Marine Corps (MMSR-4) authorize the member's retention on active duty in a Permanent Limited Duty (PLD) status, if found Unfit? (Yes ☐ No ☒.

- Has the member ever served in a PLD status? (Yes ☐ No ☒.
- Do you recommend PLD unconditionally? (Yes ☐ No ☒); or
- Do you recommend PLD only to complete retirement eligibility? (Yes ☐ No ☒ NA ☐); or
- Do you recommend PLD only to complete EAS? (Yes ☐ No ☒ NA ☐.
- If "No" to any of the PLD recommendations above, please explain why.

p. Has the member ever forward deployed in support of Operation Enduring Freedom, Operation Iraqi Freedom, or other Combat Operations? (Yes ☐ No ☒.

q. For Combat Zone determination purposes, did the member's injury occur in a combat-zone tax exclusion area as defined in DoD Financial Management Regulation, Vol. 7A, Chapter 44, Section 440103(a) [Available at <http://www.defenselink.mil/comptroller/fmr/>]? (Yes ☐ No ☒.

- If "Yes," please state where and how the injury or illness occurred. Additionally, please state what document(s) identify the geographic location of the member's injury.

r. For Combat-Related determination purposes, did the cause of the member's injury occur:

- (i) as a direct result of armed conflict, (Yes ☐ No ☒.
- (ii) while engaged in extra hazardous service, (Yes ☐ No ☒.
- (iii) under conditions simulating war; (Yes ☐ No ☒.
- (iv) by an instrumentality of war. (Yes ☐ No ☒.

- If "Yes," to any of the above, please state where and how the injury or illness occurred. Additionally, please state what document(s) identify the cause of the member's injury. N/A

s. Please provide the member's Defense Travel Service (DTS) Agency Program Coordinator's (APC) name Jim Potter; phone: 667-812-2258; and email jepotte@nsa.gov.

3. PART II – COMMANDING OFFICER'S COMMENTS: The NMA is a critical element of the Physical Evaluation Board's (PEB) adjudication. The PEB relies on your comments to explain how your Marine/Sailor's medical condition impacts his/her ability to perform the duties of his/her MOS/Rate, and the resulting impact on the command. Please note, the NMA is not an evaluation for promotion, and remains in the member's medical record. To ensure a comprehensive NMA, you must comment on all of the member's referred medical conditions and you are encouraged to comment on any of the member's VA claimed conditions. Please use additional pages as necessary.

a. The Commanding Officer submits the following comments so the PEB can make determination of Fitness/Unfitness for this member: PO2 ANDERSON, DANIEL, XXX-XX-
[REDACTED] USN/ACTIVE DUTY.

b. How does the medical condition(s) impact the member's work capacity in relation to his/her MOS/RATE? (MOS/RATE requirements can be found in MCO 1200.17A (4 Jun 09) for Marines; Volume 1 of NAVPERS 18068F October 2010 for Sailors).

Upon receipt of CTN2 Anderson's LIMDU paperwork and July 2017 NJP, assigned Special Security Officer (SSO) recommended and I endorsed service member's TS/SCI classified access and classified facility access badge be suspended, Security Access Eligibility Report (SAER) released, and process initiated for DoD Clearance Adjudication Facility (CAF) to determine if he should maintain a clearance. Final outcome of this decision is pending. The conditions listed in his LIMDU paperwork and the extensive range of medical appointments CTN2 Anderson's medical practitioners have recommended/assigned for his treatment prevent him from conducting his assigned mission for his MOS/RATE. Specifically, not having classified material/facility access prevents him from conducting his assign mission. Should his clearance be revoked, he would likely be required to cross-rate.

c. Include an explanation on what Mission Essential Tasks the member substantively can or cannot do regarding the primary duties of his/her MOS/Rate.

Without TS/SCI classified access and with his classified facility access badge suspended, Security Access Eligibility Report (SAER) released, and DoD Clearance Adjudication Facility (CAF) assessment for clearance eligibility pending, CTN2 Anderson is currently limited in his ability to complete primary duties assigned of his MOS/Rate and is unable to complete Mission Essential Tasks associated with his MOS/Rate. He is however, contributing approximately 10 hours weekly in a general mission capacity that is not specific to his MOS/Rate outside of classified facilities at this time.

d. Submit Performance Evaluations/Fitness Reports (or Proficiency & Conduct Marks) for the two years immediately prior to the date the MEB was initiated.

14NOV16-15NOV15-Promotable, 15NOV16-16SEP01-Early Promote, 16SEP02-16NOV15-Non-observed, 16NOV16-17JUL20-Significant Problems.

e. Submit any pertinent information in reference to line of duty determinations and investigations that affect the member's unfitting condition(s).

Upon receipt of CTN2 Anderson's LIMDU paperwork and July 2017 NJP, assigned Special Security Officer (SSO) recommended and I endorsed service member's TS/SCI classified access and classified facility access badge be suspended, Security Access Eligibility Report (SAER) released, and process initiated for DoD Clearance Adjudication Facility (CAF) to determine if he should maintain a clearance. Final outcome of this decision is pending.

4. CONTACT INFO. For follow-on questions concerning this NMA, the POC at this command is Herbert M. Lamb, CTNCM, Command Senior Enlisted Leader, Cyber Strike Activity SIXTY THREE; (Commercial) 443-479-6065; hmlamb@cybercom.mil (email).


D. B. YUSKO

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 7/13/17 Patient Name: Daniel Dennis Merwin

Patient SSN: [REDACTED]

Proposed start date for limited duty: 7/13/17

Proposed end date (≤ 6 months): 12/13/2017

This period of limited duty is for: (Select one)

- ☒ 1st LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary).
- ☐ 2nd LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.
- ☐ 1st LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).
- ☐ 2nd LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).
- ☐ 3rd or subsequent LIMDU periods on Navy and Marine ADSM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").
- ☒ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) IBS - D/P

ICD-9 CM Code K58.0

(2) GAD

ICD-9 CM Code 296.32

(3) MOD recurrent mod

ICD-9 CM Code

Circumstances of injury/illness:

The pt is a 32 y.o male who has anxiety, depression and comorbid medical conditions that have significantly negatively impacted his ability to function at home work & in his social environment.

Treatment plan:

The GI confirmed IBS-D is of such severity that it daily interferes with military ADUs.

Pt returned to IOP (mental health R+) he is on multiple bowel

Limitations from full duty (including whether transfer/TEMU for treatment is indicated, and any PRT limitations):

1) Access to all med appointments / no PT
2) ensure opportunity for 8 consecutive hrs sleep / 24h he has close proximity to ARR at all times
3) no access to weapons 4) no PCS / deploy / or he to ARR at all times

MARTIN A. LINKER MD

Printed MEB Member Name and Signature/Date

Printed MEB Member Name and Signature/Date

LARRY GRUBB

Printed CA Name and Signature/Date

2/8/17

SECTION 2: PATIENT INFORMATION, TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

Daniel Merwin

Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- ☒ Completion of Patient Information Sheet
- ☒ Notification to PSD/Personnel Office
- ☐ LODD Requested from Parent Command (if LODD required)
- ☐ Entry into MedBOLFF

☒ Briefing to Patient on Limited Duty/MEBs☒ Notification to MTF LIMDU Coordinator☒ Notification to Parent Command

Patient Administration Officer/Medical Boards Official Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEBR Case File, and PERS-4821 or MMSR-4

NAVMED 6100/5 (Rev. 08-2004)
PREVIOUS EDITIONS OBSOLETE

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

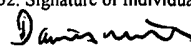
RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 16SEP01	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 16SEP02 15. To: 16NOV15						
16. Not Observed Report <input checked="" type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness P			21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title DIR HEAD		26. UIC 62936	
									27. SSN [REDACTED]	
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DNEA DIGITAL NETWORK EXPLOITATION ANALYST-2. Provides digital network analysis and target development in support of USCYBERCOM and Cyber National Mission Force (CNMF) operations. PFA: 16-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>Daniel Merwin</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input checked="" type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input checked="" type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input checked="" type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input checked="" type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input checked="" type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)


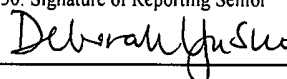
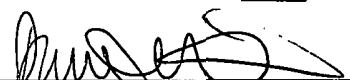
RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards			
38. TEAMWORK: Contributions to team building and team results. NOB <input checked="" type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	<input type="checkbox"/>	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		<input type="checkbox"/>	-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.			
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input checked="" type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	<input type="checkbox"/>	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		<input type="checkbox"/>	-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.			
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 0.00		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific)			42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. TRAYLOR, M R, CTNC (IW/EXW) Date: 12 Dec 16				
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Member on board less than 90 days.									
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.									
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input type="checkbox"/>		
45. INDIVIDUAL	X						48. Reporting Senior Address COMMANDING OFFICER NAVIJCOM MARYLAND FT MEADE, MD 20755-5290		
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	0	0			
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. WORDEN, B P, LCDR Date: 9 Dec 16					50. Signature of Reporting Senior Dee yue Summary Group Average: 0.00 Date: 28 Nov 16				
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> Date: 29 Dec 16					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:				

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 13JUL22		
Occasion for Report 10. Periodic <input type="checkbox"/> 11. Detachment of Individual <input checked="" type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 15NOV16 15. To: 16SEP01							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>			20. Physical Readiness P		21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title DIR HEAD		26. UIC 62936		
							27. SSN [REDACTED]				
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) CYBER ANALYST CYBER INTELLIGENCE ANALYST-11. Responsible for conducting research, analysis and multi-organization collaboration in support of USCYBERCOM. COLL: ASSISTANT DEPARTMENT DAPA-5. PFA: 16-1.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 15MAY16		31. Counselor KELLY, A J			32. Signature of Individual Counseled 		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>		- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.		<input type="checkbox"/>		- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.		<input type="checkbox"/>		- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>		- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.		<input type="checkbox"/>		- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.		<input type="checkbox"/>		- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>		- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.		<input type="checkbox"/>		- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.		<input checked="" type="checkbox"/>		- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>		- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.		<input type="checkbox"/>		- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.		<input checked="" type="checkbox"/>		- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>		- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.		<input type="checkbox"/>		- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.		<input type="checkbox"/>		- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	-	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		-	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.	
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	-	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		-	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.43		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) LPO SPECIAL PROGRAMS		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  Date: 01SEP16 SACZYNSKI, C T, CTCR (IW/EXW)			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Submitted upon transfer to 02 National Mission Team. Executing a local UIC swap. - Deckplate leader. Led seven joint-service analysts in the review of 4,000 technical documents which produced 180 intelligence reports. Production resulted in the creation of 25 tailored defensive cyber options for USCYBERCOM's Cyber Protection Teams (CPT). - Outstanding Sailor. Dedicated over 300 hours to the establishment of USCYBERCOM's operational planning team in support of multiple CPTs. Collaborated with multiple National Security Agency offices and Joint organizations to create over 25 Defensive Cyber Operations options for USCYBERCOM's J3, leading to seven TASKORDs directing CPT operations. - Subject matter expert. Developed procedures to respond to 347 requests for information. Efforts led to the review of 57,000 documents and identified 25 critical information gaps. - Devoted mentor. Provided 40 hours of computer network exploitation training to nine joint-service cyber analysts. Qualified 7 of 9 personnel, resulting in an 80 percent increase in qualified analysts. - Command impact. Dedicated 40 hours of training to 260 Sailors on the Command's drug and alcohol program. Additionally provided Chart the Course training to 84 Sailors within his department meeting fleet standards ahead of required deadline. Highly recommended for advancement to Chief Petty Officer.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: AREA1120.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL						X	48. Reporting Senior Address COMMANDING OFFICER NAVICOM MARYLAND FT MEADE, MD 20755-5290
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	0	1	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. UNAVAILABLE CUMMINGS, B D, LCDR Date:				50. Signature of Reporting Senior  Date: 01SEP16 Summary Group Average: 3.43			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 01SEP16				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			


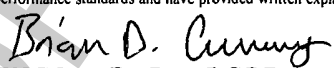
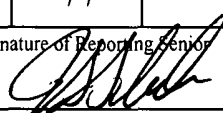
EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 13JUL22	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 14NOV16 15. To: 15NOV15						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness PP			21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) SCHEIDT, J S			23. Grade CAPT		24. Desig 1810		25. Title CO		26. UIC 62936	
									27. SSN [REDACTED]	
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DNEA Digital Network Exploitation Analyst-5; Exploitation Analyst(EA)-7. COLL: Asst Dept DAPA-4. WATCH: OOD-12. Performs global network analysis, target development, and network topology mapping. TEMDUINS: 15MAR25-15APR22. PFA: 15-1/15-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 15MAY15		31. Counselor LEITNER, R C		32. Signature of Individual Counseled		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D			2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]				
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>		-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.		-		-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		-		-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.		-		-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		-		-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.43		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) LPO SPECIAL PROGRAMS				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  Date: 8 JAN 16 LEITNER, R C, CTNC (IDW)					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Talented FCPO performing at an advanced technical level. - Mission focused. Led more than 20 hours of interactive operations, conducted over 40 hours of analysis; efforts resulted in expanded capabilities and acquisition of critical intelligence in support of Cyber National Mission Force(CNMF) and national priorities. - Technical expert. Devoted over 80 hours to on-the-job training; qualified two weeks ahead of schedule as a Digital Network Exploitation Analyst and database auditor. Efforts led to greater impact in target development and increased mission capability by 15%. - Dedicated mentor. Provided 26 hours of mentorship for two junior Sailors on Navy career progression, short and long-term goals, and benefits of special programs. - Command involved. Facilitated 20 hours of training on identification of alcohol and substance abuse problems and available assistance programs to 100 Sailors leading to increased substance abuse knowledge and command DAPA program awareness. - Selfless volunteer. Dedicated 56 off-duty hours to organizing and personally transporting two junior Sailors to Alcoholic Anonymous(AA) meetings; ensured 100% AA meeting attendance for 28 sessions. Reclassified to DNEA work-role; failed to meet EA work-role qualification requirements. Recommended for advancement.											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: Introduction to Python; CPO 365 Phase I PQS. QUALIFIED: DNEA.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>				
45. INDIVIDUAL				X			48. Reporting Senior Address COMMANDING OFFICER NAVICOM MARYLAND FT MEADE, MD 20755-5290				
46. SUMMARY	<input checked="" type="checkbox"/>	3	0	188	149	77					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  Date: 7 Jan 2016 CUMMINGS, B D, LCDR						50. Signature of Reporting Senior  Summary Group Average: 3.51 Date: 12/14/2015					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input type="checkbox"/> CERTIFIED COPY PROVIDED Date:						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1

WASHINGTON.VA.GOV

** FINAL **

Processing time: 54

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED]

C-Number: [REDACTED]

DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:

GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]

Bus Phone:

Entered active service: NOV 1,2005

Last rating exam date:

Released active service: Not specified

Priority of exam: Unknown

Examining provider: 4319

Examined on: SEP 25,2017@08:00

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY

STANDARD TITLE: C & P EXAMINATION NOTE

DATE OF NOTE: SEP 25, 2017@08:00

ENTRY DATE: SEP 25, 2017@08:55:52

AUTHOR: REDMAN,ROBERT S

EXP COSIGNER:

INSTITUTION: WASHINGTON VA MEDICAL CENTER

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

Dental and Oral Conditions
including Mouth, Lips and Tongue
(other than Temporomandibular Disorder Conditions)
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

Acceptable Clinical Evidence (ACE)

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

Evidence Review

Evidence reviewed (check all that apply):

☒ VA e-folder (VBMS or Virtual VA)

☒ Other (please identify other evidence reviewed):

The C-File was reviewed via VBMS. Dental records show the the pt. underwent orthodontic treatment 2015-2017 in conjunction with a LeForte single piece advancement of the maxilla 04/27/2017, with early residual of V2 hypoesthesia.

SECTION I: Diagnoses

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an oral or dental condition? (This is the condition the Veteran is claiming or for which an exam has been requested)

☒ Yes ☐ No

☒ Other, specify:

Other diagnosis #1: Disturbance in sensation ,part of V2, residual oif orthognathic surgery
ICD code: R20.8
Date of diagnosis: 09/25/2017

SECTION II: Medical/Dental History

Describe the history (including onset and course) of the Veteran's oral and/or dental condition:

DENTAL C&P EXAMINATION

Form 21-2507 lists "Dental condition--S/P surgery in mouth and jaw" as the item for C&P Dental evaluation.

SUBJECTIVE:

CC: Pt. has had a Class III malocclusion corrected vua orthodontic treatemnt and orthognathic surgery, the latter in April, 2017. His upper front gingiva and was, but no longer is, numb. Part of the face bilaterally is numb, and a small part of the upper front gingiva is swollen, but these

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

problems are much improved and still slowly improving. He reports that he is gradually getting used to the new position of his front teeth.

SECTION III: Dental and Oral Conditions

Does the Veteran have any of the following dental or oral conditions?

☒ Yes ☐ No

☒ Other dental or oral conditions, pertinent physical findings or scars due to dental or oral conditions

1. Mandible, including anatomical loss or bony injury (NOT due to edentulous atrophy or periodontal disease)

Not Applicable

2. Maxilla, including anatomical loss or bony injury (NOT due to edentulous atrophy or periodontal disease)

Not Applicable

3. Teeth, including anatomical loss or bony injury leading to loss of any teeth (other than that due to the loss of the alveolar process as a result of periodontal disease)

Not Applicable

4. Mouth, lips, tongue and disfiguring scars to the mouth or lips (anatomical loss or injury)

Not Applicable

5. Osteomyelitis/osteoradionecrosis/osteonecrosis of the jaw

Not Applicable

6. Tumors and neoplasms

Not Applicable

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

7. Other pertinent physical findings, complications, conditions, signs, symptoms and scars
-

- a. Does the veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the diagnosis section above?

☒ Yes ☐ No

If yes, describe (brief summary):

Occlusion is WNL. Interdental papilla #8 and 9 is slightly swollen and erythematous but not sensitive or painful. Teeth # 5 through 12 have normal sensation. Portions of the facial skin over # 5 and 12 are numb to the touch. This is further addressed under DBQ Neuro Cranial Nerves.

- b. Does the veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?

☐ Yes ☒ No

- c. Comments, if any:

No response provided.

SECTION IV: Diagnostic Testing

- a. Have imaging studies or procedures been performed?

☒ Yes ☐ No

☒ Panoraphic / intraoral imaging to demonstrate loss of teeth, mandible or maxilla

Date: 09/25/2017

Results:

Four L-shaped plates are attached to the anterior maxilla via screws, two each on the left and right, and two pins also are noted in the maxilla, one each on the left and right. The TMJs are WNL. Teeth # 1, 16, 17, and 32 are missing, and tooth # 12 is S/P RCT, no residual periapical radiolucency.

SECTION V: Functional Impact

1. Functional Impact
-

Continued on next page
VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

Does the Veteran's oral or dental condition impact his or her ability to work?

[] Yes [X] No

2. Remarks (If any):

No remarks provided.

Questions for Historical Rating Criteria

=====

Is the Veteran's date of claim or date of intent to file, if applicable, on or prior to September 9, 2017?

[X] Yes [] No

If yes, please answer the additional questions below.

Historical 1a. Has the Veteran lost any part of the mandible to include the ramus (not due to edentulous atrophy or periodontal disease)?

[] Yes [X] No

If yes, indicate severity (check all that apply):

No response provided.

Historical 1d. Has the Veteran had an injury resulting in malunion or nonunion of the mandible?

[] Yes [X] No

If yes, indicate severity:

No response provided.

Historical 2e. Has the Veteran had an injury resulting in malunion or nonunion of the maxilla?

[] Yes [X] No

If yes, indicate severity:

No response provided.

Continued on next page

VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ DENTAL Dental & oral (other than TMJ) Exam
=====

Exam Results Continued

Cranial Nerve Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)

[X] Other (please identify other evidence reviewed):

The C-File was reviewed via VBMS. Dental records show the the pt. underwent orthodontic treatment 2015-2017 in conjunction with a LeFort single piece advancement of the maxilla 04/27/2017, with early residual of V2 hypoesthesia.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a cranial nerve condition? (This is the condition the Veteran is claiming or for which an exam has been requested)

[X] Yes [] No

Diagnosis #1: Disturbance in Sensation, Cranial Nerve V2, bilaterally, residual of orthognathic surgery

ICD code: R20.8

Date of diagnosis: 09/25/2017

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

2. Medical History

- a. Describe the history (including etiology, onset and course) of the Veteran's cranial nerve condition (brief summary):
DENTAL C&P EXAMINATION

Form 21-2507 lists "Dental condition--S/P surgery in mouth and jaw" as the item for C&P Dental evaluation.

SUBJECTIVE:

CC: Pt. has had a Class III malocclusion corrected via orthodontic treatment and orthognathic surgery, the latter in April, 2017. His upper front gingiva and was, but no longer is, numb. Part of the face bilaterally is numb, and a small part of the upper front gingiva is swollen, but these problems are much improved and still slowly improving.

- b. Indicate the cranial nerves affected by the Veteran's condition (check all that apply):
☒ Cranial nerve V (trigeminal)

3. Findings, signs and symptoms

Does the Veteran have findings, signs or symptoms attributable to any conditions affecting cranial nerves V, VII, and/or IX-XII?

☒ Yes ☐ No

☒ Numbness

Mid face

Right: ☒ Mild ☐ Moderate ☐ Severe

Left: ☒ Mild ☐ Moderate ☐ Severe

For all checked findings, signs or symptoms, indicate cranial nerve involved:
V2

4. Muscle strength testing

No response provided.

5. Sensory exam

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

Mid face:

Right: ☐ Normal ☒ Decreased ☐ AbsentLeft: ☐ Normal ☒ Decreased ☐ Absent

6. Cranial nerve summary evaluation

[X] Cranial nerve V (trigeminal):

Right:

☐ Not affected☒ Incomplete, moderate☐ Incomplete, severe☐ Complete

Left:

☐ Not affected☒ Incomplete, moderate☐ Incomplete, severe☐ Complete

7. Other pertinent physical findings, scars, complications, conditions, signs, symptoms and scars

No response provided.

8. Diagnostic testing

- a. Have imaging or other diagnostic studies been performed and are the results available?

[X] Yes ☐ No

If yes, provide type of study, date and results:

Panoramic dental radiograph 09/25/2017 shows plates, screws and pins in the anterior maxilla consistent with s/p maxillary advancement surgery and resulting areas of V2 numbness.

- b. Are there any other significant diagnostic test findings and/or results?

[X] Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary):

Brushing with a wooden tongue depressor reveals complete numbness of the surface of the skin in an oval area 2.0 x 1.0 cm of the left and right face over teeth # 5-6 and 11-12. The gingiva, lip, labial and buccal mucosae, and teeth have normal sensation. His inter-incisal ROM is 42 mm vertically and 20 mm laterally (i.e., WNL) and painless.

Continued on next page
VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ DENTAL Dental & oral (other than TMJ) Exam
=====

Exam Results Continued

9. Functional impact

Does the Veteran's cranial nerve condition impact his or her ability to work?
☐ Yes ☒ No

10. Remarks, if any:

Further improvement of the loss of sensation might well occur.

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Subspecialty - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Name of patient/Service member and FULL SSN:

Anderson, Daniel Dennis; [REDACTED]

Was a DD Form 2807-1, Report of Medical History, completed by the Service member and available for review at the time of this examination?
☐ Yes ☐ No ☒ N/A

Any changes to his/her health status since DD 2807-1 completed?
☐ Yes ☐ No ☒ N/A

(Proposed) Date of separation from active service: 09/24/2018.

Continued on next page
VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ DENTAL Dental & oral (other than TMJ) Exam

Exam Results Continued

1. Medical record review

Was the Veteran's VA claims file reviewed?.

[] Yes [] No

The C-File was reviewed via VBMS. Dental records show the the pt. underwent orthodontic treatment 2015-2017 in conjunction with a LeForte single piece advancement of the maxilla 04/27/2017, with early residual of V2 hypoesthesia.

2. Medical history (Review of Systems): For each claimed condition you are addressing, please provide the following:

#1. Claimed Condition as per 2507: "Dental condition--S/P surgery in mouth and jaw"

Onset: 04/2017

Diagnosis: Disturbance in sensation, V2

Rationale: Per his report and my tests, supported by findings with a dental panograph.

Prognosis: Improvement might well continue.

6. Remarks, if any:

All additional DBQs found to be necessary completed as appropriate at time of signing this DBQ?

[x] Yes [] No

/es/ ROBERT S. REDMAN

DDS, ORAL PATHOLOGIST

Signed: 09/25/2017 08:55

This exam has been reviewed and approved by the examining provider.

VA Form 2507

AR 1317

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1

WASHINGTON.VA.GOV

** FINAL **

Processing time: 54
For DBQ Medical SHA Exam

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED]

C-Number: [REDACTED]

DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:

GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]

Bus Phone:

Entered active service: NOV 1,2005 Last rating exam date:

Released active service: Not specified

Priority of exam: Unknown

Examining provider: 776087

Examined on: SEP 29,2017@16:15

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY

STANDARD TITLE: C & P EXAMINATION NOTE

DATE OF NOTE: SEP 29, 2017@16:15 ENTRY DATE: OCT 19, 2017@14:27:06

AUTHOR: ARORA,MANISH S EXP COSIGNER:

INSTITUTION: WASHINGTON VA MEDICAL CENTER

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

General Medical - Separation Health Assessment

Disability Benefits Questionnaire

* Internal VA or DoD Use Only*

Name of claimant/ Servicemember: ANDERSON,DANIEL DENNIS

SSN: [REDACTED]

Diagnosis Summary

NOTE: Neuro exams/reports pending

CLAIMED CONDITION: generalized anxiety disorder

DIAGNOSIS: Generalized Anxiety Disorder (per psych C&P)

CLAIMED CONDITION: major depressive disorder, recurrent, moderate

DIAGNOSIS: Major Depressive Disorder, Recurrent, Moderate (per psych C&P)

CLAIMED CONDITION: mental health condition to include schizoid effect, sleep

Continued on next page

VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

disturbance to include insomnia
DIAGNOSIS: No diagnosis (per psych C&P)

CLAIMED CONDITION: skin condition to include scrotal cyst,
DIAGNOSIS: epidermal cyst of the scrotum (per derm C&P)

CLAIMED CONDITION: scarring from MRSA back of neck and top of head
DIAGNOSIS: a) left neck - folliculitis, inactive, no residual scar; b) scalp
- please refer to hair loss below (per derm C&P)

CLAIMED CONDITION: hair loss
DIAGNOSIS: scarring alopecia - folliculitis decalvans (per derm C&P)

CLAIMED CONDITION: sleep paralysis (sleep study dates 10/02/2017)
DIAGNOSIS: see neuro C&P

CLAIMED CONDITION: headaches /migraines
DIAGNOSIS: see neuro C&P

CLAIMED CONDITION: dry eye syndrome
DIAGNOSIS: Dry eye syndrome (per ophthal C&P)

CLAIMED CONDITION: dental condition s/p surgery in mouth and jaw
DIAGNOSIS: Disturbance in sensation, V2 (per dental C&P)

CLAIMED CONDITION: ankle condition left
DIAGNOSIS: Left ankle sprain resolved with no residual (per podiatry C&P)

CLAIMED CONDITION: ingrown toe nail left foot
DIAGNOSIS: Paronychia left hallux (per podiatry C&P)

CLAIMED CONDITION: wrist condition bilateral
DIAGNOSIS: (1) R. wrist tendinitis (2) No pathology found, L. wrist

CLAIMED CONDITION: hand condition right hand knuckle condition
DIAGNOSIS: R. hand 5th proximal phalanx, well healed without residual (no
active pathology found)

CLAIMED CONDITION: IBS d/p
DIAGNOSIS: IBS

CLAIMED CONDITION: hemorrhoids, anal fissures, anus spasms
DIAGNOSIS: (1) hemorrhoids (2) no pathology found, anal fissure (3) anal
spasms work up ongoing, no pathology found for now

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

CLAIMED CONDITION: GERD
DIAGNOSIS: GERD

CLAIMED CONDITION: allergic to cats
DIAGNOSIS: allergic rhinitis

CLAIMED CONDITION: asthma
DIAGNOSIS: no pathology found, work up incomplete

List of Symptomatic Systems:

- b. Nose:
- f. Eyes:
- h. Lungs and Chest:
- j. Vascular (Varicosities, hypertension, etc.):
- k. Anus and Rectum (Hemorrhoids, Fistulae, Prostate):
- l. Abdomen and Viscera (include hernia):
- m. Genitourinary:
- n. Upper Extremities:
- p. Feet:
- q. Spine:
- r. Miscellaneous musculoskeletal conditions:
 - Fracture(s)
- s. Identifying body marks, scars, tattoos:
- t. Skin, Lymphatic:
- u. Neurologic:
- v. Psychiatric:

List of Abnormal Findings:

- 2. Identifying body marks, scars, tattoos
- 3. Skin
- 7. Dental defects and disease
- 8. Eyes - General (Visual acuity and refraction to be completed on Eye DBQ if appropriate)
- 9. Ophthalmoscopic
- 10. Pupils (Equality and reaction)
- 11. Ocular motility (Associated parallel movements, nystagmus)
- 22. Feet (other than arch)
- 23. Feet (arch) (X-rays are not required to evaluate arch)
- 24. Spine and other musculoskeletal conditions (including ribs, clavicle, etc.)
- 26. Neurologic

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

27. Psychiatric (Specify any personality deviation)

Was a DD Form 2807-1, Report of Medical History, completed by the
Servicemember and available for review at the time of this examination?
☐ Yes ☒ No ☐ N/A

Any changes to his/her health status since DD 2807-1 completed?
☐ Yes ☒ No ☐ N/A

(Proposed) Date of separation from active service: n/a

1. Evidence Review

Evidence reviewed (check all that apply):

☒ Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

2. Medical history (Review of Systems)

a. Head, face, neck and scalp:
☐ Yes ☒ No

b. Nose:
☒ Yes ☐ No

If Yes:
allergic rhinitis, triggered by cats

c. Sinuses:
☐ Yes ☒ No

d. Mouth and Throat:
☐ Yes ☒ No

e. Ears:
☐ Yes ☒ No

f. Eyes:

Continued on next page
VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

☒ Yes ☐ No

If Yes:

See C&P subspecialty exam / DBQ

g. Heart:

☐ Yes ☒ No

h. Lungs and Chest:

☒ Yes ☐ No

If Yes:

shortness of breath w/ exposure to cats

i. Breasts:

☐ Yes ☒ No

j. Vascular (Varicosities, hypertension, etc.):

☒ Yes ☐ No

If Yes:

"It's been fluctuating between high and low"

k. Anus and Rectum (Hemorrhoids, Fistulae, Prostate):

☒ Yes ☐ No

If Yes:

rectal spasms and fecal leakage 2/2 IBS. work up ongoing

l. Abdomen and Viscera (include hernia):

☒ Yes ☐ No

If Yes:

diarrhea predominant IBS
GERD, mild

m. Genitourinary:

☒ Yes ☐ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

If Yes:
genital warts and cysts

n. Upper Extremities:
☒ Yes ☐ No

If Yes:
Dorsal R. wrist pain w/ using mouse and keyboard x 2 years

o. Lower Extremities:
☐ Yes ☒ No

p. Feet:
☒ Yes ☐ No

If Yes:
See C&P subspecialty exam / DBQ

q. Spine:
☒ Yes ☐ No

If Yes:
See C&P subspecialty exam / DBQ

r. Miscellaneous musculoskeletal conditions:
☒ Yes ☐ No

☒ Fracture(s)
Traumatic fracture R. 5th proximal phalanx in 2008

s. Identifying body marks, scars, tattoos:
☒ Yes ☐ No

If Yes:
See C&P subspecialty exam / DBQ

t. Skin, Lymphatic:
☒ Yes ☐ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

If Yes:
See C&P subspecialty exam / DBQ

u. Neurologic:
☒ Yes ☐ No

If Yes:
See C&P subspecialty exam / DBQ

v. Psychiatric:
☒ Yes ☐ No

If Yes:
See C&P subspecialty exam / DBQ

w. Gynecologic: (excluding breasts)
☐ Yes ☒ No

x. Endocrine:
☐ Yes ☒ No

y. Infectious disease, immune disorder or nutritional deficiency:
☐ Yes ☒ No

z. Miscellaneous conditions:
☐ Yes ☒ No

3. Physical Exam

a. Dominant hand
☒ Right ☐ Left ☐ Ambidextrous

b. Vital signs and Labs
Blood pressure #1: 136/90

Blood pressure #2: 134/85

Blood pressure #3: 141/85

Pulse: 77

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

Respiratory rate: 12

Height: 69"

Weight: 160 lbs

c. Visual Acuity:

Near:

Right Eye Corrected 20/See C&P subspecialty exam / DBQ

1. Head, face, neck and scalp

☒ Normal ☐ Abnormal ☐ Not examined

2. Identifying body marks, scars, tattoos

☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:

See C&P subspecialty exam / DBQ

3. Skin

☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:

See C&P subspecialty exam / DBQ

4. Nose

☒ Normal ☐ Abnormal ☐ Not examined

5. Sinuses

☒ Normal ☐ Abnormal ☐ Not examined

6. Mouth and throat

☒ Normal ☐ Abnormal ☐ Not examined

7. Dental defects and disease

☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:

See C&P subspecialty exam / DBQ

Continued on next page
VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

8. Eyes - General (Visual acuity and refraction to be completed on Eye DBQ if appropriate)
☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:
See C&P subspecialty exam / DBQ

9. Ophthalmoscopic
☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:
See C&P subspecialty exam / DBQ

10. Pupils (Equality and reaction)
☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:
See C&P subspecialty exam / DBQ

11. Ocular motility (Associated parallel movements, nystagmus)
☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:
See C&P subspecialty exam / DBQ

12. Ears - External ear and canal
☒ Normal ☐ Abnormal ☐ Not examined

13. Tympanic membranes (Perforation)
☒ Normal ☐ Abnormal ☐ Not examined

14. Heart (Thrust, size, rhythm, sounds)
☒ Normal ☐ Abnormal ☐ Not examined

15. Lungs and chest (Include breasts)
☒ Normal ☐ Abnormal ☐ Not examined

16. Vascular system (Varicosities, etc.)
☒ Normal ☐ Abnormal ☐ Not examined

Continued on next page
VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

17. Abdomen and viscera (Include hernia)
[X] Normal [] Abnormal [] Not examined
18. Anus and rectum (Hemorrhoids, fistulae, prostate if indicated)
[X] Normal [] Abnormal [] Not examined
19. Genitourinary (Male and female)
[] Normal [] Abnormal [X] Not examined
20. Upper extremities
[X] Normal [] Abnormal [] Not examined
21. Lower extremities (Except feet)
[X] Normal [] Abnormal [] Not examined
22. Feet (other than arch)
[] Normal [X] Abnormal [] Not examined
- If abnormal:
See C&P subspecialty exam / DBQ
23. Feet (arch) (X-rays are not required to evaluate arch)
[] Normal [X] Abnormal [] Not examined
- If abnormal:
See C&P subspecialty exam / DBQ
24. Spine and other musculoskeletal conditions (including ribs, clavicle, etc.)
[] Normal [X] Abnormal [] Not examined
- If abnormal:
See C&P subspecialty exam / DBQ
25. Lymphatic
[X] Normal [] Abnormal [] Not examined
26. Neurologic
[] Normal [X] Abnormal [] Not examined
- If abnormal:

Continued on next page
VA Form 2507

C&P Final Report

Page: 11

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

See C&P subspecialty exam / DBQ

27. Psychiatric (Specify any personality deviation)
☐ Normal ☒ Abnormal ☐ Not examined

If abnormal:

See C&P subspecialty exam / DBQ

28. Pelvic and external genitalia (Females only)
☐ Normal ☐ Abnormal ☒ Not examined

29. Breast
☐ Normal ☐ Abnormal ☒ Not examined

30. Endocrine
☒ Normal ☐ Abnormal ☐ Not examined

31. Other, describe:
 No response provided.

32. Air Conduction Threshold Audiogram
 Has an audiogram been completed in the last 30 days?
☒ Yes ☐ No

If yes, provide date: 10/5/17

RIGHT EAR								
A	B	C	D	E	F	G		
500	1000	2000	3000	4000	6000	8000	Avg Hz	
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **	

LEFT EAR								
A	B	C	D	E	F	G		
500	1000	2000	3000	4000	6000	8000	Avg Hz	
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **	

Continued on next page
VA Form 2507

C&P Final Report

Page: 12

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

```

|=====+=====+=====+=====+=====+=====+=====+=====+
|         |         |         |         |         |         |         |
+=====+=====+=====+=====+=====+=====+=====+=====+

```

May paste results of audiogram here if more convenient
 see remarks, below

33. Tinnitus:

Are you bothered by noises in your head or ears such as ringing, roaring,
 buzzing, crickets, or a humming tone?

[] Yes [X] No

4. Lab Studies:

No response provided.

5. Diagnosis:

[X] Diagnosis/diagnoses are listed on additional DBQs (This is just a
 reminder to please fill out the DBQs as needed for VA rating purposes)

Comments, if any:

No comments provided.

6. Remarks, if any:

NOTE: Neuro exams/reports pending

LOCAL TITLE: COMPENSATION ASSESSMENT COPY

STANDARD TITLE: C & P EXAMINATION NOTE

DATE OF NOTE: SEP 10, 2017@09:30

ENTRY DATE: SEP 18, 2017@14:18:19

AUTHOR: THAI, MINHTAM

EXP COSIGNER:

URGENCY:

STATUS: COMPLETED

Miscellaneous
 Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis [REDACTED]

Continued on next page
 VA Form 2507

C&P Final Report

Page: 13

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Subspecialty - Separation Health Assessment
 Disability Benefits Questionnaire
 * Internal VA or DoD Use Only*

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?

☐ Yes ☐ No ☐ N/A

Any changes to his/her health status since DD 2807-1 completed?

☐ Yes ☐ No ☐ N/A

(Proposed) Date of separation from active service:

1. Medical record review

Was the Veteran's VA claims file reviewed?

☒ Yes ☐ No

2. Medical claims: For each claimed condition you are Addressing as per 2507, please provide the following:

#1. Claimed Condition: ankle condition left.

Onset: 2013 and 2014

Diagnosis: Left ankle sprain resolved with no residual.

Rationale: history, xrays, MRI, exam.

Prognosis: good.

#2. Claimed Condition: ingrown toe nail left foot.

Onset: unknown.

Diagnosis: Paronychia left hallux.

Rationale: history, exam.

Prognosis: stable.

***Veteran was strongly recommended to follow up with PCM for treatment/referral for this condition.

Continued on next page
 VA Form 2507

C&P Final Report

Page: 14

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Miscellaneous

Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Subspecialty - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Name of patient/Service member and FULL SSN:

Anderson, Daniel Dennis; [REDACTED]

Was a DD Form 2807-1, Report of Medical History, completed by the Service member and available for review at the time of this examination?

[] Yes [] No [X] N/A

Any changes to his/her health status since DD 2807-1 completed?
[] Yes [] No [X] N/A

(Proposed) Date of separation from active service: 09/24/2018.

1. Medical record review

Was the Veteran's VA claims file reviewed?.
[] Yes [] No

The C-File was reviewed via VBMS. Dental records show the the pt. underwent orthodontic treatment 2015-2017 in conjunction with a LeForte single piece advancement of the maxilla 04/27/2017, with early residual of V2

Continued on next page
VA Form 2507

C&P Final Report

Page: 15

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

hypoesthesia.

2. Medical history (Review of Systems): For each claimed condition you

are addressing, please provide the following:

#1. Claimed Condition as per 2507: "Dental condition--S/P surgery in mouth

and jaw"

Onset: 04/2017

Diagnosis: Disturbance in sensation, V2

Rationale: Per his report and my tests, supported by findings with a dental panograph.

Prognosis: Improvement might well continue.

6. Remarks, if any:

All additional DBQs found to be necessary completed as appropriate at time

of signing this DBQ?

[x] Yes [] No

/es/ ROBERT S. REDMAN
DDS, ORAL PATHOLOGIST
Signed: 09/25/2017 08:55

Addendum / Clarification
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis; c-file: [REDACTED] [REDACTED]

Please utilize this form when responding to VBA requests for either addendums

Continued on next page
VA Form 2507

C&P Final Report

Page: 16

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

or clarifications of prior VHA examination reports.

Mental health - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?

☐ Yes ☒ No ☐ N/A

Any changes to his/her health status since DD 2807-1 completed?

☐ Yes ☐ No ☒ N/A

(Proposed) Date of separation from active service: No response provided.

1. Medical record review

Was the Veteran's VA claims file reviewed?

☒ Yes ☐ No

2. Medical history (Review of Systems)

1. Psychiatric:

☒ Yes ☐ No

#1. Claimed Condition: Generalized Anxiety Disorder

Onset: unknown

History: chronic

Prognosis: uncertain

#2. Claimed Condition: Major Depressive Disorder, Recurrent, Moderate

Onset: unknown

History: recurrent

Prognosis: uncertain

Continued on next page
VA Form 2507

AR 1333

C&P Final Report

Page: 17

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

#3. Claimed Condition: Mental Health Condition to Include Schizoid Effect,
Sleep Disturbances to Include Insomnia
Onset: n/a
History:
Prognosis:

#4. Claimed Condition: Sleep Paralysis
Onset: n/a
History:
Prognosis:

(Please follow format if more claims are being addressed)

PTSD SCREEN PC-PTSD

In your life, have you ever had any experience that was so
frightening, horrible, or upsetting that, in the past month,
you:

1. Have had nightmares about it or thought about it when you
did
not want to?
[] Yes [X] No
2. Tried hard not to think about it or went out of your way
to
avoid situations that reminded you of it?
[] Yes [X] No
3. Were constantly on guard, watchful, or easily startled?
[] Yes [X] No
4. Felt numb or detached from others, activities, or your
surroundings?
[] Yes [X] No

Depression screen: PHQ2

Over the past two weeks, how often have you been bothered by
any
of the following problems?

Continued on next page
VA Form 2507

C&P Final Report

Page: 18

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Little interest or pleasure in doing things.
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than
half the days ☒ 3 = Nearly every day

Feeling down, depressed, or hopeless.
☐ 0 = Not at all ☐ 1 = Several days ☒ 2 = More than
half the days ☐ 3 = Nearly every day

Total Point Score: 5

Brief Suicide Risk Assessment

- (Perform if score positive on Depression or PTSD screens)

Are you feeling hopeless about the present or future?
☒ Yes ☐ No

Have you had thoughts about taking your life - if yes - when
did you have these thoughts and do you have a plan to take
your

life?
☒ Yes ☐ No - no current suicidal plan or intent was
reported

Have you ever had a suicide attempt?
☒ Yes ☐ No

3. Physical Exam

1. Psychiatric (Specify any personality deviation)
☒ Normal ☐ Abnormal ☐ Not examined

5. Diagnosis:

#1. Claimed condition: Generalized Anxiety Disorder
Diagnosis/Rationale: Generalized Anxiety Disorder - the
service

Continued on next page
VA Form 2507

C&P Final Report

Page: 19

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

member meets full DSM-5 criteria for this diagnosis

Moderate #2. Claimed condition: Major Depressive Disorder, Recurrent,
Moderate - Diagnosis/Rationale: Major Depressive Disorder, Recurrent,
the service member meets full DSM-5 criteria for this diagnosis

Schizoid #3. Claimed condition: Mental Health Condition to Include
Effect, Sleep Disturbances to Include Insomnia
Health Diagnosis/Rationale: No diagnosos - symptoms of a Mental
Condition to Include Schizoid Effect, Sleep Disturbances to Include
Insomnia
can be considered part of the Major Depressive Disorder and Generalized
Anxiety Disorder and do not warrant a separate diagnosis

#4. Claimed condition: Sleep Paralysis
Diagnosis/Rationale: No diagnosis - symptoms of Sleep
Paralysis can
be considered part of the Generalized Anxiety Disorder and do not warrant
a
separate diagnosis

(for additional Claim/diagnosis, please follow above format)

6. Remarks, if any:

All additional DBQs found to be necessary completed as appropriate at
time
of signing this DBQ?
[X] Yes [] No

/es/ MEGAN K RAVE LANKENAU
PSYCHOLOGIST
Signed: 09/25/2017 11:56

Miscellaneous

Continued on next page
VA Form 2507

C&P Final Report

Page: 20

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Normal hearing bilaterally.
Subjective Tinnitus. Veteran reports tinnitus effects his ability to sleep and uses a white noise machine to mask it out.

RIGHT EAR

	A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg	
Hz	Hz*	Hz	Hz	Hz	Hz	Hz	Hz	
(B-E) **								

5	10	10	15	10	15	10	
---	----	----	----	----	----	----	--

11

LEFT EAR

	A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg	
Hz	Hz*	Hz	Hz	Hz	Hz	Hz	Hz	
(B-E) **								

Continued on next page
VA Form 2507

C&P Final Report

Page: 21

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

```

|=====+=====+=====+=====+=====+=====+=====+=====|
|  10  |  15  |  15  |  25  |  15  |  25  |  15  |
18
+=====+

```

LOCAL TITLE: EYE C&P NOTE

STANDARD TITLE: EYE C & P EXAMINATION CONSULT

DATE OF NOTE: OCT 12, 2017@09:00

ENTRY DATE: OCT 12, 2017@09:49:35

AUTHOR: BELKIN, SAMUEL S

EXP COSIGNER:

URGENCY:

STATUS: COMPLETED

Eye Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Daniel Anderson

Is this DBQ being completed in conjunction with a VA 21-2507, C&P
Examination

Request?

☒ Yes ☐ No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this
document:☒ In-person examination

Evidence Review

Evidence reviewed (check all that apply):☒ Other (please identify other evidence reviewed):

JLV- AHALTA

SECTION I: Diagnoses

Continued on next page
VA Form 2507

C&P Final Report

Page: 22

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination

Does the Veteran now have or has he/she ever been diagnosed with an eye condition (other than congenital or developmental errors of refraction)?
 [X] Yes [] No

If yes, provide only diagnoses that pertain to eye conditions:

Diagnosis #1: Dry eye syndrome
 ICD code(s): H04.123
 Date of diagnosis: years

SECTION II: Medical history

Describe the history (including onset and course) of the Veteran's current eye condition(s) (brief summary): 1. Current 2507 requests assessment for Dry eye syndrome.

2. S/P PRK completed while active duty, 2011

3. Requires dry eye drops daily.

REVIEW OF OLD NOTES:

S/P PRK completed 2011

SECTION III: Physical examination

1. Visual acuity

a. Uncorrected distance:

Right: [] 5/200 or worse [] 5/200 [] 10/200 [] 15/200 []
 20/200 [] 20/100 [] 20/70 [] 20/50 [X] 20/40 or better

Left: [] 5/200 or worse [] 5/200 [] 10/200 [] 15/200 []
 20/200 [] 20/100 [] 20/70 [] 20/50 [X] 20/40 or better

b. Uncorrected near:

Continued on next page
 VA Form 2507

C&P Final Report

Page: 23

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

c. Corrected distance:

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

d. Corrected near:

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐
 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

2. Difference in corrected visual acuity for distance and near vision

Does the Veteran have a difference equal to two or more lines on the
 Snellen
 test type chart or its equivalent between distance and near corrected
 vision,
 with the near vision being worse?
☐ Yes ☒ No

3. Pupils

a. Pupil diameter: Right: 4 mm Left: 4 mm

b. ☒ Pupils are round and reactive to light

Continued on next page
VA Form 2507

C&P Final Report

Page: 24

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

c. Is an afferent pupillary defect present?
☐ Yes ☒ No

d. ☐ Other, describe:

No answer provided

4. Anatomical loss, light perception only, extremely poor vision or blindness

Does the Veteran have anatomical loss, light perception only, extremely poor

vision or blindness of either eye?
☐ Yes ☒ No

5. Astigmatism

Does the Veteran have a corneal irregularity that results in severe irregular astigmatism?

☐ Yes ☒ No

6. Diplopia

Does the Veteran have diplopia (double vision)?
☐ Yes ☒ No

7. Tonometry

a. If tonometry was performed, provide results:
Right eye pressure: 15 Left eye pressure: 16

b. Tonometry method used:

☒ Goldmann applanation
☐ Other, describe:

8. Slit lamp and external eye exam

a. External exam/lids/lashes:
Right ☒ Normal ☐ Other, describe:
Left ☒ Normal ☐ Other, describe:

Continued on next page
VA Form 2507

C&P Final Report

Page: 25

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

b. Conjunctiva/sclera:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

c. Cornea:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

d. Anterior chamber:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

e. Iris:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

f. Lens:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

9. Internal eye exam (fundus)

Fundus:

☒ Normal bilaterally
☐ Abnormal

10. Visual fields

Does the Veteran have a visual field defect (or a condition that may result

in visual field defect)?

☐ Yes ☒ No

a. Was visual field testing performed?

☒ Yes ☐ No

Results:

☒ Other, describe:

CONFRONTATION VF FULL -- confirms that formal Visual Field

is NOT required

Continued on next page
 VA Form 2507

C&P Final Report

Page: 26

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

b. Does the Veteran have contraction of a visual field?
☐ Yes ☒ No

c. Does the Veteran have loss of a visual field?
☐ Yes ☒ No

d. Does the Veteran have a scotoma?
☐ Yes ☒ No

e. Does the Veteran have legal (statutory) blindness (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20) based upon visual field loss?
☐ Yes ☒ No

SECTION IV: Eye conditions

1. Conditions

Does the Veteran have any of the following eye conditions?
☒ Yes ☐ No

If yes, check all that apply:

☒ Other eye conditions

14. Other eye conditions, pertinent physical findings, complications, conditions, signs and symptoms

Does the Veteran have any other eye conditions, pertinent physical findings, complications, conditions, signs or symptoms related to the condition at hand?
☒ Yes ☐ No

If yes, describe: 1. Current 2507 requests assessment for Dry eye syndrome.

2. S/P PRK completed while active duty, 2011, mild residual refractive error, correctable to good vision both eyes.

3. Dry eye syndrome, uses daily eyedrops in past, not visually significant at this time.

Continued on next page
 VA Form 2507

C&P Final Report

Page: 27

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

4. No other active ocular pathology seen at this time

SECTION V: Scarring and disfigurement

Does the Veteran have scarring or disfigurement attributable to any eye condition?

[] Yes [X] No

SECTION VI: Incapacitating episodes

During the past 12 months, has the Veteran had any incapacitating episodes

attributable to any eye conditions?

[] Yes [X] No

SECTION VII

1. Functional impact

Does the Veteran's eye condition(s) impact his or her ability to work?

[] Yes [X] No

2. Remarks, if any:

PATIENT IS ACTIVE DUTY/IDES/QUICKSTART

Was a DD Form 2807-1, Report of Medical History, completed by the Service member and available for review at the time of this examination?
[] Yes [X] No [] N/A

PHYSICAL EXAM: All[Eyes, Ophthalmoscope, Pupils, ocular motility]
Normal except:

ASSESSMENT:

#1. Claimed Condition: Dry eye syndrome
Onset: years
History: ongoing
Prognosis: Unable to estimate
Diagnosis/Rationale: Dry eye syndrome

Continued on next page
VA Form 2507

C&P Final Report

Page: 28

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

/es/ SAMUEL S BELKIN
ATTENDING PHYSICIAN
Signed: 10/12/2017 09:49

LOCAL TITLE: COMPENSATION ASSESSMENT COPY
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: OCT 18, 2017@13:00 ENTRY DATE: OCT 18, 2017@11:34:24
AUTHOR: CHEU, TAMMY MEI-CHEN EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS [REDACTED] [REDACTED]

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

SUBSPECIALTY - Separation Health Assessment (SHA)
Disability Benefits Questionnaire
* Internal VA or DOD Use Only*

Name of Claimant/Service member: ANDERSON, DANIEL DENNIS
SSN: [REDACTED] [REDACTED]

MEDICAL RECORD REVIEW:
No physical VA claims file was received for review.
VBMS was reviewed.
JLV (Joint Legacy Viewer) reviewed.
Other records reviewed: CPRS, DOD REMOTE DATA.

SUBSPECIALTY SHA
SKIN/SCAR

Continued on next page
VA Form 2507

C&P Final Report

Page: 29

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

MEDICAL HISTORY OF CLAIMED CONDITION(S):
 SM Anderson is a 32 y.o. Caucasian male who is undergoing the IDES process @ the DC VAMC C&P Clinic. He presents to this appointment for the Skin and Scars portion of the examination.

Active Duty Service Dates - Navy: 11/01/2005 to present.

Pertinent Medical Hx of Claimed Conditions:

1. ALLERGIC TO CATS
 Reported history of allergies to dogs and cats since childhood. Improved after joining the military, especially during the 3 years on ship duty as there were no exposure to pets. Recurrence of symptoms around 2010 when SM Anderson was exposed to cats again, from "staying over at friend's with cats and parents' house". Symptoms included "skin itching, and I started having issues breathing." He takes Zyrtec and "over the counter inhalers". In the last 30 days, has had to take Zyrtec twice and one day use of inhaler due to overnight stay at a friend's house who has cats.
2. "SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD"
 Reported history of "a large bump on my neck...started having a fever" in 2007 while on ship duty. Records review confirmed onset of abscess in January of 2007. Please refer to handwritten Chronological Record of Medical Care dated 01/24/2007 as well as multiple subsequent STRs through to March 2007. Abscess on left neck and scalp were treated with oral antibiotics, topical antibiotics and I & D. SM reported recurrence of mild abscess on the left side of neck with every other haircut. Self-treats with over the counter antibiotic ointment with effective outcome. Lesion resolves in few days. Residual scars asymptomatic and stable.
3. HAIR LOSS
 SM reported noticing dry and flaky scalp in 2007 after MRSA abscess of the scalp. Since then, patch of alopecia on the crown of scalp has been

Continued on next page
 VA Form 2507

C&P Final Report

Page: 30

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

gradually enlarging. Status post evaluation by Dermatology and biopsies in

2015. Currently no interventions nor treatment.

RECORDS REVIEW GLEANING:

- 06/22/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.

"...The Chief Complaint is: Scalp. History of pre sent illness The Patient is

a 30 year old male. 30 y/o male. Per patient, has history of MRSA infection

on scalp about 5 to 6 years ago. Hair has never completely grown back.

More

recently has started to develop scale in same area as well as other areas of

scalp. Unsure if area has remained the same size. He feels it has been getting larger...Physical findings...Skin: Skin: Scalp: Approx 1.5 to 2 cm

annular patch of noticeably decreased hair density on posterior apex scalp.

Smaller but also annular area next to it. Slightly raised scar like plaque.

Follicle drop and tufting of hair noted. Mild erythema and scale...A/P Last

Updated by T AYLOR, BRADLEY M @ 23 Jun 2015 1135 EDT. 1. Alopecia: Tufted,

scarring alopecia on scalp after reported infection about 6 years ago.

Patient feels it is slowly progressing. Mild erythema and some scale which

feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include

treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well..."

- 07/02/2015. Lab Test: Tissue Exam Specimen Source: TISSUE.

"...SPECIMEN:

A: Skin, Scalp, Punch B: Skin, Left scalp, Punch. FINAL DIAGNOSIS: A. SKIN,

SCALP, PUNCH BIOPSY: - MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA. (SEE COMMENT).

B. SKIN, LEFT SCALP, PUNCH BIOPSY: - NORMAL SCALP.

Continued on next page
VA Form 2507

C&P Final Report

Page: 31

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

COMMENT: The sections were difficult to interpret due to processing and orientation. In part A, the sections show a normal number of terminal hair follicles with a slightly increased number of vellus hairs. Mild superficial perifollicular lymphocytic inflammation is present. Evidence of scarring alopecia is not present in multiple additional step sections. If clinically indicated additional biopsies may be helpful..."

- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.

"...Physical findings...Skin: Multiple skin lesions. Lesions located. Lesions on the scalp Vertex scalp with short vellus hairs, mild boggy of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp...A/P Last Updated by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1037 EDT... 2.

FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo. Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered..."

4. SKIN CONDITION TO INCLUDE SCROTAL CYST SM reported recurrent cysts on scrotum since 2011. Has had as many as 6 lesions at the same time. Was evaluated by Dermatology in June 2017 and 3 lesions were excised and biopsied.

RECORDS REVIEW GLEANING:
- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
"...The Chief Complaint is: Rash...30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, ST D workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses alclara on them but has not been using it on the areas in

Continued on next page
VA Form 2507

C&P Final Report

Page: 32

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

question.

Partner currently does not have any ST D or similar rash. Uses condoms.
Has

recently had bronchitis with subjective fevers which began before the
papules

appeared. HIV testing recently negative...Physical findings...Skin:

Multiple

skin lesions. Lesions located. Lesions on the scalp Vertex scalp with
short

vellus hairs, mild boggy of scalp and mild erythema with generalized
mild

scale. Pustule on R parietal scalp. Perineal lesions. Lesions in the
inguinal region. Punched out erythematous eroded papules on L and R
groin

without papules on the penis or scrotum on exam. Lesions on the right
side

of the groin. Lesions on the left side of the groin...Specimen: Groin,
Left...Results: Final report. A/P Last Updated by CUNNINGHAM, RACHEL E @
29

Sep 2015 1037 EDT 1. SKIN NEOPLASM GROIN: Given punched out erosions on
groin hx of multiple sexual partners, will get DFA today to rule out HSV
infection. Previous tests showed non acute phase of HSV (IgG positive,
IgM
negative). Has had course of valtrex 500 twice daily for 10 days 1 month
ago

but did not resolve, may not have been correct treatment or may represent
atypical presentation of another herpetic infection. Rest of STD workup
negative...2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on
biopsy with scarring alopecia from inflammation and manipulation.

Continued

reports of itching, flaking and occasional pustules. Will use topical
steroid

solution daily as needed with antifungal shampoo. Medication(s):
-FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3
Ordered..."

- 06/21/2017. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
"...The Chief Complaint is: Excision. The Patient is a 32 year old male.

32

y/o male presents for excision of scrotal cysts. In the Navy and
currently

on active duty. No systemic symptoms, not feeling tired or poorly, no
fever,

and no chills. No skin symptoms - No skin symptoms other than described

Continued on next page
VA Form 2507

C&P Final Report

Page: 33

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

in
the HPI...Physical findings...Skin:: On exam the following lesions were identified and examined: Multiple round subcutaneous cysts on the scrotum. *

Complexion type II. A/P Last Updated by DIBLASI, DANIEL R @ 21 Jun 2017 1540

EDT. 1. Epidermal cyst: 32 y/o male with multiple EICs on the scrotum. 3 lesions excised. Patient tolerated the procedure..."

- 06/27/2017. Tissue Exam Specimen Source: TISSUE. "...SPECIMEN: Excision, scrotum. FINAL DIAGNOSIS: SKIN, SCROTUM, EXCISION: - CALCINOSIS CUTIS...CLINICAL DIAGNOSIS AND HISTORY: 32 year old male with several subcutaneous cysts on the scrotum. Three lesions excised. One was performed using punch biopsy..."

Ingrown Toenail Left foot: Please refer to Podiatry.

Body marks, tattoos: Not examined.

SKIN conditions of the Head, face, neck and scalp: Please refer to DBQ Skin/Scar template.

SKIN condition of the trunk, upper extremities, and/or lower extremities: Please refer to DBQ Skin/Scar template.

SCARS conditions of the Head, face, neck and scalp: Please refer to DBQ Skin/Scar template.

SCARS of the trunk, upper extremities, and/or lower extremities: Please refer to DBQ Skin/Scar template.

DIAGNOSIS

Claimed condition (Verbatim from 2507): ALLERGIC TO CATS
Diagnosis: ALLERGY TO CATS AND DOGS (ICD Code L23.81)
Date of Dx: History of Allergies to Cats and Dogs since childhood
Rationale: Please refer to med hx
Prognosis: With allergen exposure

Claimed condition (Verbatim from 2507): "SCARRING FROM MERSA BACK OF NECK
AND TOP OF HEAD"

Continued on next page
VA Form 2507

C&P Final Report

Page: 34

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Diagnosis: a) LEFT NECK - FOLLICULITIS, INACTIVE, NO RESIDUAL SCAR; b)
SCALP

- PLEASE REFER TO HAIR LOSS BELOW (ICD Code L73.91)

Date of Dx: 1/18/2017

Rationale: Please refer to med hx and physical exam

Prognosis: N/A

Claimed condition (Verbatim from 2507): HAIR LOSS

Diagnosis: SCARRING ALOPECIA - FOLLICULITIS DECALVANS (ICD Code L66.2)

Date of Dx: 09/29/2015

Rationale: Please refer to med hx and physical exam

Prognosis: Ongoing

Claimed condition (Verbatim from 2507): SKIN CONDITION TO INCLUDE
SCROTAL

CYST

Diagnosis: EPIDERMAL CYST OF THE SCROTUM (ICD Code L72.0)

Date of Dx: 06/21/2017

Rationale: Please refer to med hx and physical exam

Prognosis: Improved

RELEVANT LAB TESTS: Please refer to med hx

All additional DBQs found to be necessary completed as appropriate at time of
signing this DBQ?

[X] Yes [] No

[X] Designated VA materials regarding military sexual trauma (MST) were
provided to the Veteran/Servicemember.

Wrist Conditions
Disability Benefits Questionnaire

Continued on next page
VA Form 2507

C&P Final Report

Page: 35

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

1. Diagnosis

a. List the claimed condition(s) that pertain to this DBQ: wrist condition bilateral

b. Select diagnoses associated with the claimed condition(s) (Check all that apply):

[X] Other (specify)
Other diagnosis #1: R. wrist tendinitis
ICD code: 799.9
Side affected: [X] Right [] Left [] Both
Date of diagnosis: Right: 9/2017 (today)

Other diagnosis #2: No pathology found, L. wrist
ICD code: 799.9
Side affected: [] Right [X] Left [] Both
Date of diagnosis: Left: today

Continued on next page
VA Form 2507

C&P Final Report

Page: 36

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

c. Comments (if any):
 No answer provided.

d. Was an opinion requested about this condition (internal VA only)?
☐ Yes ☒ No ☐ N/A

2. Medical history

a. Describe the history (including onset and course) of the Veteran's wrist condition (brief summary):
 Dorsal R. wrist pain w/ using mouse and keyboard x 2 years. No rest pain or functional limitation. No paresthesias. States he was seen by primary care 2 days ago and advised activity modification. No diagnosis or imaging.

SM denies any issues with his left wrist.

Bilat wrist exam today is normal.

b. Dominant hand:
☒ Right ☐ Left ☐ Ambidextrous

c. Does the Veteran report flare-ups of the wrist?
☐ Yes ☒ No

d. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this DBQ (regardless of repetitive use)?
☐ Yes ☒ No

3. Range of motion (ROM) and functional limitations

a. Initial range of motion

Right Wrist

☒ All Normal
☐ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

Palmar Flexion (0-80): 0 to 80 degree
 Dorsiflexion (0-70): 0 to 70 degree

Continued on next page
 VA Form 2507

C&P Final Report

Page: 37

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Ulnar Deviation (0-45): 0 to 45 degree
Radial Deviation (0-20): 0 to 20 degree

Description of pain (select best response):
No pain noted on exam

Is there evidence of pain with weight bearing? ☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation
of the joint or associated soft tissue? ☐ Yes ☒ No

Is there objective evidence of crepitus? ☐ Yes ☒ No

Left Wrist

☒ All Normal
☐ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

Palmar Flexion (0-80): 0 to 80 degree
Dorsiflexion (0-70): 0 to 70 degree
Ulnar Deviation (0-45): 0 to 45 degree
Radial Deviation (0-20): 0 to 20 degree

Description of pain (select best response):
No pain noted on exam

Is there evidence of pain with weight bearing? ☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation
of the joint or associated soft tissue? ☐ Yes ☒ No

Is there objective evidence of crepitus? ☐ Yes ☒ No

b. Observed repetitive use

Right Wrist

Is the Veteran able to perform repetitive use testing with at least three
repetitions? ☒ Yes ☐ No

Is there additional loss of function or range of motion after three
repetitions? ☐ Yes ☒ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 38

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Left Wrist

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☒ Yes ☐ No

Is there additional loss of function or range of motion after three repetitions? ☐ Yes ☒ No

c. Repeated use over time

Right Wrist

Is the Veteran being examined immediately after repetitive use over time?
☐ Yes ☒ No

If the examination is not being conducted immediately after repetitive use over time:

☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.

☒ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☒ Unable to say w/o mere speculation

If unable to say w/o mere speculation, please explain:
Pt is not being examined after repeated use over time

Left Wrist

Is the Veteran being examined immediately after repetitive use over time?
☐ Yes ☒ No

If the examination is not being conducted immediately after repetitive

Continued on next page
VA Form 2507

C&P Final Report

Page: 39

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

use over time:

- ☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.
- ☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.
- ☒ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☒ Unable to say w/o mere speculation

If unable to say w/o mere speculation, please explain:

Pt is not being examined after repeated use over time

d. Flare-ups: Not applicable

e. Additional factors contributing to disability

Right Wrist

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

None

Left Wrist

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

None

4. Muscle strength testing

a. Muscle strength - rate strength according to the following scale:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

Continued on next page
VA Form 2507

C&P Final Report

Page: 40

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

5/5 Normal strength

Right Wrist:

Flexion Rate Strength 5/5

Extension Rate Strength 5/5

Is there a reduction in muscle strength?

☐ Yes ☒ No

Left Wrist:

Flexion Rate Strength 5/5

Extension Rate Strength 5/5

Is there a reduction in muscle strength?

☐ Yes ☒ No

b. Does the Veteran have muscle atrophy?

☐ Yes ☒ No

c. Comments, if any:

No answer provided.

5. Ankylosis

a. Indicate severity of ankylosis and side affected (check all that apply):

Right side:

☒ No ankylosis

Left side:

☒ No ankylosis

b. Comments, if any:

No answer provided.

6. Surgical procedures

No answer provided.

7. Other pertinent physical findings, complications, conditions, signs,
symptoms and scars

Continued on next page
VA Form 2507

C&P Final Report

Page: 41

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No

c. Comments, if any:
No response provided

8. Assistive devices

a. Does the Veteran use any assistive devices?
☐ Yes ☒ No

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:
No response provided.

9. Remaining effective function of the extremities

Due to the Veteran's wrist conditions, is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well served by an amputation with prosthesis? (Function of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☒ No

10. Diagnostic testing

a. Have imaging studies of the wrist been performed and are the results available?
☐ Yes ☒ No

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☒ No

c. If any test results are other than normal, indicate relationship of

Continued on next page
VA Form 2507

C&P Final Report

Page: 42

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

abnormal findings to diagnosed conditions:
No answer provided.

11. Functional impact

Regardless of the Veteran's current employment status, do the condition(s) listed in the Diagnosis Section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?
☐ Yes ☒ No

12. Remarks, if any:

Is the contralateral joint uninjured / normal?
Claimed condition is bilateral

Pain with non-weight bearing (at rest)?
None noted on exam.

Pain with passive ROM?
None noted on exam.

Pain with weight bearing?
None noted on exam

Hand and Finger Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?
☒ Yes ☐ No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

Continued on next page
VA Form 2507

C&P Final Report

Page: 43

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

☒ In-person examination

Evidence Review

Evidence reviewed (check all that apply):

☒ Other (please identify other evidence reviewed):
 Online STRs thru Janus system were reviewed
 VBMS

1. Diagnosis

- a. List the claimed condition(s) that pertain to this DBQ:
 hand condition right hand knuckle condition
- b. Select diagnoses associated with the claimed condition(s) (check all that apply):

☒ Other (specify)
 Other diagnosis #1: R. hand 5th proximal phalanx, well healed without residual (no active pathology found)
 ICD Code: 799.9
 Side affected: Right
 Date of diagnosis: Right 2008

- c. Comments, if any:
 No response provided
- d. Was an opinion requested about this condition (internal VA only)?
☐ Yes ☒ No ☐ N/A

2. Medical history

- a. Describe the history (including onset and course) of the Veteran's hand, finger or thumb condition (brief summary):
 Traumatic fracture R. 5th proximal phalanx in 2008. Now well healed without clinically significant residuals. Bilat hand exam today is normal.

Continued on next page
 VA Form 2507

C&P Final Report

Page: 44

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- b. Dominant hand:
☒ Right ☐ Left ☐ Ambidextrous
- c. Does the Veteran report flare-ups of the hand, finger or thumb joints?
☐ Yes ☒ No
- d. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this DBQ, including but not limited to repeated use over time?
☐ Yes ☒ No

3. Range of motion (ROM) and functional limitations

a. Initial range of motion

Right Hand

- ☒ All normal
☐ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

Index finger

Max extension to:

MCP 0 deg
 PIP 0 deg
 DIP 0 deg

Max flexion to:

MCP 90 deg
 PIP 100 deg
 DIP 70 deg

Long finger

Max extension to:

MCP 0 deg
 PIP 0 deg
 DIP 0 deg

Max flexion to:

MCP 90 deg
 PIP 100 deg
 DIP 70 deg

Ring finger

Continued on next page
VA Form 2507

C&P Final Report

Page: 45

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Max extension to:

MCP 0 deg
PIP 0 deg
DIP 0 deg

Max flexion to:

MCP 90 deg
PIP 100 deg
DIP 70 deg

Little finger

Max extension to:

MCP 0 deg
PIP 0 deg
DIP 0 deg

Max flexion to:

MCP 90 deg
PIP 100 deg
DIP 70 deg

Thumb

Max extension to:

MCP 0 deg
IP 0 deg

Max flexion to:

MCP 100 deg
IP 90 deg

Is there a gap between the pad of the thumb and the fingers?

☐ Yes☒ NoIs there a gap between the finger and proximal transverse crease of
the hand on maximal finger flexion?☐ Yes ☒ No

Description of pain (select best response):

No pain noted on exam

Is there evidence of pain with use of the hand? ☐ Yes ☒ NoIs there objective evidence of localized tenderness or pain on palpation
of the joint or associated soft tissue? ☐ Yes ☒ NoContinued on next page
VA Form 2507

C&P Final Report

Page: 46

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Left Hand

[X] All normal
[] Abnormal or outside of normal range
[] Unable to test (please explain)
[] Not indicated (please explain)

Index finger

Max extension to:
MCP 0 deg
PIP 0 deg
DIP 0 deg
Max flexion to:
MCP 90 deg
PIP 100 deg
DIP 70 deg

Long finger

Max extension to:
MCP 0 deg
PIP 0 deg
DIP 0 deg
Max flexion to:
MCP 90 deg
PIP 100 deg
DIP 70 deg

Ring finger

Max extension to:
MCP 0 deg
PIP 0 deg
DIP 0 deg
Max flexion to:
MCP 90 deg
PIP 100 deg
DIP 70 deg

Little finger

Max extension to:
MCP 0 deg
PIP 0 deg
DIP 0 deg
Max flexion to:

Continued on next page
VA Form 2507

C&P Final Report

Page: 47

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

MCP 90 deg
PIP 100 deg
DIP 70 deg

Thumb

Max extension to:

MCP 0 deg
IP 0 deg

Max flexion to:

MCP 100 deg
IP 90 deg

Is there a gap between the pad of the thumb and the fingers?

[] Yes

[X] No

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

[] Yes [X] No

Description of pain (select best response):

No pain noted on exam

Is there evidence of pain with use of the hand? [] Yes [X] No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? [] Yes [X] No

b. Observed repetitive use

Right Hand

Is the Veteran able to perform repetitive use testing with at least three repetitions? [X] Yes [] No

Is there additional functional loss or range of motion after three repetitions? [] Yes [X] No

Left Hand

Continued on next page
VA Form 2507

C&P Final Report

Page: 48

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☒ Yes ☐ No

Is there additional functional loss or range of motion after three repetitions? ☐ Yes ☒ No

c. Repeated use over time

Right Hand

Is the Veteran being examined immediately after repetitive use over time?
☐ Yes ☒ No

If the examination is not being conducted immediately after repetitive use over time:

☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.

☒ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☒ Unable to say w/o mere speculation

If unable to say w/o mere speculation, please explain:
Pt is not being examined after repetitive use over time

Left Hand

Is the Veteran being examined immediately after repetitive use over time?
☐ Yes ☒ No

If the examination is not being conducted immediately after repetitive

Continued on next page
VA Form 2507

C&P Final Report

Page: 49

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

use over time:

- ☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.
- ☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.
- ☒ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☒ Unable to say w/o mere speculation

If unable to say w/o mere speculation, please explain:

Pt is not being examined after repetitive use over time

d. Flare-ups
Not applicable

e. Additional factors contributing to disability

Right Hand

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe: None

Left Hand

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe: None

4. Muscle strength testing

a. Rate strength according to the following scale:

- 0/5 No muscle movement
- 1/5 Palpable or visible muscle contraction, but no joint movement
- 2/5 Active movement with gravity eliminated
- 3/5 Active movement against gravity
- 4/5 Active movement against some resistance

Continued on next page
VA Form 2507

C&P Final Report

Page: 50

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

5/5 Normal strength

Hand grip:

Right: 5/5

Left: 5/5

b. Does the Veteran have muscle atrophy?

☐ Yes ☒ No

c. Comments, if any:

No response provided

5. Ankylosis

Complete this section if Veteran has ankylosis of any thumb or finger joints.

a. Indicate location, severity and side affected (check all that apply):

Right hand:

☒ No ankylosis

Left hand:

☒ No ankylosis

b. Does the ankylosis result in limitation of motion of other digits or interference with overall function of the hand?

☐ Yes ☒ No

c. Comments, if any:

No response provided

6. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?

☐ Yes ☒ No

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?

☐ Yes ☒ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 51

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

c. Comments, if any:
No response provided

7. Assistive devices

a. Does the Veteran use any assistive devices?
☐ Yes ☒ No

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:
No response provided

8. Remaining effective function of the extremities

Due to the Veteran's hand, finger or thumb conditions, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☒ No

9. Diagnostic Testing

a. Have imaging studies of the hands been performed and are the results available?
☐ Yes ☒ No

b. Are there any other significant diagnostic test findings or results?
☐ Yes ☒ No

c. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:
No response provided

10. Functional impact

Regardless of the Veteran's current employment status, do the condition(s) listed in the Diagnosis Section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Continued on next page
VA Form 2507

C&P Final Report

Page: 52

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

[] Yes [X] No

11. Remarks, if any:

Is the contralateral joint uninjured / normal?
YES

Pain with non-weight bearing (at rest)?
None noted on exam.

Pain with passive ROM?
None noted on exam.

Pain with weight bearing?
None noted on exam

Esophageal Conditions
(Including gastroesophageal reflux disease (GERD), hiatal hernia
and other esophageal disorders)
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination
Request?
[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

Continued on next page
VA Form 2507

C&P Final Report

Page: 53

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

[X] Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an
esophageal condition? Yes
Gastroesophageal reflux disease (GERD)
ICD code: R69 Date of diagnosis: 2016

Medical history

Description of the history (including onset and course) of the Veteran's
esophageal conditions: Heartburn in 2016, triggered by alcohol and sleeping
shortly after eating, now resolved with avoidance of triggers. Last episode
2 months ago. Not on any meds. No red flag s/s or prior EGD.

Does the Veteran's treatment plan include taking continuous medication for
the diagnosed condition? No

Signs and symptoms

Does the Veteran have any of the following signs or symptoms due to any
esophageal conditions (including GERD)? Yes
Sign and Symptoms:
Pyrosis
Reflux

Esophageal stricture, spasm and diverticula

Does the Veteran have an esophageal stricture, spasm of esophagus
(cardiospasm or achalasia), or an acquired diverticulum of the esophagus? No

Other pertinent physical findings, complications, conditions, signs, symptoms and
scars

Does the Veteran have any other pertinent physical findings, complications,
conditions, signs or symptoms related to any conditions listed in the
Diagnosis Section above? No

Continued on next page
VA Form 2507

C&P Final Report

Page: 54

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above? No

Diagnostic Testing

Have diagnostic imaging studies or other diagnostic procedures been performed? No

Has laboratory testing been performed? No

Are there any other significant diagnostic test findings and/or results? No

Functional impact

Do any of the Veteran's esophageal conditions impact on his or her ability to work? No

Remarks, if any: No response provided

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Rectum and Anus Conditions (including Hemorrhoids)
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Continued on next page
VA Form 2507

C&P Final Report

Page: 55

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Evidence Review

Evidence reviewed (check all that apply):

[X] Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

1. Diagnosis

Does the Veteran now have or has he/she ever had any condition of the rectum or anus?

[X] Yes [] No

[X] Internal or external hemorrhoids
ICD code: 799.9
Date of diagnosis: 2005

[X] Other, specify below:

Other diagnosis #1: no pathology found, "anal fissures"
ICD code: 799.9
Date of diagnosis: today

Other diagnosis #2: no pathology found, "anal spasms" (work up ongoing)
ICD code: 799.9
Date of diagnosis: today

2. Medical History

a. Describe the history (including onset and course) of the Veteran's rectum or anus conditions (brief summary):
CLAIM: hemorrhoids, anal fissures, anus spasms

Intermittent blood on toilet paper since 2010, diagnosed per SM as internal hemorrhoids by colonoscopy in 2005. Currently bleeding is infrequent. Not on any treatments.

Anal spasms are likely part of his IBS, however work up is ongoing.

Continued on next page
VA Form 2507

C&P Final Report

Page: 56

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Anorectal manometry testing completed earlier today, results pending.
For now, no pathology found.

SM has not been diagnosed with anal fissures.

- b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed conditions?
☐ Yes ☒ No

3. Signs and Symptoms

Does the Veteran have any findings, signs or symptoms attributable to any of the diagnoses in Section 1?

☒ Yes ☐ No

- ☒ a. Internal or external hemorrhoids

If checked, indicate severity (check all that apply):

☒ Other, describe:
intermittent blood on TP

4. Exam

Provide results of examination of rectal/anal area: (check all that apply)
☒ Normal; no external hemorrhoids, anal fissures or other abnormalities

5. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

- a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- c. Comments, if any:
No response provided

Continued on next page
VA Form 2507

C&P Final Report

Page: 57

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

6. Diagnostic testing

a. Has laboratory testing been performed?
☐ Yes ☒ No

b. Have imaging studies or diagnostic procedures been performed and are the results available?
☒ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary):

Anorectal manometry testing completed earlier today, results pending

c. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☒ No

7. Functional impact

Does the Veteran's rectum or anus condition impact his or her ability to work?

☐ Yes ☒ No

8. Remarks, if any:

No remarks provided.

Sinusitis, Rhinitis and Other Conditions of the Nose, Throat,
Larynx and Pharynx
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

☒ Yes ☐ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 58

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

☒ In-person examination

Evidence Review

Evidence reviewed (check all that apply):

☒ Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

SECTION I: Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with a sinus, nose, throat, larynx, or pharynx condition? (This is the condition the Veteran is claiming or for which an exam has been requested)

☒ Yes ☐ No

☒ Allergic rhinitis ICD code: 477.8 Date of diagnosis: 2017

SECTION II: Medical history

6/2017 allergy clinic notes reviewed.

Pt w/ hx of childhood cat allergy which resolved and returned in ~2011. Pt reports nasal congestion, sneezing, itching, and shortness of breath w/ exposure to cats.

Allergy skin tested in 6/2017 and found to be allergic to cats only of all allergens tested. He was diagnosed with allergic rhinitis and advised daily Zyrtec which he uses prn.

SECTION III: Nose, throat, larynx or pharynx conditions

Does the Veteran have any of the following nose, throat, larynx or pharynx conditions?

Continued on next page
VA Form 2507

C&P Final Report

Page: 59

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

☒ Yes ☐ No

☒ Rhinitis

2. Rhinitis

-
- a. Is there greater than 50% obstruction of the nasal passage on both sides due to rhinitis?
☐ Yes ☒ No
- b. Is there complete obstruction on the left side due to rhinitis?
☐ Yes ☒ No
- c. Is there complete obstruction on the right side due to rhinitis?
☐ Yes ☒ No
- d. Is there permanent hypertrophy of the nasal turbinates?
☐ Yes ☒ No
- e. Are there nasal polyps?
☐ Yes ☒ No
- f. Does the Veteran have any of the following granulomatous conditions?
☐ Yes ☒ No

If yes, check all that apply:

- ☐ Granulomatous rhinitis ☐ Rhinoscleroma
☐ Wegener's granulomatosis ☐ Lethal midline granuloma
☐ Other granulomatous infection, describe:

6. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

-
- a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- c. Comments, if any:

Continued on next page
VA Form 2507

C&P Final Report

Page: 60

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

No answer provided

- d. Does the Veteran have loss of part of the nose or other scars of the nose exposing both nasal passages?
[] Yes [X] No
- e. Does the Veteran have loss of part of the nose or other scars causing loss of part of one ala?
[] Yes [X] No
- f. Does the Veteran have loss of part of the nose or other scars causing other obvious disfigurement?
[] Yes [X] No

SECTION IV: Diagnostic testing

- a. Have imaging studies of the sinuses or other areas been performed?
[] Yes [X] No
- b. Has endoscopy been performed?: No
- c. Has the Veteran had a biopsy of the larynx or pharynx?: No
- d. Has the Veteran had pulmonary function testing to assess for upper airway obstruction due to laryngeal stenosis?: No
- e. Are there any other significant diagnostic test findings and/or results?: No

SECTION V: Functional impact and remarks

1. Functional impact

Does the Veteran's sinus, nose, throat, larynx or pharynx condition impact his or her ability to work?
[] Yes [X] No

2. Remarks, if any:

No answer provided

Continued on next page
VA Form 2507

C&P Final Report

Page: 61

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

CLAIM: asthma

2017 allergy notes reviewed

SM has not been diagnosed with adult asthma. SM had childhood asthma. He now reports dyspnea and chest tightness on exposure to cats, dogs, and grass since ~2011.

Per allergy note 5/2017:

"History and symptoms could be consistent with allergic asthma, however, could also be due to VCD. If SPT negative, would consider referral to pulmonology for consideration of MCCT vs laryngoscopy to evaluate for asthma and VCD"

This further work up was never initiated and definitive diagnosis of dyspnea not made.

Based on above, no pathology found. SM was advised to re-file if/when a definitive diagnosis is made.

Intestinal Conditions (other than surgical or infectious),
including irritable bowel syndrome, Crohn's disease, ulcerative
colitis and diverticulitis
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS

Continued on next page
VA Form 2507

C&P Final Report

Page: 62

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] Other (please identify other evidence reviewed):
Online STRs thru Janus system were reviewed
VBMS

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an intestinal condition (other than surgical or infectious)?

[X] Yes [] No

[X] Irritable bowel syndrome
ICD code: 799.9
Date of diagnosis: 2012

2. Medical history

a. Describe the history (including onset and course) of the Veteran's intestinal condition (brief summary):

This is one of the med board referred conditions. 2017 GI notes reviewed.

Long hx of GI symptoms since childhood, worse x several years. IBS diagnosed in 2012, diarrhea predominant. Colonoscopy and follow up MRI at that time were ultimately unrevealing with negative biopsies.

Presently loose stools several times a week, improved since starting

Continued on next page
VA Form 2507

C&P Final Report

Page: 63

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

venlafaxine ~4 months ago. Abd cramping several times a week relieved by BM. Triggered by strong smells, anxiety, and physical activity.

Pain after PT, rectal pain and spasms. Fecal leakage and 5-15 min urgency before every defecation. Intermittent blood on toilet paper attributed to hemorrhoids.

He has previously failed hyocymaine. Currently managed w/ low fodmap diet, venlafaxine. He was seen earlier today by GI and plan is to try citrucel and peppermint oil.

Anorectal manometry testing completed earlier today, results pending

- b. Is continuous medication required for control of the Veteran's intestinal condition?

☒ Yes ☐ No

If yes, list only those medications required for the intestinal condition:
see history

- c. Has the Veteran had surgical treatment for an intestinal condition?

☐ Yes ☒ No

3. Signs and symptoms

Does the Veteran have any signs or symptoms attributable to any non-surgical non-infectious intestinal conditions?

☒ Yes ☐ No

If yes, check all that apply:

☒ Other, describe:
see history

4. Symptom episodes, attacks and exacerbations

Does the Veteran have episodes of bowel disturbance with abdominal distress, or exacerbations or attacks of the intestinal condition?

☒ Yes ☐ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 64

Name: ANDERSON, DANIEL DENNIS
 For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

If yes, indicate severity and frequency: (check all that apply)

☒ Episodes of bowel disturbance with abdominal distress

If checked, indicate frequency:

☐ Occasional episodes

☒ Frequent episodes

☐ More or less constant abdominal distress

5. Weight loss

Does the Veteran have weight loss attributable to an intestinal condition (other than surgical or infectious condition)?

☐ Yes ☒ No

6. Malnutrition, complications and other general health effects

Does the Veteran have malnutrition, serious complications or other general health effects attributable to the intestinal condition?

☐ Yes ☒ No

7. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?

☐ Yes ☒ No

8. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?

☐ Yes ☒ No

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?

☐ Yes ☒ No

c. Comments, if any:

9. Diagnostic testing

Continued on next page
 VA Form 2507

C&P Final Report

Page: 65

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

a. Has laboratory testing been performed?
☐ Yes ☒ No

b. Have imaging studies or diagnostic procedures been performed and are the results available?
☒ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary):
see history

c. Are there any other significant diagnostic test findings and/or results?
☒ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary):
see history

10. Functional impact

Does the Veteran's intestinal condition impact his or her ability to work?
☒ Yes ☐ No

If yes, describe the impact of each of the Veteran's intestinal conditions, providing one or more examples:
abdominal pain with physical training, increased tardiness and absenteesim.

11. Remarks, if any:

Exam Date/Time
11/02/2012 07:18
Procedure Name
MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)
Report
MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)

Exm Date: 11/02/2012 07:18
Req Phys: Pat Loc:

Continued on next page
VA Form 2507

C&P Final Report

Page: 66

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Img Loc: GSURG GI APU BE WRNMMC BETHESDA, MD
Service:

Exam: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) CPT:

Report Status: FINAL Date Verified: 11/05/2012 09:48

Reason For Order:

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)

20121023155400

Exam #: 12359730

Exam Date/Time: 20121102071800

Transcription Date/Time: 20121105095600

Provider: 173827 COPSEY, HELEN C

Requesting Location: GSURG GI APU BE WRNMMC BETHESDA, MD

Status: COMPLETE

<E>

Amended Result Code: 9 SEE RADIOLOGIST'S REPORT

Interpreted By: 179340 MOLLURA, JOSEPH G

Supervised By: 115455 MARCIA JAVITT, MD

Approved By: 115455 JAVITT, MARCIA C

Approved Date: 20121105094800

Supervised By: 115455 MARCIA JAVITT, MD

Supervised By Date: 20121105094800

Report Text: ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or

Continued on next page
VA Form 2507

C&P Final Report

Page: 67

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

SEE RADIOLOGIST'S REPORT
Facility: WRNMMC

=====

Exam Date/Time
10/11/2012 00:30
Procedure Name
CT, ABDOMEN / PELVIS WITH (PG)
Report
CT, ABDOMEN / PELVIS WITH (PG)

Exm Date: 10/11/2012 00:30

Continued on next page
VA Form 2507

C&P Final Report

Page: 68

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Req Phys: Pat Loc:
 Img Loc: EMERGENCY RM BE WRNMMC BETHESDA, MD
 Service:

Exam: CT, ABDOMEN / PELVIS WITH (PG) CPT:

Report Status: FINAL Date Verified: 10/11/2012 08:16
 Reason For Order:
 Procedure: CT, ABDOMEN / PELVIS WITH (PG)
 20121011013000
 Exam #: 12343907
 Exam Date/Time: 20121011003000
 Transcription Date/Time: 20121012070000
 Provider: 21472 HARDWARE, LESLIE
 Requesting Location: EMERGENCY RM BE WRNMMC BETHESDA, MD
 Status: COMPLETE
 <E>
 Amended Result Code: 9 SEE RADIOLOGIST'S REPORT
 Interpreted By: 179340 MOLLURA, JOSEPH G
 Supervised By: 61813 BERNARD, JACQUELINE, MD, CDR, USN
 Approved By: 61813 BERNARD, JACQUELINE M
 Approved Date: 20121011081600
 Supervised By: 61813 BERNARD, JACQUELINE, MD, CDR, USN
 Supervised By Date: 20121011081600
 Report Text: ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is

Continued on next page
VA Form 2507

C&P Final Report

Page: 69

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12
Time:07:22

Continued on next page
VA Form 2507

C&P Final Report

Page: 70

Name: ANDERSON, DANIEL DENNIS
For DBQ Medical SHA Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

Electronically signed by: Dr. Jacqueline M Bernard Date: 10/11/12
Time: 08:16

SEE RADIOLOGIST'S REPORT
Facility: WRNMMC

=====

/es/ MANISH S ARORA
Attending Physician, Internal Medicine
Signed: 10/19/2017 14:27

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1
WASHINGTON.VA.GOV
** FINAL **
Processing time: 54
For DBQ OPHTH Eye Exam
=====

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED])
C-Number: [REDACTED]
DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:
GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]
Bus Phone:

Entered active service: NOV 1,2005 Last rating exam date:
Released active service: Not specified

Priority of exam: Unknown
=====

Examining provider: 1822
Examined on: OCT 12,2017@09:00
=====

Examination results:

LOCAL TITLE: EYE C&P NOTE
STANDARD TITLE: EYE C & P EXAMINATION CONSULT
DATE OF NOTE: OCT 12, 2017@09:00 ENTRY DATE: OCT 12, 2017@09:49:35
AUTHOR: BELKIN,SAMUEL S EXP COSIGNER:
INSTITUTION: WASHINGTON VA MEDICAL CENTER
DIVISION: WASHINGTON VAMC
URGENCY: STATUS: COMPLETED

Eye Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Daniel Anderson

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?
[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Evidence reviewed (check all that apply):

[X] Other (please identify other evidence reviewed):
JLV- AHALTA

SECTION I: Diagnoses

NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination

Does the Veteran now have or has he/she ever been diagnosed with an eye condition (other than congenital or developmental errors of refraction)?

[X] Yes [] No

If yes, provide only diagnoses that pertain to eye conditions:

Diagnosis #1: Dry eye syndrome
ICD code(s): H04.123
Date of diagnosis: years

SECTION II: Medical history

Describe the history (including onset and course) of the Veteran's current eye condition(s) (brief summary): 1. Current 2507 requests assessment for Dry eye syndrome.

2. S/P PRK completed while active duty, 2011

3. Requires dry eye drops daily.

REVIEW OF OLD NOTES:

S/P PRK completed 2011

SECTION III: Physical examination

1. Visual acuity

a. Uncorrected distance:

Right: [] 5/200 or worse [] 5/200 [] 10/200 [] 15/200 [] 20/200
[] 20/100 [] 20/70 [] 20/50 [X] 20/40 or better

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS
For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Left: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

b. Uncorrected near:

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

c. Corrected distance:

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

d. Corrected near:

Right: ☐ 5/200 or worse ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

Left: ☐ 5/200 ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200
☐ 20/100 ☐ 20/70 ☐ 20/50 ☒ 20/40 or better

2. Difference in corrected visual acuity for distance and near vision

Does the Veteran have a difference equal to two or more lines on the Snellen test type chart or its equivalent between distance and near corrected vision, with the near vision being worse?

☐ Yes ☒ No

3. Pupils

a. Pupil diameter: Right: 4 mm Left: 4 mm

b. ☒ Pupils are round and reactive to light

c. Is an afferent pupillary defect present?

☐ Yes ☒ No

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

d. ☐ Other, describe:

No answer provided

4. Anatomical loss, light perception only, extremely poor vision or blindness

Does the Veteran have anatomical loss, light perception only, extremely poor vision or blindness of either eye?☐ Yes ☒ No

5. Astigmatism

Does the Veteran have a corneal irregularity that results in severe irregular astigmatism?

☐ Yes ☒ No

6. Diplopia

Does the Veteran have diplopia (double vision)?

☐ Yes ☒ No

7. Tonometry

a. If tonometry was performed, provide results:

Right eye pressure: 15 Left eye pressure: 16

b. Tonometry method used:

☒ Goldmann applanation☐ Other, describe:

8. Slit lamp and external eye exam

a. External exam/lids/lashes:

Right ☒ Normal ☐ Other, describe:Left ☒ Normal ☐ Other, describe:

b. Conjunctiva/sclera:

Right ☒ Normal ☐ Other, describe:Left ☒ Normal ☐ Other, describe:

c. Cornea:

Right ☒ Normal ☐ Other, describe:Left ☒ Normal ☐ Other, describe:Continued on next page
VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS
 For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

d. Anterior chamber:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

e. Iris:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

f. Lens:
 Right ☒ Normal ☐ Other, describe:
 Left ☒ Normal ☐ Other, describe:

9. Internal eye exam (fundus)

Fundus:

☒ Normal bilaterally
☐ Abnormal

10. Visual fields

Does the Veteran have a visual field defect (or a condition that may result in visual field defect)?

☐ Yes ☒ No

a. Was visual field testing performed?

☒ Yes ☐ No

Results:

☒ Other, describe:

CONFRONTATION VF FULL -- confirms that formal Visual Field
 is NOT required

b. Does the Veteran have contraction of a visual field?

☐ Yes ☒ No

c. Does the Veteran have loss of a visual field?

☐ Yes ☒ No

d. Does the Veteran have a scotoma?

☐ Yes ☒ No

Continued on next page
 VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- e. Does the Veteran have legal (statutory) blindness (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20) based upon visual field loss?
☐ Yes ☒ No

SECTION IV: Eye conditions

1. Conditions

Does the Veteran have any of the following eye conditions?
☒ Yes ☐ No

If yes, check all that apply:

☒ Other eye conditions

14. Other eye conditions, pertinent physical findings, complications, conditions, signs and symptoms

Does the Veteran have any other eye conditions, pertinent physical findings, complications, conditions, signs or symptoms related to the condition at hand?

☒ Yes ☐ No

If yes, describe: 1. Current 2507 requests assessment for Dry eye syndrome.

2. S/P PRK completed while active duty, 2011, mild residual refractive error, correctable to good vision both eyes.

3. Dry eye syndrome, uses daily eyedrops in past, not visually significant at this time.

4. No other active ocular pathology seen at this time

SECTION V: Scarring and disfigurement

Does the Veteran have scarring or disfigurement attributable to any eye condition?

☐ Yes ☒ No

SECTION VI: Incapacitating episodes

During the past 12 months, has the Veteran had any incapacitating episodes

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS
For DBQ OPHTH Eye Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

attributable to any eye conditions?
☐ Yes ☒ No

SECTION VII

1. Functional impact

Does the Veteran's eye condition(s) impact his or her ability to work?
☐ Yes ☒ No

2. Remarks, if any:

PATIENT IS ACTIVE DUTY/IDES/QUICKSTART

Was a DD Form 2807-1, Report of Medical History, completed by the
Service member and available for review at the time of this
examination?
☐ Yes ☒ No ☐ N/A

PHYSICAL EXAM: All[Eyes, Ophthalmoscope, Pupils, ocular motility]
Normal except:

ASSESSMENT:

- #1. Claimed Condition: Dry eye syndrome
Onset: years
History: ongoing
Prognosis: Unable to estimate
Diagnosis/Rationale: Dry eye syndrome

/es/ SAMUEL S BELKIN
ATTENDING PHYSICIAN
Signed: 10/12/2017 09:49

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1
WASHINGTON.VA.GOV
** FINAL **
Processing time: 54
For DBQ PSYCH Mental disorders Exam
=====

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED])
C-Number: [REDACTED]
DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:
GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]
Bus Phone:

Entered active service: NOV 1,2005 Last rating exam date:
Released active service: Not specified

Priority of exam: Unknown
=====

Examining provider: 773016
Examined on: SEP 25,2017@09:00
=====

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: SEP 25, 2017@09:00 ENTRY DATE: SEP 25, 2017@11:56:17
AUTHOR: RAVE LANKENAU,MEGAN EXP COSIGNER:
INSTITUTION: WASHINGTON VA MEDICAL CENTER
DIVISION: WASHINGTON VAMC
URGENCY: STATUS: COMPLETED

Mental Disorders
(other than PTSD and Eating Disorders)
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis; c-file: [REDACTED] [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?
[X] Yes [] No

SECTION I:

1. Diagnosis

a. Does the Veteran now have or has he/she ever been diagnosed with a mental disorder(s)?
[X] Yes [] No

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

ICD code: F41.1

If the Veteran currently has one or more mental disorders that conform to DSM-5 criteria, provide all diagnoses:

Mental Disorder Diagnosis #1: Generalized Anxiety Disorder
 ICD code: F41.1

Mental Disorder Diagnosis #2: Major Depressive Disorder, Recurrent,
 Moderate
 ICD code: F33.1

Mental Disorder Diagnosis #3: Alcohol Use Disorder, Moderate, in early
 remission
 ICD code: F10.20

- b. Medical diagnoses relevant to the understanding or management of the Mental Health Disorder (to include TBI): Irritable Bowel Syndrome, Headaches

2. Differentiation of symptoms

- a. Does the Veteran have more than one mental disorder diagnosed?

☒ Yes ☐ No

- b. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?

☒ Yes ☐ No ☐ Not applicable (N/A)

If yes, list which symptoms are attributable to each diagnosis and discuss whether there is any clinical association between these diagnoses:

Symptoms of Major Depressive Disorder include chronic suicidal ideation, sad mood, low energy, feelings of helplessness and hopelessness, and anhedonia. Symptoms of Generalized Anxiety Disorder include worry thoughts, rumination, restlessness, sleep disturbance, and panic attacks. Symptoms of Alcohol Use Disorder include a maladaptive pattern of substance use, excessive use of alcohol, tolerance, and interpersonal/occupational problems as a result of use.

Continued on next page
 VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- c. Does the Veteran have a diagnosed traumatic brain injury (TBI)?
☐ Yes ☒ No ☐ Not shown in records reviewed

3. Occupational and social impairment

- a. Which of the following best summarizes the Veteran's level of occupational and social impairment with regards to all mental diagnoses? (Check only one)

☒ Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood

- b. For the indicated level of occupational and social impairment, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by each mental disorder?
☐ Yes ☒ No ☐ No other mental disorder has been diagnosed

If no, provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

Symptoms of Major Depressive Disorder and Generalized Anxiety Disorder both significantly contribute to the service member's level of occupational and social impairment, to the extent that it is not possible to tease out how each contributes independently of the other. Symptoms of Alcohol Use Disorder are in early remission.

- c. If a diagnosis of TBI exists, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by the TBI?
☐ Yes ☐ No ☒ No diagnosis of TBI

SECTION II:

Clinical Findings:

1. Evidence Review

Evidence reviewed (check all that apply):

- ☒ VA e-folder (VBMS or Virtual VA)
☒ Other (please identify other evidence reviewed):
 JLV

Continued on next page
 VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

2. History

a. Relevant Social/Marital/Family history (pre-military, military, and post-military):

The service member grew up in California. His parents divorced when the service member was young and he was raised by his father. He has two sisters with whom he grew up. He also has a half brother and a half sister. He reported that his childhood was unstable; his father was verbally abusive during childhood and "sometimes physically" [abusive].

The service member is single and has never been married. He is not currently dating anyone. No children. Socially, the service member reported that he has one good friend to whom he keeps in touch via text but he has few other social connections. He just started talking to his mother and sisters again this past year, "I've been living in isolation". He is not particularly close with anyone. The service member spends his free time alone, watching TV and doing programming.

b. Relevant Occupational and Educational history (pre-military, military, and post-military):

The service member did not do well in school. He typically got Ds and stated that, "I don't learn that well in school". He denied that he was ever tested for a learning disability. He graduated high school and moved out of state, he tried to go to college and started working. He joined the Navy at age 20.

The service member joined the Navy in November 2005. Rank is E5, rate is cryptologic technician networking. He is currently stationed at Ft. Meade where he has been since August 2012. He has also been stationed in Pensacola, Florida and USS Essex. No combat deployments.

c. Relevant Mental Health history, to include prescribed medications and family mental health (pre-military, military, and post-military):

No history of mental health treatment prior to the period of military service was reported.

The service member first began participating in mental health treatment

Continued on next page
VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

in August 2012. He has been in treatment regularly for the last several years. Current medications are Effexor, Rozerem, and Naltrexone. He just completed the Intensive Outpatient Program which he had done for 30 days. He meets with his psychiatrist weekly. He also participates in weekly individual therapy. He was hospitalized in 2015 for 30 days at Ft. Belvoir for inpatient substance abuse treatment. No other psychiatric hospitalizations.

According to the c-file, the service member has been diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder and Alcohol Use Disorder.

- d. Relevant Legal and Behavioral history (pre-military, military, and post-military):

None

- e. Relevant Substance abuse history (pre-military, military, and post-military):

The service member stated that he has been sober for 70 days. Prior to this, he would have approximately 5 ounces of liquor per day and 2 beers daily. He started to drink heavily while he was stationed in Japan. He is currently going to substance abuse treatment at Walter Reed National Military Medical Center.

- f. Other, if any:

None

3. Symptoms

For VA rating purposes, check all symptoms that actively apply to the Veteran's diagnoses:

- ☒ Depressed mood
- ☒ Anxiety
- ☒ Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
- ☒ Chronic sleep impairment

Continued on next page
 VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
 For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- [X] Flattened affect
- [X] Disturbances of motivation and mood
- [X] Difficulty in establishing and maintaining effective work and social relationships
- [X] Difficulty in adapting to stressful circumstances, including work or a worklike setting
- [X] Suicidal ideation
- [X] Obsessional rituals which interfere with routine activities

4. Behavioral observations

 The service member reported that he started to have problems with anxiety while on the USS Essex. He stated that he experiences "anticipation anxiety" and he worries about "everything". He is worrying about scheduled appointments, uniform inspections, evaluations, "at the moment, it's been mostly work related". He stated that he picks his hair, he bites his nails, he is often fidgety. He stated that he feels restless, he feels tense and is "stressed out overall". He stated that he worrying 50-70% of the day and he has a hard time controlling the worry.

The service member also endorsed symptoms of depression. He has times when he will sleep most of the day, he will not want to engage in activities. He feels tired, experiences low motivation. He often feels flat and "I try not to think about the things that make me sad...if I do, I start to feel suicidal". He rated his mood at a 3 or 4 on a 10 point scale (with 10 being high). Appetite is low, in part due to medical issues (irritable bowel syndrome). Energy levels are low. He stated that he experiences anhedonia, he has times when he no longer engages in activities but he is trying to do programming more regularly. He reported feelings of helplessness and hopelessness about his life, his future. He stated that he had a time when he felt suicidal, he wondered about the purpose of life, why does he get up every day. He reported ongoing suicidal ideation, but he denied current suicidal plan or intent. He noted that when he is drinking, he experiences more frequent suicidal ideation. He had a suicide attempt at age 16 where he swallowed a bottle of aspirin, but he denied any other suicide attempts.

The service member endorsed sleep disturbances. He has an upcoming sleep study scheduled to rule out sleep apnea. He reported that he typically goes to bed at 10pm; he denied frequent sleep onset problems. Once asleep, the service member wakes up during the night, "there's usually three or four times a night". He might be awake for only "minutes" but he can fall right back asleep. He gets out of bed at 6am. He is bed for 7-8 hours but his sleep is restless. The service member also endorsed mild episodes of sleep paralysis which occur two or three times a week; he stated that it might

Continued on next page
 VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

happen for a few minutes and then he falls right to sleep. He also reported anxiety related nightmares.

5. Other symptoms

Does the Veteran have any other symptoms attributable to mental disorders that are not listed above?
☐ Yes ☒ No

6. Competency

Is the Veteran capable of managing his or her financial affairs?
☒ Yes ☐ No

7. Remarks (including any testing results), if any:

No remarks provided.

Addendum / Clarification
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis; c-file: [REDACTED]

Please utilize this form when responding to VBA requests for either addendums or clarifications of prior VHA examination reports.

Mental health - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

[] Yes [X] No [] N/A

Any changes to his/her health status since DD 2807-1 completed?

[] Yes [] No [X] N/A

(Proposed) Date of separation from active service: No response provided.

1. Medical record review

Was the Veteran's VA claims file reviewed?

[X] Yes [] No

2. Medical history (Review of Systems)

1. Psychiatric:

[X] Yes [] No

#1. Claimed Condition: Generalized Anxiety Disorder

Onset: unknown

History: chronic

Prognosis: uncertain

#2. Claimed Condition: Major Depressive Disorder, Recurrent, Moderate

Onset: unknown

History: recurrent

Prognosis: uncertain

#3. Claimed Condition: Mental Health Condition to Include Schizoid
Effect,

Sleep Disturbances to Include Insomnia

Onset: n/a

History:

Prognosis:

#4. Claimed Condition: Sleep Paralysis

Onset: n/a

History:

Prognosis:

(Please follow format if more claims are being addressed)

Continued on next page
VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

PTSD SCREEN PC-PTSD

In your life, have you ever had any experience that was so
frightening, horrible, or upsetting that, in the past month,
you:

1. Have had nightmares about it or thought about it when you
did

not want to?
☐ Yes ☒ No

2. Tried hard not to think about it or went out of your way to
avoid situations that reminded you of it?
☐ Yes ☒ No

3. Were constantly on guard, watchful, or easily startled?
☐ Yes ☒ No

4. Felt numb or detached from others, activities, or your
surroundings?
☐ Yes ☒ No

Depression screen: PHQ2

Over the past two weeks, how often have you been bothered by
any

of the following problems?

Little interest or pleasure in doing things.
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than
half
the days ☒ 3 = Nearly every day

Feeling down, depressed, or hopeless.
☐ 0 = Not at all ☐ 1 = Several days ☒ 2 = More than
half
the days ☐ 3 = Nearly every day

Total Point Score: 5

Brief Suicide Risk Assessment

Continued on next page
VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- (Perform if score positive on Depression or PTSD screens)

Are you feeling hopeless about the present or future?
☐ Yes ☐ No

Have you had thoughts about taking your life - if yes - when
did

you have these thoughts and do you have a plan to take your
life?

☐ Yes ☐ No - no current suicidal plan or intent was
reported

Have you ever had a suicide attempt?
☐ Yes ☐ No

3. Physical Exam

1. Psychiatric (Specify any personality deviation)
☒ Normal ☐ Abnormal ☐ Not examined

5. Diagnosis:

#1. Claimed condition: Generalized Anxiety Disorder
Diagnosis/Rationale: Generalized Anxiety Disorder - the
service
member meets full DSM-5 criteria for this diagnosis

#2. Claimed condition: Major Depressive Disorder, Recurrent,
Moderate
Diagnosis/Rationale: Major Depressive Disorder, Recurrent,
Moderate -
the service member meets full DSM-5 criteria for this diagnosis

#3. Claimed condition: Mental Health Condition to Include Schizoid
Effect,
Sleep Disturbances to Include Insomnia
Diagnosis/Rationale: No diagnosos - symptoms of a Mental
Health
Condition to Include Schizoid Effect, Sleep Disturbances to Include Insomnia
can be considered part of the Major Depressive Disorder and Generalized

Continued on next page
VA Form 2507

C&P Final Report

Page: 11

Name: ANDERSON, DANIEL DENNIS
For DBQ PSYCH Mental disorders Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Anxiety Disorder and do not warrant a separate diagnosis

#4. Claimed condition: Sleep Paralysis

Diagnosis/Rationale: No diagnosis - symptoms of Sleep

Paralysis can

be considered part of the Generalized Anxiety Disorder and do not warrant a
separate diagnosis

(for additional Claim/diagnosis, please follow above format)

6. Remarks, if any:

All additional DBQs found to be necessary completed as appropriate at
time

of signing this DBQ?

[X] Yes [] No

/es/ MEGAN K RAVE LANKENAU
PSYCHOLOGIST
Signed: 09/25/2017 11:56

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1
WASHINGTON.VA.GOV
** FINAL **
Processing time: 54
For DBQ AUDIO Hearing loss & tinnitus Exam
=====

Name: ANDERSON,DANIEL DENNIS SSN: [REDACTED] ([REDACTED])
C-Number: [REDACTED]
DOB: [REDACTED] 1985
Address: [REDACTED]
City,State,Zip+4: Res Phone: [REDACTED]
GLEN BURNIE MARYLAND [REDACTED] Bus Phone:

Entered active service: NOV 1,2005 Last rating exam date:
Released active service: Not specified

Priority of exam: Unknown
=====

Examining provider: 2952104
Examined on: OCT 5,2017@09:00
=====

Examination results:

LOCAL TITLE: C&P AUDIOLOGY NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: OCT 05, 2017@09:00 ENTRY DATE: OCT 05, 2017@09:04:26
AUTHOR: MAHMOOD,SALLY L EXP COSIGNER:
INSTITUTION: WASHINGTON VA MEDICAL CENTER
DIVISION: WASHINGTON VAMC
URGENCY: STATUS: COMPLETED

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Normal hearing bilaterally.
Subjective Tinnitus. Veteran reports tinnitus effects his ability to sleep and uses a white noise machine to mask it out.

RIGHT EAR

+=====+

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

Exam Results Continued

A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg Hz
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **
5	10	10	15	10	15	10	11

LEFT EAR

A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg Hz
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **
10	15	15	25	15	25	15	18

Hearing Loss and Tinnitus
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] Not requested

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

Exam Results Continued

[X] Other (please identify other evidence reviewed):

IDES; Per VA 21-2507, Service member entered duty on 11/1/05 and is currently on active duty, pending MEB. Service member is claiming/reporting tinnitus today. Hearing is within normal limits bilaterall and Tinnitus is found today (see CAPRI report).

This exam is for: Hearing loss and/or tinnitus (audiologist, performing current exam)

SECTION 1: HEARING LOSS (HL)

1. Objective Findings

a. Puretone thresholds in decibels (air conduction):

RIGHT EAR

A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg Hz
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **
5	10	10	15	10	15	10	11

LEFT EAR

A	B	C	D	E	F	G	
500	1000	2000	3000	4000	6000	8000	Avg Hz
Hz*	Hz	Hz	Hz	Hz	Hz	Hz	(B-E) **
10	15	15	25	15	25	15	18

* The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

** The average of B, C, D, and E.

*** CNT - Could Not Test

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

Exam Results Continued

b. Were there one or more frequency(ies) that could not be tested: No

c. Validity of puretone test results: Test results are valid for rating purposes.

d. Speech Discrimination Score (Maryland CNC word list):

```

=====+
| RIGHT EAR | 100%
|=====+=====|
| LEFT EAR | 100%
|=====+=====|

```

e. Appropriateness of Use of Word Recognition Score (Maryland CNC word list):

Right Ear:

Is Word Discrimination Score available? Yes

Word Discrimination Score appropriateness:

Use of word recognition score is appropriate for this Veteran.

Left Ear:

Is Word Discrimination Score available? Yes

Word Discrimination Score appropriateness:

Use of word recognition score is appropriate for this Veteran.

f. Audiologic Findings

Summary of Immittance (Tympanometry) Findings:

```

=====+=====+=====+=====+=====+=====+=====+=====+=====+
|                | RIGHT EAR                | LEFT EAR                |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|
| Acoustic immittance | [X] Normal [ ] Abnormal | [X] Normal [ ] Abnormal |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|
| Ipsilateral        |                |                |
| Acoustic Reflexes | [X] Normal [ ] Abnormal | [X] Normal [ ] Abnormal |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|
| Contralateral       |                |                |
| Acoustic Reflexes | [X] Normal [ ] Abnormal | [X] Normal [ ] Abnormal |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|
| Unable to interpret |                |                |
| reflexes due to    | [ ]                | [ ]                |
| artifact           |                |                |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|
| Unable to obtain/   |                |                |
| maintain seal       | [ ]                | [ ]                |
|=====+=====+=====+=====+=====+=====+=====+=====+=====|

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Continued on next page

VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

=====

Exam Results Continued

2. Diagnosis

RIGHT EAR

☒ Normal hearing☐ Conductive hearing loss ICD code:☐ Mixed hearing loss ICD code:☐ Sensorineural hearing loss (in the frequency range of 500-4000 Hz)*
ICD code:☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or
higher frequencies)** ICD code:☐ Significant changes in hearing thresholds in service***

LEFT EAR

☒ Normal hearing☐ Conductive hearing loss ICD code:☐ Mixed hearing loss ICD code:☐ Sensorineural hearing loss (in the frequency range of 500-4000 Hz)*
ICD code:☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or
higher frequencies)** ICD code:☐ Significant changes in hearing thresholds in service***

NOTES:

* The Veteran may have hearing loss at a level that is not considered to be a disability for VA purposes. This can occur when the auditory thresholds are greater than 25 dB at one or more frequencies in the 500-4000 Hz range.

** The Veteran may have impaired hearing, but it does not meet the criteria to be considered a disability for VA purposes. For VA purposes, the diagnosis of hearing impairment is based upon testing at frequency ranges of 500, 1000, 2000, 3000, and 4000 Hz. If there is no HL in the 500-4000 Hz range, but there is HL above 4000 Hz, check this box.

Continued on next page
VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

Exam Results Continued

*** The Veteran may have a significant change in hearing threshold in service, but it does not meet the criteria to be considered a disability for VA purposes. (A significant change in hearing threshold may indicate noise exposure or acoustic trauma.)

3. Etiology

[X] Etiology opinion not indicated as:

[X] VBA did not request etiology

4. Functional impact of hearing loss

Does the Veteran's hearing loss impact ordinary conditions of daily life, including ability to work: No

5. Remarks, if any, pertaining to hearing loss:

Veteran reports he is in the Navy (2005 to present). Veteran reports from 2005 to 2009 he worked as an aviation boatsman on the flight deck and from 2009 to present works as cryptologic technician networking. Contralateral acoustic reflexes were not performed bilaterally; DBQ could not be completed without filling in these sections.

SECTION 2: TINNITUS

1. Medical history

Does the Veteran report recurrent tinnitus: Yes

Date and circumstances of onset of tinnitus: Veteran reports tinnitus began in 2010. Circumstance of onset of tinnitus is reportedly unknown.

2. Etiology of tinnitus

[X] Etiology opinion not indicated as:

[X] VBA did not request etiology

3. Functional impact of tinnitus

Does the Veteran's tinnitus impact ordinary conditions of daily life, including ability to work: Yes

If yes, describe impact in the Veteran's own words: Veteran reports

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ AUDIO Hearing loss & tinnitus Exam

=====

Exam Results Continued

tinnitus effects his sleep and uses white noise machine to mask it out.

4. Remarks, if any, pertaining to tinnitus:

Bilateral and intermittent.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

/es/ Sally L Mahmood, Au.D.

AUDIOLOGIST

Signed: 10/05/2017 09:04

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1

WASHINGTON.VA.GOV

** FINAL **

Processing time: 54
For DBQ DERM Skin Exam

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED]

C-Number: [REDACTED]

DOB: [REDACTED],1985

Address: [REDACTED]

City,State,Zip+4:

GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]

Bus Phone:

Entered active service: NOV 1,2005 Last rating exam date:

Released active service: Not specified

Priority of exam: Unknown

Examining provider: 792958

Examined on: OCT 18,2017@13:00

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY

STANDARD TITLE: C & P EXAMINATION NOTE

DATE OF NOTE: OCT 18, 2017@13:00 ENTRY DATE: OCT 18, 2017@11:34:24

AUTHOR: CHEU,TAMMY MEI-CHEN EXP COSIGNER:

INSTITUTION: WASHINGTON VA MEDICAL CENTER

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

Miscellaneous

Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS [REDACTED] [REDACTED]

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

SUBSPECIALTY - Separation Health Assessment (SHA)

Disability Benefits Questionnaire

* Internal VA or DOD Use Only*

Name of Claimant/Service member: ANDERSON, DANIEL DENNIS

SSN: [REDACTED] [REDACTED]

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

MEDICAL RECORD REVIEW:

No physical VA claims file was received for review.
VBMS was reviewed.
JLV (Joint Legacy Viewer) reviewed.
Other records reviewed: CPRS, DOD REMOTE DATA.

SUBSPECIALTY SHA
SKIN/SCAR

MEDICAL HISTORY OF CLAIMED CONDITION(S):

SM Anderson is a 32 y.o. Caucasian male who is undergoing the IDES process @ the DC VAMC C&P Clinic. He presents to this appointment for the Skin and Scars portion of the examination.

Active Duty Service Dates - Navy: 11/01/2005 to present.

Pertinent Medical Hx of Claimed Conditions:

1. ALLERGIC TO CATS

Reported history of allergies to dogs and cats since childhood. Improved after joining the military, especially during the 3 years on ship duty as there were no exposure to pets. Recurrence of symptoms around 2010 when SM Anderson was exposed to cats again, from "staying over at friend's with cats and parents' house". Symptoms included "skin itching, and I started having issues breathing." He takes Zyrtec and "over the counter inhalers". In the last 30 days, has had to take Zyrtec twice and one day use of inhaler due to overnight stay at a friend's house who has cats.

2. "SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD"

Reported history of "a large bump on my neck...started having a fever" in 2007 while on ship duty. Records review confirmed onset of abscess in January of 2007. Please refer to handwritten Chronological Record of Medical Care dated 01/24/2007 as well as multiple subsequent STRs through to March 2007. Abscess on left neck and scalp were treated with oral antibiotics, topical antibiotics and I & D. SM reported recurrence of mild abscess on the left side of neck with every other haircut. Self-treats with over the counter antibiotic ointment with effective outcome. Lesion resolves in few days. Residual scars asymptomatic and stable.

3. HAIR LOSS

SM reported noticing dry and flaky scalp in 2007 after MRSA abscess of the scalp. Since then, patch of alopecia on the crown of scalp has been gradually enlarging. Status post evaluation by Dermatology and biopsies in 2015. Currently no interventions nor treatment.

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS
 For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

RECORDS REVIEW GLEANING:

- 06/22/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
 "...The Chief Complaint is: Scalp. History of pre sent illness The Patient is a 30 year old male. 30 y/o male. Per patient, has history of MRSA infection on scalp about 5 to 6 years ago. Hair has never completely grown back. More recently has started to develop scale in same area as well as other areas of scalp. Unsure if area has remained the same size. He feels it has been getting larger...Physical findings...Skin: Skin: Scalp: Approx 1.5 to 2 cm annular patch of noticeably decreased hair density on posterior apex scalp. Smaller but also annular area next to it. Slightly raised scar like plaque. Follicle drop and tufting of hair noted. Mild erythema and scale...A/P Last Updated by T AYLOR, BRADLEY M @ 23 Jun 2015 1135 EDT. 1. Alopecia: Tufted, scarring alopecia on scalp after reported infection about 6 years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well..."

- 07/02/2015. Lab Test: Tissue Exam Specimen Source: TISSUE. "...SPECIMEN: A: Skin, Scalp, Punch B: Skin, Left scalp, Punch. FINAL DIAGNOSIS: A. SKIN, SCALP, PUNCH BIOPSY: - MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA. (SEE COMMENT).
 B. SKIN, LEFT SCALP, PUNCH BIOPSY: - NORMAL SCALP.
 COMMENT: The sections were difficult to interpret due to processing and orientation. In part A, the sections show a normal number of terminal hair follicles with a slightly increased number of vellus hairs. Mild superficial perifollicular lymphocytic inflammation is present. Evidence of scarring alopecia is not present in multiple additional step sections. If clinically indicated additional biopsies may be helpful..."

- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
 "...Physical findings...Skin: Multiple skin lesions. Lesions located. Lesions on the scalp Vertex scalp with short vellus hairs, mild bogginess of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp...A/P Last Updated by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1037 EDT... 2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo. Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered..."

Continued on next page
 VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

4. SKIN CONDITION TO INCLUDE SCROTAL CYST

SM reported recurrent cysts on scrotum since 2011. Has had as many as 6 lesions at the same time. Was evaluated by Dermatology in June 2017 and 3 lesions were excised and biopsied.

RECORDS REVIEW GLEANING:

- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
"...The Chief Complaint is: Rash...30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, ST D workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses aldara on them but has not been using it on the areas in question. Partner currently does not have any ST D or similar rash. Uses condoms. Has recently had bronchitis with subjective fevers which began before the papules appeared. HIV testing recently negative...Physical findings...Skin: Multiple skin lesions. Lesions located. Lesions on the scalp Vertex scalp with short vellus hairs, mild bogginess of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp. Perineal lesions. Lesions in the inguinal region. Punched out erythematous eroded papules on L and R groin without papules on the penis or scrotum on exam. Lesions on the right side of the groin. Lesions on the left side of the groin...Specimen: Groin, Left...Results: Final report. A/P Last Updated by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1037 EDT 1. SKIN NEOPLASM GROIN: Given punched out erosions on groin hx of multiple sexual partners, will get DFA today to rule out HSV infection. Previous tests showed non acute phase of HSV (IgG positive, IgM negative). Has had course of valtrex 500 twice daily for 10 days 1 month ago but did not resolve, may not have been correct treatment or may represent atypical presentation of another herpetic infection. Rest of STD workup negative...2. FOLLICULITIS DECAVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo. Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered..."

- 06/21/2017. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL.
"...The Chief Complaint is: Excision. The Patient is a 32 year old male. 32 y/o male presents for excision of scrotal cysts. In the Navy and currently on active duty. No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI...Physical findings...Skin:: On exam the following lesions were identified and examined: Multiple round subcutaneous cysts on the scrotum. * Complexion type II. A/P Last Updated by DIBLASI, DANIEL R @ 21 Jun 2017 1540 EDT. 1. Epidermal cyst: 32 y/o male with multiple EICs on the scrotum. 3

Continued on next page
VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

lesions excised. Patient tolerated the procedure..."

- 06/27/2017. Tissue Exam Specimen Source: TISSUE. "...SPECIMEN: Excision, scrotum. FINAL DIAGNOSIS: SKIN, SCROTUM, EXCISION: - CALCINOSIS CUTIS...CLINICAL DIAGNOSIS AND HISTORY: 32 year old male with several subcutaneous cysts on the scrotum. Three lesions excised. One was performed using punch biopsy..."

Ingrown Toenail Left foot: Please refer to Podiatry.

Body marks, tattoos: Not examined.

SKIN conditions of the Head, face, neck and scalp: Please refer to DBQ Skin/Scar template.

SKIN condition of the trunk, upper extremities, and/or lower extremities: Please refer to DBQ Skin/Scar template.

SCARS conditions of the Head, face, neck and scalp: Please refer to DBQ Skin/Scar template.

SCARS of the trunk, upper extremities, and/or lower extremities: Please refer to DBQ Skin/Scar template.

DIAGNOSIS

Claimed condition (Verbatim from 2507): ALLERGIC TO CATS
Diagnosis: ALLERGY TO CATS AND DOGS (ICD Code L23.81)
Date of Dx: History of Allergies to Cats and Dogs since childhood
Rationale: Please refer to med hx
Prognosis: With allergen exposure

Claimed condition (Verbatim from 2507): "SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD"
Diagnosis: a) LEFT NECK - FOLLICULITIS, INACTIVE, NO RESIDUAL SCAR; b) SCALP - PLEASE REFER TO HAIR LOSS BELOW (ICD Code L73.91)
Date of Dx: 1/18/2017
Rationale: Please refer to med hx and physical exam
Prognosis: N/A

Claimed condition (Verbatim from 2507): HAIR LOSS
Diagnosis: SCARRING ALOPECIA - FOLLICULITIS DECALVANS (ICD Code L66.2)
Date of Dx: 09/29/2015
Rationale: Please refer to med hx and physical exam

Continued on next page
VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Prognosis: Ongoing

Claimed condition (Verbatim from 2507): SKIN CONDITION TO INCLUDE SCROTAL CYST

Diagnosis: EPIDERMAL CYST OF THE SCROTUM (ICD Code L72.0)

Date of Dx: 06/21/2017

Rationale: Please refer to med hx and physical exam

Prognosis: Improved

RELEVANT LAB TESTS: Please refer to med hx

Skin Diseases
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS [REDACTED] [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)

[X] CPRS

[X] Other (please identify other evidence reviewed):
JLV (Joint Legacy Viewer)

Evidence Comments:

Please refer to Med hx.

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

FYI, name change court documentation available in VBMS. Name changed from Daniel Dennis Merwin to Daniel Anderson, court document signed 04/07/2017.

1. Diagnosis:

Does the Veteran now have or has he/she ever had a skin condition?

[X] Yes [] No

[X] Alopecia

ICD code: L66.2

Date of diagnosis: 09/29/2015

[X] Other skin condition

Other diagnosis #1: ALLERGY TO CATS AND DOGS

ICD code: L23.81

Date of diagnosis: History of Allergies to cats and dogs since childhood

Other diagnosis #2: LEFT NECK - FOLLICULITIS, INACTIVE

ICD code: L73.91

Date of diagnosis: 01/24/2007

Other diagnosis #3: EPIDERMAL CYST OF THE SCROTUM

ICD code: L72.0

Date of diagnosis: 06/21/2017

2. Medical History

- a. Describe the history (including onset and course) of the Veteran's skin conditions (brief summary):

SM Anderson is a 32 y.o. Caucasian male who is undergoing the IDES process @ the DC VAMC C&P Clinic. He presents to this appointment for the Skin and Scars portion of the examination.

Active Duty Service Dates - Navy: 11/01/2005 to present.

Pertinent Medical Hx of Claimed Conditions:

1. ALLERGIC TO CATS

Reported history of allergies to dogs and cats since childhood. Improved after joining the military, especially during the 3 years on ship duty as there were no exposure to pets. Recurrence of symptoms around 2010 when SM Anderson was exposed to cats again, from "staying over at friend's with cats and parents' house". Symptoms included "skin itching, and I started having issues breathing." He takes Zyrtec and "over the counter inhalers". In the last 30 days, has had to take Zyrtec twice and one day use of inhaler due to overnight stay at a

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS
 For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

friend's house who has cats.

2. "SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD"

Reported history of "a large bump on my neck...started having a fever" in 2007 while on ship duty. Records review confirmed onset of abscess in January of 2007. Please refer to handwritten Chronological Record of Medical Care dated 01/24/2007 as well as multiple subsequent STRs through to March 2007. Abscess on left neck and scalp were treated with oral antibiotics, topical antibiotics and I & D. SM reported recurrence of mild abscess on the left side of neck with every other haircut. Self-treats with over the counter antibiotic ointment with effective outcome. Lesion resolves in few days. Residual scars asymptomatic and stable.

3. HAIR LOSS

SM reported noticing dry and flaky scalp in 2007 after MRSA abscess of the scalp. Since then, patch of alopecia on the crown of scalp has been gradually enlarging. Status post evaluation by Dermatology and biopsies in 2015. Currently no interventions nor treatment.

RECORDS REVIEW GLEANING:

- 06/22/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL. "...The Chief Complaint is: Scalp. History of pre sent illness The Patient is a 30 year old male. 30 y/o male. Per patient, has history of MRSA infection on scalp about 5 to 6 years ago. Hair has never completely grown back. More recently has started to develop scale in same area as well as other areas of scalp. Unsure if area has remained the same size. He feels it has been getting larger...Physical findings...Skin: Skin: Scalp: Approx 1.5 to 2 cm annular patch of noticeably decreased hair density on posterior apex scalp. Smaller but also annular area next to it. Slightly raised scar like plaque. Follicle drop and tufting of hair noted. Mild erythema and scale...A/P Last Updated by T AYLLOR, BRADLEY M @ 23 Jun 2015 1135 EDT. 1. Alopecia: Tufted, scarring alopecia on scalp after reported infection about 6 years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well..."

- 07/02/2015. Lab Test: Tissue Exam Specimen Source: TISSUE.
 "...SPECIMEN:

Continued on next page
 VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS
 For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

A: Skin, Scalp, Punch B: Skin, Left scalp, Punch. FINAL DIAGNOSIS: A. SKIN, SCALP, PUNCH BIOPSY: - MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA. (SEE COMMENT).

B. SKIN, LEFT SCALP, PUNCH BIOPSY: - NORMAL SCALP.

COMMENT: The sections were difficult to interpret due to processing and orientation. In part A, the sections show a normal number of terminal hair follicles with a slightly increased number of vellus hairs. Mild superficial perifollicular lymphocytic inflammation is present. Evidence of scarring alopecia is not present in multiple additional step sections. If clinically indicated additional biopsies may be helpful..."

- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL. "...Physical findings...Skin: Multiple skin lesions. Lesions located. Lesions on the scalp Vertex scalp with short vellus hairs, mild bogginess of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp...A/P Last Updated by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1037 EDT... 2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo. Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered..."

4. SKIN CONDITION TO INCLUDE SCROTAL CYST

SM reported recurrent cysts on scrotum since 2011. Has had as many as 6 lesions at the same time. Was evaluated by Dermatology in June 2017 and 3 lesions were excised and biopsied.

RECORDS REVIEW GLEANING:

- 09/29/2015. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL. "...The Chief Complaint is: Rash...30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, ST D workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses aldara on them but has not been using it on the areas in question. Partner currently does not have any ST D or similar rash. Uses condoms. Has recently had bronchitis with subjective fevers which began before the papules appeared. HIV testing recently negative...Physical findings...Skin: Multiple skin lesions. Lesions located. Lesions on the scalp Vertex scalp with short vellus hairs, mild bogginess of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp. Perineal lesions. Lesions in the inguinal region. Punched out erythematous eroded papules on L and R

Continued on next page
 VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

groin without papules on the penis or scrotum on exam. Lesions on the right side of the groin. Lesions on the left side of the groin...Specimen: Groin, Left...Results: Final report. A/P Last Updated by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1037 EDT 1. SKIN NEOPLASM GROIN: Given punched out erosions on groin hx of multiple sexual partners, will get DFA today to rule out HSV infection. Previous tests showed non acute phase of HSV (IgG positive, IgM negative). Has had course of valtrex 500 twice daily for 10 days 1 month ago but did not resolve, may not have been correct treatment or may represent atypical presentation of another herpetic infection. Rest of STD workup negative...2. FOLLICULITIS DECAVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo. Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered..."

- 06/21/2017. WALTER REED NATIONAL MILITARY MEDICAL CNTR DERMATOLOGY CL. "...The Chief Complaint is: Excision. The Patient is a 32 year old male. 32 y/o male presents for excision of scrotal cysts. In the Navy and currently on active duty. No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI...Physical findings...Skin:: On exam the following lesions were identified and examined: Multiple round subcutaneous cysts on the scrotum. * Complexion type II. A/P Last Updated by DIBLASI, DANIEL R @ 21 Jun 2017 1540 EDT. 1. Epidermal cyst: 32 y/o male with multiple EICs on the scrotum. 3 lesions excised. Patient tolerated the procedure..."

- 06/27/2017. Tissue Exam Specimen Source: TISSUE. "...SPECIMEN: Excision, scrotum. FINAL DIAGNOSIS: SKIN, SCROTUM, EXCISION: - CALCINOSIS CUTIS...CLINICAL DIAGNOSIS AND HISTORY: 32 year old male with several subcutaneous cysts on the scrotum. Three lesions excised. One was performed using punch biopsy..."

Ingrown Toenail Left foot: Please refer to Podiatry.

- b. Do any of the Veteran's skin conditions cause scarring (regardless of location), or disfigurement of the head, face or neck?
[] Yes [X] No
- c. Does the Veteran have any benign or malignant skin neoplasms (including malignant melanoma)?

Continued on next page
VA Form 2507

C&P Final Report

Page: 11

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

☐ Yes ☒ No

- d. Does the Veteran have any systemic manifestations due to any skin diseases (such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)?

☐ Yes ☒ No

- e. Comments, if any:

No response provided.

3. Treatment

- a. Has the Veteran been treated with oral or topical medications in the past 12 months for any skin condition?

☒ Yes ☐ No☒ Antihistamines

If checked, list medication(s): ZYRTEC

Specify condition medication used for: Environmental Allergies to cats

Total duration of medication use in past 12 months:

☒ < 6 weeks☐ 6 weeks or more, but not constant☐ Constant/near-constant

- b. Has the Veteran had any treatments or procedures other than systemic or topical medications in the past 12 months for exfoliative dermatitis or papulosquamous disorders?

☐ Yes ☒ No

4. Debilitating and non-debilitating episodes

- a. Has the Veteran had any debilitating episodes in the past 12 months due to urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis?

☐ Yes ☒ No

- b. Has the Veteran had any non-debilitating episodes of urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis in the past 12 months?

☐ Yes ☒ No

5. Physical exam

Continued on next page
VA Form 2507

C&P Final Report

Page: 12

Name: ANDERSON, DANIEL DENNIS
 For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- a. Indicate the Veteran's visible skin conditions; indicate the approximate total body area and approximate total EXPOSED body area (face, neck and hands) affected on current examination (check all that apply):

☒ The Veteran does not have any of the above listed visible skin conditions

6. Specific Skin Conditions

 Indicate the Veteran's specific skin conditions and complete all applicable subsequent questions (check all that apply):

☒ Scarring alopecia

If checked, indicate percent of scalp affected:

☒ < 20% ☐ 20 to 40% ☐ > 40%

7. Tumors and neoplasms

- a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☒ No

8. Other pertinent physical findings, complications, conditions, signs or symptoms

- a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
☒ Yes ☐ No

If yes, describe:

Claimed condition (Verbatim from 2507): ALLERGIC TO CATS
 - No active lesions found on today's exam. No active exposure today.
 - % total body area affected: 0%
 - % exposed area affected: 0%
 - Severity: Inactive on today's exam
 - DIAGNOSIS: ALLERGY TO CATS AND DOGS (ICD Code L23.81)
 Date of Dx: History of Allergies to Cats and Dogs since childhood
 Rationale: Please refer to med hx
 Prognosis: With allergen exposure

Continued on next page
 VA Form 2507

C&P Final Report

Page: 13

Name: ANDERSON, DANIEL DENNIS
 For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Claimed condition (Verbatim from 2507): "SCARRING FROM MERSA BACK OF NECK AND TOP OF HEAD"

- LEFT LATERAL NECK: No scarring found for measurement. Mobile nodule of 0.5 cm or less, flesh color, non-erythematous, non-pustular.
- CROWN OF SCALP: Please refer to Hair Loss condition below.
- % total body area affected: <5%
- % exposed area affected: <5%
- Severity: Inactive Folliculitis of the left neck
- DIAGNOSIS: a) LEFT NECK - FOLLICULITIS, INACTIVE, NO RESIDUAL SCAR (ICD Code L73.91); b) SCALP - PLEASE REFER TO HAIR LOSS BELOW (ICD Code Please see Hair Loss Condition)
- Date of Dx: 1/18/2017
- Rationale: Please refer to med hx and physical exam
- Prognosis: N/A

Claimed condition (Verbatim from 2507): HAIR LOSS

- Vertex Scalp: Patch alopecia measuring approx 2.5 cm x 2 cm. Smooth surface with absence of follicular orifice with the exception of a few tufting of hair within the alopecia patch. Mild scaling and erythema on periphery of alopecia. No active pustules noted on this exam.
- % total body area affected: <5%
- % exposed area affected: <5%
- Severity: Measures 2.5 cm x 2 cm on today's exam. Last measurement on 06/22/2015 was ~1.5 to 2 cm patch.
- DIAGNOSIS: SCARRING ALOPECIA - FOLLICULITIS DECALVANS (ICD Code L66.2)
- Date of Dx: 09/29/2015
- Rationale: Please refer to med hx and physical exam
- Prognosis: Ongoing

Claimed condition (Verbatim from 2507): SKIN CONDITION TO INCLUDE SCROTAL CYST

- Three subcutaneous, flesh color, non-erythematous, non-tender, non-draining, mobile cysts of less than 0.3 cm noted on right scrotum.
- % total body area affected: <5%
- % exposed area affected: 0%
- Severity: Mild
- DIAGNOSIS: EPIDERMAL CYST OF THE SCROTUM (ICD Code L72.0)
- Date of Dx: 06/21/2017
- Rationale: Please refer to med hx and physical exam
- Prognosis: Improved

Continued on next page
 VA Form 2507

C&P Final Report

Page: 14

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

b. Comments, if any:
No response provided.

9. Functional impact

Do any of the Veteran's skin conditions impact his or her ability to work?

[] Yes [X] No

10. Remarks, if any:

No remarks provided.

Scars/Disfigurement
Disability Benefits Questionnaire

Name of patient/Veteran: ANDERSON, DANIEL DENNIS [REDACTED] [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)

[X] CPRS

[X] Other (please identify other evidence reviewed):
JLV (Joint Legacy Viewer)

Continued on next page
VA Form 2507

C&P Final Report

Page: 15

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Evidence Comments:

Please refer to Med hx.

FYI, name change court documentation available in VBMS. Name changed from Daniel Dennis Merwin to Daniel Anderson, court document signed 04/07/2017.

1. Diagnosis

Does the Veteran have one or more scars anywhere on the body, or disfigurement of the head, face, or neck? No

Does the Veteran have any scars on the trunk or extremities (regions other than the head, face or neck): No

Does the Veteran have any scars or disfigurement of the head, face or neck: No

SECTION I: Scars of the trunk and extremities: No response provided

SECTION II: Scars or other disfigurement of the head, face, or neck: No response provided

SECTION III: Miscellaneous

1. Limitation of function/other conditions

Do any of the scars (regardless of location) or disfigurement of the head, face, or neck result in limitation of function? No

Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms (such as muscle or nerve damage) associated with any scar (regardless of location) or disfigurement of the head, face, or neck? No

Comments, if any: No residual scar found on left lateral neck for measurement. Please refer to DBQ Skin for Left neck folliculitis finding and documentation.

2. Color photographs

Color photographs for any scars or disfiguring conditions of the head, face,

Continued on next page
VA Form 2507

C&P Final Report

Page: 16

Name: ANDERSON, DANIEL DENNIS
For DBQ DERM Skin Exam

SSN: [REDACTED]

C-number: [REDACTED]

=====

Exam Results Continued

or neck: Photographs not indicated

3. Functional impact

Does the Veteran's scar(s) (regardless of location) or disfigurement of the head, face, or neck impact his or her ability to work? No

4. Remarks, if any: No response provided

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

/es/ TAMMY MEI-CHENG CHEU
NURSE PRACTITIONER
Signed: 10/18/2017 11:34

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1
WASHINGTON.VA.GOV
** FINAL **
Processing time: 54
For DBQ MUSC Ankle Exam
=====

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED])
C-Number: [REDACTED]
DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:
GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]
Bus Phone: [REDACTED]

Entered active service: NOV 1,2005 Last rating exam date:
Released active service: Not specified

Priority of exam: Unknown
=====

Examining provider: 2964755
Examined on: SEP 10,2017@09:30
=====

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: SEP 10, 2017@09:30 ENTRY DATE: SEP 18, 2017@14:18:19
AUTHOR: THAI,MINHTAM EXP COSIGNER:
INSTITUTION: WASHINGTON VA MEDICAL CENTER
DIVISION: WASHINGTON VAMC
URGENCY: STATUS: COMPLETED

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis [REDACTED]

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

Subspecialty - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

☐ Yes ☐ No ☐ N/A

Any changes to his/her health status since DD 2807-1 completed?

☐ Yes ☐ No ☐ N/A

(Proposed) Date of separation from active service:

1. Medical record review

Was the Veteran's VA claims file reviewed?

☒ Yes ☐ No2. Medical claims: For each claimed condition you are
Addressing as per 2507, please provide the following:

#1. Claimed Condition: ankle condition left.

Onset: 2013 and 2014

Diagnosis: Left ankle sprain resolved with no residual.

Rationale: history, xrays, MRI, exam.

Prognosis: good.

#2. Claimed Condition: ingrown toe nail left foot.

Onset: unknown.

Diagnosis: Paronychia left hallux.

Rationale: history, exam.

Prognosis: stable.

***Veteran was strongly recommended to follow up with PCM for
treatment/referral for this condition.

Ankle Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination
Request?☒ Yes ☐ NoContinued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

☒ In-person examination

Evidence Review

Evidence reviewed (check all that apply):

☒ VA e-folder (VBMS or Virtual VA)
☒ CPRS

1. Diagnosis

a. List the claimed condition(s) that pertain to this DBQ: ankle condition left.

b. Select diagnoses associated with the claim condition(s) (Check all that apply):

☒ Other (specify):

Other diagnosis: Left ankle sprain resolved with no residual.
ICD Code: 799.9
Side affected: Left
Date of diagnosis: Left:9/10/2017

c. Comments (if any): No response provided

d. Was an opinion requested about this condition (Internal VA only)?
☐ Yes ☒ No ☐ N/A

2. Medical History

a. Describe the history (including onset and course) of the Veteran's ankle condition (brief summary): Claimed Condition: ankle condition left.

Veteran stated that his left ankle "hurts" and "cracks" with he walks on it.

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS
 For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

He started having this problem around 2014. He was treated with physical therapy. Besides physical therapy he has not had any other treatment so far.

***STRs: Reviewed of STRs showed that veteran was treated for left ankle sprain in November 2013 and June 2014. These injuries resolved with no residual. There was no problem related to left ankle documented on Medical Evaluation Board Reported dated 7/13/2017.

- b. Does the Veteran report flare-ups of the ankle?
☐ Yes ☒ No
- c. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this DBQ (regardless of repetitive use)?
☒ Yes ☐ No

If yes, document the Veteran's description of functional loss or functional impairment in his or her own words:

Veteran stated that he cannot be active as before due to left ankle pain.

3. Range of motion (ROM) and functional limitations

a. Initial range of motion

Right ankle

- ☒ All Normal
☐ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

Dorsiflexion (0-20): 0 to 20 degrees
 Plantar Flexion (0-45): 0 to 45 degrees

Description of pain (select best response):
 No pain noted on exam

Is there evidence of pain with weight bearing? ☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☒ No

Is there objective evidence of crepitus? ☐ Yes ☒ No

Continued on next page
 VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Left ankle

- ☒ All Normal
☐ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

Dorsiflexion (0-20): 0 to 20 degrees
Plantar Flexion (0-45): 0 to 45 degrees

Description of pain (select best response):
No pain noted on exam

Is there evidence of pain with weight bearing? ☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☒ No

Is there objective evidence of crepitus? ☐ Yes ☒ No

b. Observed repetitive use

Right ankle

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☒ Yes ☐ No

Is there additional loss of function or range of motion after three repetitions? ☐ Yes ☒ No

Left ankle

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☒ Yes ☐ No

Is there additional loss of function or range of motion after three repetitions? ☐ Yes ☒ No

c. Repeated use over time

Continued on next page
VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Right ankle

Is the Veteran being examined immediately after repetitive use over time?
☒ Yes ☐ No

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?
☐ Yes ☒ No ☐ Unable to say w/o mere speculation

Left ankle

Is the Veteran being examined immediately after repetitive use over time?
☒ Yes ☐ No

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?
☐ Yes ☒ No ☐ Unable to say w/o mere speculation

d. Flare-ups: Not applicable

e. Additional factors contributing to disability

Right ankle

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
None

Left ankle

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
None

4. Muscle strength testing

a. Muscle strength - rate strength according to the following scale

- 0/5 No muscle movement
- 1/5 Palpable or visible muscle contraction, but no joint movement
- 2/5 Active movement with gravity eliminated
- 3/5 Active movement against gravity

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

4/5 Active movement against some resistance
5/5 Normal strength

Right ankle:

Rate Strength: Plantar Flexion: 5/5
Dorsiflexion: 5/5

Is there a reduction in muscle strength? ☐ Yes ☒ No

Left ankle:

Rate Strength: Plantar Flexion: 5/5
Dorsiflexion: 5/5

Is there a reduction in muscle strength? ☐ Yes ☒ No

b. Does the Veteran have muscle atrophy? ☐ Yes ☒ No

c. Comments, if any:

No response provided

5. Ankylosis

Complete this section if Veteran has ankylosis of the ankle

a. Indicate severity of ankylosis and side affected (check all that apply):

Right side:

☐ In plantar flexion
☐ In dorsiflexion
☐ With an abduction deformity
☐ With an inversion deformity
☐ With an eversion deformity
☐ In good weight-bearing position
☐ In poor weight-bearing position
☒ No ankylosis

Left side:

☐ In plantar flexion
☐ In dorsiflexion
☐ With an abduction deformity
☐ With an inversion deformity
☐ With an eversion deformity
☐ In good weight-bearing position
☐ In poor weight-bearing position
☒ No ankylosis

b. Comments, if any:

No response provided

6. Joint stability

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Right ankle

Is ankle instability or
dislocation suspected? [] Yes [X] No

Left ankle

Is ankle instability or
dislocation suspected? [] Yes [X] No

7. Additional comments

Does the Veteran now have or has he or she ever had "shin splints", stress fractures, achilles tendonitis, achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a talectomy (astragalectomy)? [] Yes [X] No

8. Surgical procedures

No response provided

9. Other pertinent physical findings, complications conditions, signs, symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above? [] Yes [X] No

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above? [] Yes [X] No

c. Comments, if any:
No response provided

10. Assistive devices

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
[] Yes [X] No

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:

Continued on next page
VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS
 For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

No response provided

11. Remaining effective function of the extremities

 Due to the Veteran's ankle condition, is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

[] Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.

[X] No

12. Diagnostic testing

- a. Have imaging studies of the ankle been performed and are the results available? [X] Yes [] No

If yes, is degenerative or traumatic arthritis documented?

[] Yes [X] No

- b. Are there any other significant diagnostic test findings or results?

[X] Yes [] No

If yes, provide type of test or procedure, date and results (brief summary):

Exam Date/Time

02/16/2016 14:10

Procedure Name

ANKLE, LT 3 VIEWS

Report

ANKLE, LT 3 VIEWS

Exm Date: 02/16/2016 14:10

Req Phys: Pat Loc:

Img Loc: INT MED MEDICAL HOME CL C BE

WRNMMC BETHESDA, MD

Service:

Exam: ANKLE, LT 3 VIEWS CPT:

Report Status: FINAL Date Verified: 02/16/2016 14:54

Continued on next page
 VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Reason For Order:
Procedure: ANKLE, LT 3 VIEWS
20160216140700
Exam #: 16054521
Exam Date/Time: 20160216141000
Transcription Date/Time: 20160216145500
Provider: 243469 WILSON, BRYAN JAMES
Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC
BETHESDA, MD
Status: COMPLETE
<E>
Amended Result Code: 9 SEE RADIOLOGIST'S REPORT
Interpreted By: 92925 FISHER, ZACHARY ETHAN
Supervised By: 92925 ZACHARY E FISHER, MAJ, MC, Dept of Radiology
Approved By: 92925 FISHER, ZACHARY ETHAN
Approved Date: 20160216145400
Supervised By: 92925 ZACHARY E FISHER, MAJ, MC, Dept of Radiology
Supervised By Date: 20160216145400
Report Text: Comparison: MRI October 5, 2014 and prior radiographs
May 6, 2014

Findings: Routine radiographs of the ankle were obtained. Normal alignment is present without evidence for acute fracture or dislocation. There is mild lateral soft tissue swelling present. The ankle mortise and talar dome are intact. The joint spaces are preserved without significant degenerative changes.

Impression: Lateral soft tissue swelling without evidence for acute bony abnormality

Electronically signed by: Dr. ZACHARY ETHAN FISHER Department of Radiology Walter Reed National Military Medical Center

Date: 02/16/16 Time: 14:54

SEE RADIOLOGIST'S REPORT

Primary Diagnostic Code: NONE
Secondary Diagnostic Codes:

Continued on next page
VA Form 2507

C&P Final Report

Page: 11

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Facility: WRNMMC

Exam Date/Time

10/05/2014 14:43

Procedure Name

MRI, ANKLE LT W OR W/O CON

Report

MRI, ANKLE LT W OR W/O CON

Exm Date: 10/05/2014 14:43

Req Phys: Pat Loc:

Img Loc: INT MED MEDICAL HOME CL C BE
WRNMMC BETHESDA, MD

Service:

Exam: MRI, ANKLE LT W OR W/O CON CPT:

Report Status: FINAL Date Verified: 10/06/2014 15:52

Reason For Order:

Procedure: MRI, ANKLE LT W OR W/O CON

20140926132800

Exam #: 14327823

Exam Date/Time: 20141005144300

Transcription Date/Time: 20141006155100

Provider: 87746 AUSTIN, MARIE

Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC
BETHESDA, MD

Status: COMPLETE

<E>

Amended Result Code: 9 SEE RADIOLOGIST'S REPORT

Interpreted By: 180048 LUTYNSKI, MATTHEW LEO

Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN

Approved By: 180048 LUTYNSKI, MATTHEW LEO

Approved Date: 20141006155200

Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN

Supervised By Date: 20141006155200

Report Text:

HISTORY: Continuous pain following injury

COMPARISONS: Left foot and ankle radiographs dated 5/6/14

Continued on next page
VA Form 2507

C&P Final Report

Page: 12

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

TECHNIQUE: WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS: ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons: Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments: Syndesmotomic ankle ligaments: within normal limits.

Low lateral ankle ligaments: The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Continued on next page
VA Form 2507

C&P Final Report

Page: 13

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Chondral surfaces: within normal limits.

FOREFOOT: Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments: Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae: No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION: Findings suggestive of prior lateral ankle sprain.

Electronica
lly signed by resident: Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14
Time:14:23

- c. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:
No response provided

13. Functional impact

Continued on next page
VA Form 2507

C&P Final Report

Page: 14

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Regardless of the Veteran's current employment status, do the condition(s) listed in the Diagnosis Section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?
[] Yes [X] No

14. Remarks, if any

Claimed Condition: ankle condition left.
Onset: 2013 and 2014
Diagnosis: Left ankle sprain resolved with no residual.

***STRs: Reviewed of STRs showed that veteran was treated for left ankle sprain in November 2013 and June 2014. These injuries resolved with no residual. There was no problem related to left ankle documented on Medical Evaluation Board Reported dated 7/13/2017.

Correia Criteria:

1. Is there evidence of pain on left ankle's ROM testing: No.
2. Is there evidence of pain when left ankle joint is used in non-weight bearing? No.

Foot Conditions, including Flatfoot (Pes Planus)
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?
[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Continued on next page
VA Form 2507

C&P Final Report

Page: 15

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Evidence Review

Evidence reviewed (check all that apply):

- ☒ VA e-folder (VBMS or Virtual VA)
☒ CPRS

1. Diagnosis

a. List the claimed condition(s) that pertain to this DBQ:

ingrown toe nail left foot.

b. Select diagnoses associated with the claimed condition(s):

☒ Other (specify):

Other diagnosis: Paronychia left hallux.

Side affected: Left

ICD code: 388983002

Date of diagnosis (left side): 9/10/2017

c. Comments (if any):

No response provided

d. Was an opinion requested about this condition (internal VA only)?

☐ Yes ☒ No ☐ N/A

2. Medical history

a. Describe the history (including onset and course) of the Veteran's foot condition (brief summary):

Claimed Condition: ingrown toe nail left foot.

Veteran stated that he dropped a weight on top of his left foot while on the ship around 2007. Since then he developed ingrown nail problem in left big toe. He has tried to self treat it with neosporin ointment so far.

Continued on next page
VA Form 2507

C&P Final Report

Page: 16

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

- b. Does the Veteran report pain of the foot being evaluated on this DBQ?
☐ Yes ☒ No
- c. Does the Veteran report that flare-ups impact the function of the foot?
☐ Yes ☒ No
- d. Does the Veteran report having any functional loss or functional impairment of the foot being evaluated on this DBQ (regardless of repetitive use)?
☐ Yes ☒ No

3. Flatfoot (pes planus)

No response provided

4. Morton's neuroma (Morton's disease) and metatarsalgia

No response provided

5. Hammer toe

No response provided

6. Hallux valgus

No response provided

7. Hallux rigidus

No response provided

8. Acquired pes cavus (clawfoot)

No response provided

9. Malunion or nonunion of tarsal or metatarsal bones

No response provided

Continued on next page
VA Form 2507

C&P Final Report

Page: 17

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

10. Foot injuries and other conditions

a. Does the Veteran have any foot injuries or other foot conditions not already described?

☐ Yes ☒ No

b. Indicate severity and side affected:

No response provided

c. Does the foot condition chronically compromise weight bearing?

No response provided

d. Does the foot condition require arch supports, custom orthotic inserts or shoe modifications?

No response provided

e. Comments: No comments provided

11. Surgical procedures

a. Has the Veteran had foot surgery (arthroscopic or open)?

☐ Yes ☒ No

b. Does the Veteran have any residual signs or symptoms due to arthroscopic or other foot surgery?

No response provided

12. Pain

RIGHT FOOT:

Is there pain on physical exam?

☐ Yes ☒ No

If no, but the Veteran reported pain in his/her medical history, please provide rationale below.

No response provided

LEFT FOOT:

Is there pain on physical exam?

☐ Yes ☒ No

Continued on next page
VA Form 2507

AR 1445

C&P Final Report

Page: 18

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

If no, but the Veteran reported pain in his/her medical history, please
provide rationale below.
No response provided

13. Functional loss and limitation of motion

a. Contributing factors of disability (check all that apply and indicate side
affected):

[X] No functional loss for left lower extremity attributable to claimed
condition

[X] No functional loss for right lower extremity attributable to claimed
condition

Contributing factors of disability associated with limitation of motion:

b. Is there pain, weakness, fatigability, or incoordination that significantly
limits functional ability during flare-ups or when the foot is used
repeatedly over a period of time?

RIGHT FOOT: [] Yes [X] No

LEFT FOOT: [] Yes [X] No

c. Is there any other functional loss during flare-ups or when the foot is used
repeatedly over a period of time?

RIGHT FOOT: [] Yes [X] No

LEFT FOOT: [] Yes [X] No

14. Other pertinent physical findings, complications, conditions, signs,
symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications,
conditions, signs or symptoms related to any conditions listed in the
Diagnosis section above?

[X] Yes [] No

If yes, describe (brief summary):

Continued on next page
VA Form 2507

C&P Final Report

Page: 19

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

Left hallux: mild edema and erythema on both medial and lateral nail fold.

- b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☒ No

c. Comments: No comments provided

15. Assistive devices

- a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
☐ Yes ☒ No

- b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:
No response provided.

16. Remaining effective function of the extremities

Due to the Veteran's foot condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

- ☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☒ No

17. Diagnostic testing

- a. Have imaging studies of the foot been performed and are the results available?
☐ Yes ☒ No
- b. Are there any other significant diagnostic test findings or results?
☐ Yes ☒ No
- c. If any test results are other than normal, indicate relationship of abnormal

Continued on next page
VA Form 2507

C&P Final Report

Page: 20

Name: ANDERSON, DANIEL DENNIS
For DBQ MUSC Ankle Exam

SSN: [REDACTED]

C-number: [REDACTED]

Exam Results Continued

findings to diagnosed condition:
No response provided

18. Functional impact

Regardless of the Veteran's current employment status, do the condition(s) listed in the Diagnosis section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

[] Yes [X] No

19. Remarks, if any:

Claimed Condition: ingrown toe nail left foot.

Diagnosis: Paronychia left hallux.

Onset: unknown.

Veteran was strongly recommended to follow up with PCM for treatment/referral for this condition.

/es/ MINHTAM THAI
PHYSICIAN
Signed: 09/18/2017 14:18

This exam has been reviewed and approved by the examining provider.

VA Form 2507

Date: OCT 26,2017 Compensation and Pension Exam Report Page: 1

WASHINGTON.VA.GOV

** FINAL **

Processing time: 54

For DBQ NEURO Headaches (including migraine headaches) Exam

Name: ANDERSON,DANIEL DENNIS

SSN: [REDACTED] ([REDACTED]

C-Number: [REDACTED]

DOB: [REDACTED] 1985

Address: [REDACTED]

City,State,Zip+4:

GLEN BURNIE MARYLAND [REDACTED]

Res Phone: [REDACTED]

Bus Phone:

Entered active service: NOV 1,2005

Last rating exam date:

Released active service: Not specified

Priority of exam: Unknown

Examining provider: 6452

Examined on: OCT 18,2017@12:00

Examination results:

LOCAL TITLE: COMPENSATION ASSESSMENT COPY

STANDARD TITLE: C & P EXAMINATION NOTE

DATE OF NOTE: OCT 18, 2017@12:00

ENTRY DATE: OCT 25, 2017@16:15:48

AUTHOR: LEVINE,BARBARA

EXP COSIGNER:

INSTITUTION: WASHINGTON VA MEDICAL CENTER

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

Miscellaneous

Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis - [REDACTED]

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

SUBSPECIALTY - Separation Health Assessment (SHA)

Disability Benefits Questionnaire

* Internal VA or DOD Use Only*

Name of patient/Service member: ANDERSON,DANIEL DENNIS

SSN: [REDACTED]

Continued on next page
VA Form 2507

C&P Final Report

Page: 2

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam

Exam Results Continued

MEDICAL RECORD REVIEW:

The VA claims file was reviewed.

VBMS was reviewed.

Other records reviewed: CPRS AND VBMS

SUBSPECIALTY SHA

NEUROLOGY

MEDICAL HISTORY OF CLAIMED CONDITION(s):

sleep paralysis (sleep study date 10/4/2017)

migraines/headaches

Additional history of OTHER Headache, Head Trauma, Neurological conditions?

No

PHYSICAL EXAM:

Head (to include HA, Head Trauma): Please refer to DBQ HEADACHES
templates.

Neck, Thoracolumbar, and/or Sacral Spine: Normal

Upper and Lower Extremities Neuro conditions (except feet): Normal

Sleep Apnea claimed on 2507: YES - SLEEP STUDY ON 10/4/2017; RESULTS ON
10-24-17 SHOW MILD OBSTRUCTIVE SLEEP APNEA

DIAGNOSIS:

Claimed condition (Verbatim from 2507): sleep paralysis (sleep study date
10/4/2017)

Diagnosis: MILD OBSTRUCTIVE SLEEP APNEA, NO SLEEP PARALYSIS

Rationale: REVIEW OF STRS, SLEEP CLINIC NOTES, SLEEP STUDY RESULTS

Prognosis: STABLE

Claimed condition (Verbatim from 2507): headaches/migraines

Diagnosis: MIGRAINE HEADACHES NOT INTRACTABLE

Rationale: REVIEW OF STRS, HISTORY, PHYSICAL

Prognosis: CHRONIC

Continued on next page
VA Form 2507

C&P Final Report

Page: 3

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam
=====

Exam Results Continued

Headaches (including Migraine Headaches)
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis - [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

[X] Yes [] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)

[X] CPRS

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a headache condition?

[X] Yes [] No

[X] Migraine including migraine variants

ICD code: G43.909

Date of diagnosis: active duty

2. Medical History

a. Describe the history (including onset and course) of the Veteran's headache conditions (brief summary):

claimed condition: headaches/migraines

This 32 year old SM first began to experience headaches in 2008. There was no head injury or trauma. Headaches would be present upon awakening and then sometimes during the day I would sometimes get a headache.

Continued on next page
VA Form 2507

C&P Final Report

Page: 4

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
 For DBQ NEURO Headaches (including migraine headaches) Exam

=====

Exam Results Continued

The location of headache is over the crown of the head and in back of the head
 and sometimes behind the eye.
 Currently the frequency of these headaches is 2-3 headaches a week.
 Intensity is 7-8/10. Will lay in bed if it gets too bad. Sometimes Alleve will work; the duration is usually 4-5 hours long; cannot do anything when I have a headache; if at home goes to bed or waits until it goes away; it hurts to move (due to headache); if at work just stares at screen;
 Sometimes is aware of when headache is about to happen - gets twitching in left eye.
 Takes alleve or excedrin for relief as needed

- b. Does the Veteran's treatment plan include taking medication for the diagnosed condition?
☒ Yes ☐ No

If yes, describe treatment (list only those medications used for the diagnosed condition):
 uses alleve and excedrin as needed

3. Symptoms

-
- a. Does the Veteran experience headache pain?
☒ Yes ☐ No
☒ Pulsating or throbbing head pain
☒ Pain on both sides of the head
☒ Pain worsens with physical activity
☒ Other, describe:
 pain is in the middle of the head, not left or right either in front or back of head
- b. Does the Veteran experience non-headache symptoms associated with headaches? (including symptoms associated with an aura prior to headache pain)
☒ Yes ☐ No
☒ Nausea
☒ Sensitivity to light
☒ Sensitivity to sound
- c. Indicate duration of typical head pain
☒ Less than 1 day
- d. Indicate location of typical head pain
☒ Both sides of head

Continued on next page
 VA Form 2507

C&P Final Report

Page: 5

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam
=====

Exam Results Continued

4. Prostrating attacks of headache pain

- a. Migraine / Non-Migraine- Does the Veteran have characteristic prostrating attacks of migraine / non-migraine headache pain?
☒ Yes ☐ No

If yes, indicate frequency, on average, of prostrating attacks over the last several months:

☒ Once every month

- b. Does the Veteran have very prostrating and prolonged attacks of migraines/non-migraine pain productive of severe economic inadaptability?
☐ Yes ☒ No

5. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

- a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No

- c. Comments, if any:
No response provided.

6. Diagnostic testing

Are there any other significant diagnostic test findings and/or results?
☒ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary):

Exam Date/Time
04/15/2016 04:48
Procedure Name
MRI, BRAIN W W/O CON

Exm Date: 04/15/2016 04:48

Continued on next page
VA Form 2507

C&P Final Report

Page: 6

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam
=====

Exam Results Continued

Req Phys: Pat Loc:
Img Loc: OTOLARYNG CL BE WRNMMC BETHESDA, MD
Service:

Exam: MRI, BRAIN W W/O CON CPT:

Report Status: FINAL Date Verified: 04/15/2016 08:18
Reason For Order:
Procedure: MRI, BRAIN W W/O CON

Report Text: Brain MRI without and with gadolinium: 04/15/16 04:48:00.

History: 31 y/o M with acute onset distortion taste, Please evaluate
olfactory nerves for pathology, and brain for possible
pathology, please use gad.

Technique: Sagittal T1, axial and coronal T2, axial T2 FLAIR, axial DWI,
axial GRE, axial T1, axial post T1 FS, coronal post 3D SPGR
of the brain. A total of 16 mL of ProHance was given intravenously as
part of the study.

FINDINGS: No focal mass lesion or abnormal enhancement along the
expected course of either olfactory bulb or groove is seen. There
is normal appearance of both olfactory bulb and nerves.

Acute: No hemorrhage, herniation, or hydrocephalus. No evidence of
acute ischemia.

Brain: Brain parenchyma is within normal limits in signal and volume for
age.

Vessels: No abnormal intravascular signal to suggest thrombosis. There
is note of a tubular enhancing structure posteriorly in the
left cerebellar hemisphere compatible with an incidental developmental
venous anomaly

Bones: No suspicious lesion in the calvarium or skull base.

Other: Extracranial soft tissues are unremarkable.

Continued on next page
VA Form 2507

C&P Final Report

Page: 7

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam
=====

Exam Results Continued

IMPRESSION:

1. No enhancing mass lesions along the expected course of either olfactory bulb or groove is seen. Both olfactory bulbs and nerves appear to be normally developed.

2. No intracranial pathology. No abnormal enhancement.

7. Functional impact

Does the Veteran's headache condition impact his or her ability to work?

☒ Yes ☐ No

If yes, describe the impact of the Veteran's headache condition, providing one or more examples:

cannot think or function when I have a headache - so impacts for duration of the headache - takes alleve, excedrin, or lays down for relief.

8. Remarks, if any:

No remarks provided.

Sleep Apnea
Disability Benefits Questionnaire

Name of patient/Veteran: Anderson, Daniel Dennis - [REDACTED]

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination Request?

☒ Yes ☐ No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

☒ In-person examination

Continued on next page
VA Form 2507

C&P Final Report

Page: 8

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam

Exam Results Continued

Evidence Review

Evidence reviewed (check all that apply):

☒ VA e-folder (VBMS or Virtual VA)
☒ CPRS

1. Diagnosis

Does the Veteran have or has he/she ever had sleep apnea?

☒ Yes ☐ No

☒ Obstructive

ICD code: G47.33

Date of diagnosis: 10-24-17

2. Medical history

a. Describe the history (including onset and course) of the Veteran's sleep disorder condition (brief summary):

claimed condition: sleep paralysis (sleep study date 10/4/2017)

In 2012, this 32 year old SM began to experience excessive daytime sleepiness, morning headaches, gasping awake, frequent awakenings, at least 3-4 times per night, no difficulty falling back to sleep, no difficulty falling asleep.

Often feels like dozing even while driving; no vehicular accidents due to dozing

When going to sleep, I can feel my body jerking to sleep, but unable to move body, happens about 50% of the time, (sleep paralysis); sometimes my jerking will wake me from sleep; no symptoms of restless legs; sometimes will wake up with sleep paralysis, stuck in a position and cannot move; I have to force myself awake to be able to move; sometimes feels like woken up but not really - thinks awake but really not.

No cataplexy; no hypnagogic hallucinations;

Goes to sleep at 10 pm and wakes at 6-7 am; feels like sleep is non-refreshing;

Falls asleep sitting at desk job currently.

Sitting and reading 3- high chance of dozing

watching TV - 2 -moderate chance of dozing

sitting inactive in public place - 2

as a passenger in a car - 3

lying down in afternoon - 3

Continued on next page
VA Form 2507

C&P Final Report

Page: 9

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam
=====

Exam Results Continued

sitting and talking to someone - 2
sitting quietly post lunch - 3
in a car, while stopped for a few minutes in traffic - 3
Epworth sleepiness scale score is 21/24

Was seen in sleep clinic at Walter Reed:

12 Oct 2017 1254

The Chief Complaint is:
Difficulty staying asleep.eg
History of present illness g2
The Patient is a 32 year old male.
He reported: Military service in the Navy and currently on
active duty.

Patient reports gasping , witnessed apnea, difficulty
staying asleep , non
refreshing sleep, hypersomnia, feeling tired,

Assessment/Plan: The patient presents with some symptoms
suggestive of
Obstructive Sleep Apnea. y. Polysomnography/split has been
ordered.
Discussed with patient OSA, Insufficient Sleep Syndrome
(ISS) and nasal
congestion. The patient was counseled to maintain an ideal
body weight to
reduce the severity of the disease and related
complications. The risks of
alcohol and other sedatives were discussed. The patient was
educated on
positional therapy. The patient was counseled to avoid
driving while
excessively sleepy. (was stressed to patient with
hypersomnia) !!!eg

SLEEP STUDY REPORT RESULTS:

MILD OBSTRUCTIVE SLEEP APNEA WITH AHI OF 6/HR (SEE FULL REPORT IN THE
RESULTS SECTION)

b. Is continuous medication required for control of a sleep disorder
condition?

[X] Yes [] No

Continued on next page
VA Form 2507

C&P Final Report

Page: 10

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
 For DBQ NEURO Headaches (including migraine headaches) Exam
 =====

Exam Results Continued

If yes, list only those medications required for the Veteran's sleep disorder condition:
 melatonin

- c. Does the Veteran require the use of a breathing assistance device?
☐ Yes ☒ No
- d. Does the Veteran require the use of a continuous positive airway pressure (CPAP) machine?
☒ Yes ☐ No

3. Findings, signs and symptoms

 Does the Veteran currently have any findings, signs or symptoms attributable to sleep apnea?

☒ Yes ☐ No

If yes, check all that apply:

☒ Persistent daytime hypersomnolence

☒ Other, describe: DIAGNOSIS OF SLEEP APNEA WAS MADE ON OCTOBER 24, 2017. AT THIS TIME SLEEP APNEA IS UNTREATED.

4. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

- a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
☐ Yes ☒ No
- c. Comments, if any:
 No response provided.

5. Diagnostic testing

- a. Has a sleep study been performed?
☒ Yes ☐ No

Continued on next page
 VA Form 2507

C&P Final Report

Page: 11

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
For DBQ NEURO Headaches (including migraine headaches) Exam

Exam Results Continued

If yes, does the Veteran have documented sleep disorder breathing?
[X] Yes [] No

Date of sleep study: October 4, 2017

Facility where sleep study performed, if known: Walter Reed

Results:

Note Text

Patient: ANDERSON, DANIEL DENNIS
Date: 24 Oct 2017 1021 EDT
Appt Type: PROC
Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR
Clinic: SLEEP (PULM) CL BE
Provider: KHRAMTSOV, ANDREI N.
Patient Status: Outpatient

Reason for Appointment: Written by ANDRADA, TEOTIMO F @ 24 Oct 2017
1021 EDT
psg interpretation

POLYSOMNOGRAM REPORT

Technical Description:

Physiologic data were collected using a computerized
Sensormedics polygraph interfaced with Somnostar Z4 amplifiers. The
recording montage consisted of central, frontal and occipital EEG,
EOG, chin EMG, thermocouple and pressure transducer airflow,
chest and diaphragmatic movement, combined leg EMG, tracheal sounds
and pulse oximetry. The patient was monitored throughout the
study via infrared CCTV and recorded for review. Respiratory events
and limb movements were scored according to The AASM Manual for
the Scoring of Sleep and Associated Events, Version 2.3.

Polysomnographic Data:

The patient took 3mgs Eszopiclone prior to the study. The
study duration was 419.5 minutes. The recorded total sleep time was
367.5 minutes with a sleep efficiency of 87.6%. The patients
latency to sleep was 16.5 minutes. The REM latency was 174.5

Continued on next page
VA Form 2507

C&P Final Report

Page: 12

Name: ANDERSON, DANIEL DENNIS SSN: [REDACTED] C-number: [REDACTED]
 For DBQ NEURO Headaches (including migraine headaches) Exam
 =====

Exam Results Continued

minutes.
 Sleep stage distribution revealed 12.9% Stage N1, 58.1% Stage N2, 16.1% Stage N3, 12.9% Stage REM and wake after sleep onset was 35 minutes. There were 100 arousals and 0 awakenings resulting in a total arousal index (TAI) of 16.3/hour of sleep.
 There were 0 apneas (0 obstructive, 0 centrals, 0 mixed) and 37 hypopneas with an apnea hypopnea index(AHI) of 6./hour. The apnea hypopnea index during supine sleep(88 minutes) was 19/hour and 2/hour during non-supine sleep(280 minutes). The hypopnea index was 6./hour. The Central apnea index was 0/hour. Hypopneas were scored using nasal pressure signal drop by at least 30% followed by arousal or 3% oxygen desaturation..
 Oxygen saturation was normal at baseline. Oxygen saturation remained between 86% and 97% with mean value of 95% throughout the study. During the study the oxygen saturation was below 90% for 1 percent of the total sleep time. The average heart rate was 73 beats per minute. There were 0 PLMS and 0 PLMS with arousals with a PLMS index of 0/hour and a PLMS arousal index of 0/hour.

Medical Interpretation:

The patient underwent a Diagnostic PSG: Epworth Sleepiness Scale was 20/24. Sleep efficiency was good and there was adequate total sleep time to establish a diagnosis. Sleep architecture was disrupted. The patient had an AHI consistent with mild sleep apnea. The EKG did not demonstrate arrhythmias.

Diagnosis:

1.Obstructive Sleep Apnea(G47.33)

Suggestions for Clinical Care:

- 1.AutoPAP titration with pressures of 6-15 cm H2O and close clinical follow up.
- 2.Recommend sleeping in the lateral position, obtaining 7-8 hours of sleep per night, avoid of alcohol or other sedatives and maintaining an ideal body weight as these can improve sleep quality.
- 3.The patient should be counseled- as is done with all patients directly seen at this SDC- not to engage in any hazardous activities (such as driving) if excessively sleepy. Such sleepiness is to be reported to their physicians for further evaluation and treatment.

b. Are there any other significant diagnostic test findings and/or results?

Continued on next page
 VA Form 2507

C&P Final Report

Page: 13

Name: ANDERSON, DANIEL DENNIS

SSN: [REDACTED]

C-number: [REDACTED]

For DBQ NEURO Headaches (including migraine headaches) Exam

Exam Results Continued

[] Yes [X] No

6. Functional impact

Does the Veteran's sleep apnea impact his or her ability to work?

[X] Yes [] No

If yes, describe impact of the Veteran's sleep apnea, providing one or more examples:

excessive daytime sleepiness impacts ability to stay awake at work and be able to focus and concentrate

7. Remarks, if any:

No remarks provided.

/es/ BARBARA LEVINE

PHYSICIAN



Signed: 10/25/2017 16:15

This exam has been reviewed and approved by the examining provider.

VA Form 2507



REPORT OF MEDICAL EXAMINATION				1. DATE OF EXAMINATION (YYYYMMDD) 20051013		2. SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 1.2em;"></div>	
PRIVACY ACT STATEMENT							
<p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>							
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN DANIEL DENNIS			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code) <div style="background-color: black; width: 100px; height: 1.2em;"></div> BETHLEHEM, PA <div style="background-color: black; width: 100px; height: 1.2em;"></div>			5. HOME TELEPHONE NUMBER <div style="background-color: black; width: 100px; height: 1.2em;"></div>	
6. GRADE CIVILIAN	7. DATE OF BIRTH (YYYYMMDD) 1985 <div style="background-color: black; width: 40px; height: 1.2em;"></div>	8. AGE (20)	9. SEX <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input checked="" type="checkbox"/> Not Hispanic/Latino	
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY <input type="radio"/> b. CIVILIAN <input type="radio"/>		12. AGENCY (Non-Service Members Only) DN			13. ORGANIZATION UNIT AND UIC/CODE		
14.a. RATING OR SPECIALTY (Aviators Only)			b. TOTAL FLYING TIME		c. LAST SIX MONTHS		
15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input checked="" type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) HARRISBURG MEPS 4641 Westport Drive Mechanicsburg, PA 17055-4843	
CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)							
				Normal	Ab-normal	NE	
17. Head, face, neck, and scalp				/			
18. Nose				/			
19. Sinuses				/			
20. Mouth and throat				/			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				/			
22. Drums (Perforation)				/			
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				/			
24. Ophthalmoscopic				/			
25. Pupils (Equality and reaction)				/			
26. Ocular motility (Associated parallel movements, nystagmus)				/			
27. Heart (Thrust, size, rhythm, sounds)				/			
28. Lungs and chest (Include breasts)				/			
29. Vascular system (Varicosities, etc.)				/			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				/			
31. Abdomen and viscera (Include hernia)				/			
32. External genitalia (Genitourinary)				/			
33. Upper extremities				/			
34. Lower extremities (Except feet)				/			
35. Feet (See Item 35 Continued)				/			
36. Spine, other musculoskeletal				/			
37. Identifying body marks, scars, tattoos				/			
38. Skin, lymphatics				/			
39. Neurologic				/			
40. Psychiatric (Specify any personality deviation)				/			
41. Pelvic (Females only)				/			
42. Endocrine				/			
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in item 44.)				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)			
<input checked="" type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____				35. FEET (Continued) (Circle category) <input checked="" type="radio"/> Normal Arch <input type="radio"/> C - Pes Cavus <input type="radio"/> P - Pes Planus 1 - Mild 2 - Moderate 3 - Severe A - Asymptomatic S - Symptomatic			

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS						DNR		SOCIAL SECURITY NUMBER [REDACTED]												
LABORATORY FINDINGS																				
45. URINALYSIS			a. Albumin NEG			46. URINE HCG			47. H/H		48. BLOOD TYPE									
			b. Sugar NEG																	
TESTS			RESULTS			  06085320 Initial: 20051013 (YYYYMMDD)			SECOND SPECIMEN ID LABEL											
			FIRST TEST									CODE			SECOND TEST			CODE		
49. HIV			NEG																	
50. DRUGS			NEG																	
51. ALCOHOL			NEG																	
52. OTHER																				
a. PAP SMEAR																				
b. EKG																				
c. CXR																				
MEASUREMENTS AND OTHER FINDINGS																				
53. HEIGHT 6800		54. WEIGHT 110 lbs.		55.a. MIN WGT - MAX WGT 181		55.b. ACTUAL BF % - MAX BF %		56. TEMPERATURE		57. PULSE 96										
58. BLOOD PRESSURE				59. RED/GREEN (Army Only)				60. OTHER VISION TEST:												
a. 1ST		b. 2ND		c. 3RD						a. COLOR HAIR Red		b. COLOR EYES Right: Other Left: Other								
SYS. 131		SYS.		SYS.																
DIAS. 74		DIAS.		DIAS.																
61. DISTANT VISION				62. REFRACTION BY <u>AUTOREFRACTION</u> OR MANIFEST				63. NEAR VISION												
Right 20/ 40		Corr. to 20/ 20		By -1.00 S. +0.50 CX 180		Right 20/ 20		Corr. to 20/		by										
Left 20/ 50		Corr. to 20/ 20		By -0.75 S. +0.50 CX 180		Left 20/ 20		Corr. to 20/		by										
64. HETEROPHORIA (Specify distance)																				
ES°		EX°		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD						
65. ACCOMMODATION				66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT												
Right		Left		PIP Passed /14				Uncorrected		Corrected										
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION												
								O.D.		O.S.										
71a. AUDIOMETER		Unit Serial Number 11042539						71b. Unit Serial Number		72a. READING ALOUD TEST										
Date Calibrated (YYYYMMDD)		20041111						Date Calibrated (YYYYMMDD)												
HZ		500		1000		2000		3000		4000		6000		SAT		UNSAT				
Right		05		10		15		15		15		05								
Left		10		15		15		20		10		15								
72b. VALSALVA																				
SAT																UNSAT				
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																				



DD FORM 2808, OCT 2005



LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)

DNR

SOCIAL SECURITY NUMBER

MERWIN, DANIEL DENNIS

88. Additional Remarks (extension of blocks 77 or 78).



IMPARTIAL PROVIDER REVIEW REQUEST (IPR)

I have reviewed the contests of the MEB packet and reviewed the attached Form 6100/1, NARSUM and the LIMDU (Form 6100/5). I have been granted **FIVE** (5) calendar days to concur, non-concur or request and IPR.

The PEBLO has provided me with the information on the IPR. The IPR is designed to provide the service member with an impartial review of his/her medical board findings. The review will ensure the MEB adequately reflected the complete spectrum of the service member injuries and/or illnesses.

Please circle and initial your selection below:

- a. No, I do not request an impartial medical review of my MEB.
- b. Yes, I request an impartial medical review of my MEB

(1) An impartial health care provider (not associated with your MEB) will be assigned to review your medical board to ensure the complete spectrum of injuries and/or illnesses has been addressed.

(2) After assignment, the impartial healthcare provider will have five calendar days to review your case and provide you feedback.

(3) After the review with the impartial healthcare provider you will have the opportunity to concur with the findings of the medical board or submit an appeal.

(4) Upon review of your MEB and IPR findings with your PEBLO you will be allotted **seven** (7) calendar days to make an election and to submit your appeal.

Signature



Date

13 Nov 17

Print Name/Rank/Service

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

MEDICAL RECORD

For

Anderson, Daniel Dennis

Report Criteria

From: 16 Aug 2017 To: 13 Nov 2017

Operator: Diggs,Sheereena

Created On 13 Nov 2017 17:36:20

at WRNMMC

Comprehensive Information Report; INCLUDE HIV Lab Results: Requested

Report Summary

Sections	Domain Requested	Record Counts	Warnings
Allergies	✓	1	0
Problems	✓	0	0
Diagnosis History	✓	134	0
Medications	✓	11	0
Procedures	✓	0	0
Family History	✓	22	0
Resulted Labs	✓	28	0
Radiology	✓	0	0
Immunizations	✓	1	0
Previous Encounters	✓	128	0
Clinical Notes	✓	25	0
Vitals	✓	7	0
			*0

**Report generated with no warnings.*

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Table Of Contents

MEDICAL RECORD	1
Report Criteria.....	1
Report Summary	1
Table Of Contents	2
Demographics	7
Allergies	8
Nka	8
Problems	9
Active Problems	9
Inactive Problems.....	9
Diagnosis History.....	10
Medications.....	14
Active Medications	14
Discontinued Medications.....	14
Expired Medications	15
Procedures.....	16
Family History	17
Family medical history on 17 Oct 2017	17
Paternal aunt's history of reason for visit [use for free text] on 29 Aug 2017	17
Not maternal uncle's history of referred here on 29 Aug 2017	17
Family history of supplemental HPI [use for free text] on 13 Jul 2017	17
No family history of malignant melanoma of the skin on 21 Jun 2017	17
Family history of cancer on 05 Apr 2017	17
Family history of heart disease on 05 Apr 2017	18
Family history of father is alive on 05 Apr 2017	18
Family history of mother is alive on 05 Apr 2017	18
No family history of malignant neoplasm of the gastrointestinal tract on 04 Oct 2016	18
No family history of malignant neoplasm of large intestine on 04 Oct 2016	18
Paternal grandmother's history of HPI [use for free text] on 25 Aug 2016	18
Paternal history of preliminary background HPI [use for free text] on 25 Aug 2016.....	19
Paternal grandfather's history of preliminary background HPI [use for free text] on 25 Aug 2016.....	19
Paternal grandmother's history of preliminary background HPI [use for free text] on 25 Aug 2016.....	19
Family history of test conclusions [Use for free text] on 11 Aug 2015	19
Family history of the options include referral on 28 Apr 2015.....	20
Family history of diabetes mellitus on 28 Apr 2015	20
Family history of patient counseling on 28 Apr 2015.....	20
Family history of mental illness (not retardation) on 28 Apr 2015.....	20
Fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] on 23 Apr 2015	20
No family history of chronic liver disease on 24 Oct 2012	20
Resulted Labs.....	22
ETG/ETS, UA (250 Cut-Off) on 07 Nov 2017	22
Drug Abuse Screen on 07 Nov 2017.....	22
ETG/ETS, UA (250 Cut-Off) on 31 Oct 2017	23
Drug Abuse Screen on 31 Oct 2017	24
Comment on 30 Oct 2017	25
Transferrin Carbohydrate Deficient on 30 Oct 2017	26
Gamma Glutamyl Transferase on 30 Oct 2017.....	26
Lipid Panel on 30 Oct 2017.....	26
ETG/ETS, UA (250 Cut-Off) on 17 Oct 2017	28
Drug Abuse Screen on 17 Oct 2017	29
ETG/ETS, UA (250 Cut-Off) on 10 Oct 2017	30

Anderson, Daniel Dennis

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1985

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Drug Abuse Screen on 10 Oct 2017.....	30
ETG/ETS, UA (250 Cut-Off) on 03 Oct 2017.....	32
Drug Abuse Screen on 03 Oct 2017.....	32
ETG/ETS, UA (250 Cut-Off) on 26 Sep 2017.....	34
Drug Abuse Screen on 26 Sep 2017.....	34
ETG/ETS, UA (250 Cut-Off) on 22 Sep 2017.....	36
Drug Abuse Screen on 22 Sep 2017.....	36
ETG/ETS, UA (250 Cut-Off) on 19 Sep 2017.....	38
Drug Abuse Screen on 19 Sep 2017.....	38
ETG/ETS, UA (250 Cut-Off) on 12 Sep 2017.....	39
Drug Abuse Screen on 12 Sep 2017.....	40
ETG/ETS, UA (250 Cut-Off) on 05 Sep 2017.....	41
Drug Abuse Screen on 05 Sep 2017.....	42
ETG/ETS, UA (250 Cut-Off) on 29 Aug 2017.....	43
Drug Abuse Screen on 29 Aug 2017.....	43
ETG/ETS, UA (250 Cut-Off) on 22 Aug 2017.....	45
Drug Abuse Screen on 22 Aug 2017.....	45
Radiology.....	48
Immunizations.....	49
Previous Encounters.....	50
08 Nov 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J.....	50
08 Nov 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	53
08 Nov 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY.....	58
06 Nov 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	60
06 Nov 2017 at WRNMMC, ATS Adult BE by BURTON, CARA N.....	61
03 Nov 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B.....	63
02 Nov 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E.....	65
02 Nov 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A.....	66
01 Nov 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN.....	69
01 Nov 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J.....	78
01 Nov 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.....	81
30 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by BILODEAU, NATALIE C.....	83
30 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	85
30 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	87
24 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N.....	89
20 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	91
20 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G.....	94
19 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	96
18 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J.....	99
18 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.....	102
18 Oct 2017 at WRNMMC, Psychiatry Be by TEKELENBURG, JAAP.....	103
17 Oct 2017 at WRNMMC, Int Med CL E Medical Home BE by MEYERS, NANCY.....	104
16 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	110
16 Oct 2017 at WRNMMC, Immunization Clinic Be by AGUGLIARO, ANTHONY J.....	113
16 Oct 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN.....	114
16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	115
16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	116
13 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	118
13 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G.....	121
12 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	123
12 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	128
11 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A.....	130
11 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.....	133
11 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J.....	135
11 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.....	137

Anderson, Daniel Dennis

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1985 SSN: ***-**-****

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Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

10 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A	139
06 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A	141
06 Oct 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B	143
05 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE	144
05 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A	146
05 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	150
04 Oct 2017 at WRNMMC, Sleep (Pulm) CI Be by KHRAMTSOV, ANDREI N	153
04 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	154
04 Oct 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	157
04 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	159
04 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	160
04 Oct 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY	165
03 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	167
03 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE	169
02 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	170
02 Oct 2017 at WRNMMC, Sleep (Pulm) CI Be by KHRAMTSOV, ANDREI N	173
29 Sep 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E	181
29 Sep 2017 at WRNMMC, GI Proc CI BE by DAMIANO, MARK N	182
29 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	185
28 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	186
27 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	188
27 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	190
27 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	199
26 Sep 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	204
26 Sep 2017 at WRNMMC, Int Med CL F Medical Home BE by ROBINSON, TYRONE L	206
25 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	210
22 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	215
22 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	216
22 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	219
21 Sep 2017 at WRNMMC, GI Clinic Bethesda by BELLE, LAVERN S	224
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	226
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	230
21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	233
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	237
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G	240
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G	241
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	245
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	246
20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	249
19 Sep 2017 at WRNMMC, GI Clinic Bethesda by BHUSHAN, ANITA	253
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	256
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	259
19 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	264
19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	265
18 Sep 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B	269
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	270
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	275
18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	278
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	283
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	286
15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	290
14 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	295
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	296
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	300
14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	303

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	308
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	313
13 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	317
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	318
13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	321
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	326
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	329
12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	332
11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	336
11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	339
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by GRAGNANI, CYNTHIA T.....	343
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	344
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	345
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	349
08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	351
08 Sep 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R.....	355
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	360
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.	364
07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	366
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	369
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	372
06 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	376
06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	384
05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	388
05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM	392
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	397
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	400
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	402
31 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	406
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	409
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	412
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	416
30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	418
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	422
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE	425
29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM.....	428
22 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	436
22 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	437
Clinical Notes.....	442
08 Nov 2017 1330 GMT at by RAGLAND, MARY	442
06 Nov 2017 1900 GMT at by HANGEMANOLE, DESPINA C	445
06 Nov 2017 1330 GMT at by BURTON, CARA N.....	447
03 Nov 2017 1230 GMT at by LESKO, STACEY B.....	451
02 Nov 2017 1400 GMT at by NAVARRO, CARA A	455
01 Nov 2017 1230 GMT at by DELEON, PATRICK D.	458
30 Oct 2017 1700 GMT at by HANGEMANOLE, DESPINA C	461
30 Oct 2017 1230 GMT at by HANGEMANOLE, DESPINA C	463
20 Oct 2017 1230 GMT at by HARDIN, JAMES G	466
18 Oct 2017 1230 GMT at by DELEON, PATRICK D.	469
16 Oct 2017 1230 GMT at by HANGEMANOLE, DESPINA C	471
13 Oct 2017 1230 GMT at by HARDIN, JAMES G	474
11 Oct 2017 1900 GMT at by NAVARRO, CARA A	477
11 Oct 2017 1230 GMT at by DELEON, PATRICK D.	480
06 Oct 2017 1230 GMT at by LESKO, STACEY B	483
05 Oct 2017 1800 GMT at by NAVARRO, CARA A	485

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Oct 2017 0100 GMT at by KHRAMTSOV, ANDREI N	489
04 Oct 2017 1600 GMT at by HANGEMANOLE, DESPINA C	491
04 Oct 2017 1230 GMT at by RAGLAND, MARY	493
02 Oct 2017 1500 GMT at by KHRAMTSOV, ANDREI N	495
29 Sep 2017 1300 GMT at by HANGEMANOLE, DESPINA C	501
19 Sep 2017 2030 GMT at by BHUSHAN, ANITA	503
13 Sep 2017 1600 GMT at by HANGEMANOLE, DESPINA C	508
08 Sep 2017 1300 GMT at by BENTON, JIKESHA R	510
22 Aug 2017 1300 GMT at by HANGEMANOLE, DESPINA C	516
Vitals	519

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Demographics

Name: Anderson, Daniel Dennis

SSN: ***-**-****

DoD ID: 1286180538

FMP/Sponsor SSN: 20/***-**-****

Date of Birth: [REDACTED] 1985

Sex: M

Race: White

Marital Status: Single, Never Married

Branch: N11 - United States Navy (USN) Active Duty (AD)

Rank: PETTY OFFICER SECOND CLASS (E5)

Medicare:

Religion: No Preference

PCM Location: 87832-HP0067

Addresses:

709 MILLHOUSE DR

....

GLEN BURNIE, MD 21060-8583

***** End of Demographics *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Allergies

Nka

Reaction:			
Onset:	25 May 2017	Info Source:	
Clinician:	ZZMIDTIER, GREAT	Facility:	WRNMMC
Allergy Type:	No known allergies	Origin:	Department of Defense
Comment:			

***** End of Allergies *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Problems

Active Problems

Inactive Problems

***** End of Problems *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Diagnosis History**Alcohol dependence, uncomplicated (F10.20)**

Encounter Date	Clinic	Clinician	Facility
08 Nov 2017	Pain Mgmt Clinic Bethesda	SPEVAK, CHRISTOHER J	WRNMMC
08 Nov 2017	ATS Adult BE	RAGLAND, MARY	WRNMMC
06 Nov 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
06 Nov 2017	ATS Adult BE	BURTON, CARA N	WRNMMC
03 Nov 2017	ATS Adult BE	LESKO, STACEY B	WRNMMC
01 Nov 2017	Pain Mgmt Clinic Bethesda	SPEVAK, CHRISTOHER J	WRNMMC
01 Nov 2017	ATS Adult BE	DELEON, PATRICK D.	WRNMMC
30 Oct 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
30 Oct 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
20 Oct 2017	ATS Adult BE	HARDIN, JAMES G	WRNMMC
18 Oct 2017	Pain Mgmt Clinic Bethesda	SPEVAK, CHRISTOHER J	WRNMMC
18 Oct 2017	ATS Adult BE	DELEON, PATRICK D.	WRNMMC
16 Oct 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
16 Oct 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
13 Oct 2017	ATS Adult BE	HARDIN, JAMES G	WRNMMC
11 Oct 2017	Pain Mgmt Clinic Bethesda	SPEVAK, CHRISTOHER J	WRNMMC
11 Oct 2017	ATS Adult BE	DELEON, PATRICK D.	WRNMMC
06 Oct 2017	ATS Adult BE	LESKO, STACEY B	WRNMMC
04 Oct 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
04 Oct 2017	ATS Adult BE	RAGLAND, MARY	WRNMMC
29 Sep 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
22 Sep 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
19 Sep 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
13 Sep 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
22 Aug 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC

Dry eye syndrome of bilateral lacrimal glands (H04.123)

Encounter Date	Clinic	Clinician	Facility
26 Sep 2017	Int Med CL F Medical Home BE	ROBINSON, TYRONE L	WRNMMC

Encounter for immunization (Z23)

Encounter Date	Clinic	Clinician	Facility
16 Oct 2017	Immunization Clinic Be	AGUGLIARO, ANTHONY J	WRNMMC

Encounter for observation for other suspected diseases and conditions ruled out (Z03.89)

Encounter Date	Clinic	Clinician	Facility
18 Sep 2017	ATS Adult BE	LESKO, STACEY B	WRNMMC

Encounter for other administrative examinations (Z02.89)

Encounter Date	Clinic	Clinician	Facility
18 Oct 2017	Psychiatry Be	TEKELENBURG, JAAP	WRNMMC
26 Sep 2017	Psychiatry Be	DELSESTO, BARBARA S	WRNMMC

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Fecal smearing (R15.1)

Encounter Date	Clinic	Clinician	Facility
29 Sep 2017	GI Proc Cl BE	DAMIANO, MARK N	WRNMMC

Fecal urgency (R15.2)

Encounter Date	Clinic	Clinician	Facility
29 Sep 2017	GI Proc Cl BE	DAMIANO, MARK N	WRNMMC

Generalized anxiety disorder (F41.1)

Encounter Date	Clinic	Clinician	Facility
08 Nov 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
01 Nov 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
16 Oct 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
12 Oct 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
05 Oct 2017	Psychiatry Be	ABRAHAM, FENOTE	WRNMMC
04 Oct 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
27 Sep 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
27 Sep 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
25 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
22 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
22 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
21 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
21 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
21 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
20 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
20 Sep 2017	Psych Day Hosp Be	DONKIN, LAURA G	WRNMMC
20 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
20 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
20 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
19 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
19 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
18 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
18 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
18 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
15 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
15 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
15 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
14 Sep 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
14 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
14 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
14 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
13 Sep 2017	Psych Day Hosp Be	DEUTSCH, ANNE MARIE	WRNMMC
13 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
13 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
13 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
12 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
12 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
11 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
08 Sep 2017	Psych Day Hosp Be	GRAGNANI, CYNTHIA T	WRNMMC
08 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
08 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
07 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
07 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
06 Sep 2017	Psych Day Hosp Be	DEUTSCH, ANNE MARIE	WRNMMC
06 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
06 Sep 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
06 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
05 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
05 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
31 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
31 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
30 Aug 2017	Psych Day Hosp Be	DEUTSCH, ANNE MARIE	WRNMMC
30 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
30 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
30 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
29 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

29 Aug 2017	Psych Day Hosp Be	DEUTSCH, ANNE MARIE	WRNMMC
29 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
22 Aug 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC

Ingrowing nail (L60.0)

Encounter Date	Clinic	Clinician	Facility
26 Sep 2017	Int Med CL F Medical Home BE	ROBINSON, TYRONE L	WRNMMC

Insomnia, unspecified (G47.00)

Encounter Date	Clinic	Clinician	Facility
08 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
07 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC

Irritable bowel syndrome with diarrhea (K58.0)

Encounter Date	Clinic	Clinician	Facility
02 Nov 2017	GI Clinic Bethesda	BRIDGES, EDWARD E	WRNMMC
17 Oct 2017	Int Med CL E Medical Home BE	MEYERS, NANCY	WRNMMC
29 Sep 2017	GI Clinic Bethesda	BRIDGES, EDWARD E	WRNMMC
19 Sep 2017	GI Clinic Bethesda	BHUSHAN, ANITA	WRNMMC

Major depressive disorder, recurrent, moderate (F33.1)

Encounter Date	Clinic	Clinician	Facility
02 Nov 2017	Occup Therap TBI Be	NAVARRO, CARA A	WRNMMC
20 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
19 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
16 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
13 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
12 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
11 Oct 2017	Occup Therap TBI Be	NAVARRO, CARA A	WRNMMC
11 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
10 Oct 2017	Psych Day Hosp Be	BAHROO, BHAGWAN A	WRNMMC
06 Oct 2017	Psych Day Hosp Be	BAHROO, BHAGWAN A	WRNMMC
05 Oct 2017	Psychiatry Be	ABRAHAM, FENOTE	WRNMMC
05 Oct 2017	Occup Therap TBI Be	NAVARRO, CARA A	WRNMMC
05 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
04 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
04 Oct 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
03 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
02 Oct 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
28 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
27 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
27 Sep 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
22 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
19 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
12 Sep 2017	Psych Day Hosp Be	LANDE, RAYMOND G.	WRNMMC
11 Sep 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
08 Sep 2017	Psychology Assessment Be	BENTON, JIKESHA R	WRNMMC
31 Aug 2017	Psych Day Hosp Be	POURZAND, MIRIAM	WRNMMC
31 Aug 2017	Psych Day Hosp Be	DEUTSCH, ANNE MARIE	WRNMMC
22 Aug 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC

Major depressive disorder, single episode, unspecified (F32.9)

Encounter Date	Clinic	Clinician	Facility
06 Sep 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC

Obstructive sleep apnea (adult) (pediatric) (G47.33)

Encounter Date	Clinic	Clinician	Facility
30 Oct 2017	Sleep (Pulm) CI Be	BILODEAU, NATALIE C	WRNMMC
24 Oct 2017	Sleep (Pulm) CI Be	KHRAMTSOV, ANDREI N	WRNMMC

Other specified counseling (Z71.89)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Encounter Date	Clinic	Clinician	Facility
21 Sep 2017	GI Clinic Bethesda	BELLE, LAVERN S	WRNMMC

Pain in right wrist (M25.531)

Encounter Date	Clinic	Clinician	Facility
26 Sep 2017	Int Med CL F Medical Home BE	ROBINSON, TYRONE L	WRNMMC

Sleep disorder, unspecified (G47.9)

Encounter Date	Clinic	Clinician	Facility
04 Oct 2017	Sleep (Pulm) C1 Be	KHRAMTSOV, ANDREI N	WRNMMC
02 Oct 2017	Sleep (Pulm) C1 Be	KHRAMTSOV, ANDREI N	WRNMMC

Unspecified asthma, uncomplicated (J45.909)

Encounter Date	Clinic	Clinician	Facility
17 Oct 2017	Int Med CL E Medical Home BE	MEYERS, NANCY	WRNMMC

***** End of Diagnosis History *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Medications*Active Medications*

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
JP7503166	Duloxetine Hcl, 60 Mg, Capsule Dr, Oral Take One Capsule By Mouth Every Day	Active	30	02 Nov 2017	0 of 1
JP3069936	Eszopiclone, 2 Mg, Tablet, Oral Take One Tablet By Mouth Every Night *Take For Two Weeks When You Start Cpap *	Active	14	02 Nov 2017	NR
JP7511369	Hydroxyzine Hcl, 10 Mg, Tablet, Oral Take 1 To 2 Tablets By Mouth Twice A Day As Needed Nausea/Anxiety	Active	30	16 Oct 2017	1 of 1
JP7502289	Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic Instill 1 Drop In Each Eye Four Times A Day As Needed For Dryness	Active	1	27 Sep 2017	2 of 2
BC7174607	Omega-3/Dha/Epa/Fish Oil, 1000 Mg, Capsule, Oral Take 2 By Mouth Every Day	Active	180	06 Sep 2017	2 of 3

Discontinued Medications

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
JP7511362	Venlafaxine Hcl, 37.5 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Morning	Discontinued	30	16 Oct 2017	NR
HC6025947	Ramelteon, 8 Mg, Tablet, Oral Take One Tablet By Mouth Every Night For Sleep	Discontinued	30	18 Sep 2017	2 of 2
JP7479252	Naltrexone Hcl, 50 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Discontinued	30	06 Sep 2017	0 of 1
JP7479249	Venlafaxine Hcl, 150 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Day	Discontinued	30	06 Sep 2017	0 of 1
JP7492679	Venlafaxine Hcl, 75 Mg, Cap Er 24H, Oral Take One Capsule With One 150 Mg Capsule For A Total Of 225 Mg By Mouth Every	Discontinued	30	06 Sep 2017	3 of 3

Anderson, Daniel Dennis

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1985

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Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Morning

Expired Medications

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
NB3256386	Eszopiclone, 3 Mg, Tablet, Oral Take One Tablet By Mouth Every Night As Needed For Sleep	Expired	1	02 Oct 2017	NR

***** End of Medications *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Procedures

***** End of Procedures *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Family History

Family medical history on 17 Oct 2017

Date Onset:	17 Oct 2017	Date Reported:	17 Oct 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~M -- Well~F -- DM. MI / stent at age 40. Melanoma.~		

Paternal aunt's history of reason for visit [use for free text] on 29 Aug 2017

Date Onset:	31 Aug 2017	Date Reported:	29 Aug 2017
Source:	Clinical Evidence	Relationship:	Paternal Aunt
Status:	Active		
Comment:	Limits of confidentiality reviewed with the patient who verbally expressed an understanding, signature was obtained. (See [Add Note] for any scanned in documents.)		

Not maternal uncle's history of referred here on 29 Aug 2017

Date Onset:	31 Aug 2017	Date Reported:	29 Aug 2017
Source:	Clinical Evidence	Relationship:	Maternal Uncle
Status:	Active		
Comment:	Patient was not escorted.		

Family history of supplemental HPI [use for free text] on 13 Jul 2017

Date Onset:	14 Jul 2017	Date Reported:	13 Jul 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	Patient has received other care since their last visit with this clinic		

No family history of malignant melanoma of the skin on 21 Jun 2017

Date Onset:	21 Jun 2017	Date Reported:	21 Jun 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

Family history of cancer on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	Dad- melanoma;		

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Family history of heart disease on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	dad/PGF- CAD; dad- stent 2v (alcohol); Dad/PGM/PGF/sister- DM,~ Dad- AMI (s/p heart surgery); no CVA		

Family history of father is alive on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	not in contact		

Family history of mother is alive on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	No DM, No CAD. healthy		

No family history of malignant neoplasm of the gastrointestinal tract on 04 Oct 2016

Date Onset:	04 Oct 2016	Date Reported:	04 Oct 2016
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

No family history of malignant neoplasm of large intestine on 04 Oct 2016

Date Onset:	04 Oct 2016	Date Reported:	04 Oct 2016
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

Paternal grandmother's history of HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandmother
Status:	Active		
Comment:	<<Note accomplished in TSWF-IBHC Anxiety tab>>~ ~Description of Symptoms: Extreme mood swings with depression and anxiety, irritability, concentration problems, poor sleep, fatigue, racing heart and thoughts, trouble relaxing, and worrying. PT reported dry heaving episodes for the past 2 years and pulling the hair off a spot on his scalp since 2008. Several times a week he has a "tingling sensation" with a mood change where he will suddenly smile or frown. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16.~ ~PT reported having passive SI since he was a child. He reported 2 prior suicide attempts when he was in high school: one by overdosing on OTC medicine and one by overdosing on alcohol. His last plan was to overdose on helium before self-referring to substance abuse treatment last year.		

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

He last had passive SI("why even bother") 3 weeks ago, with no plans or intent. PT denied any current SI, plans, or intent. ~ ~Duration of Problem: PT has experienced symptoms since his first ship tour in 2006. Symptoms have worsened since he re-enlisted last October.~ ~Factors correlated with onset: Anxiety started after PT joined the Navy in 2006. He regrets re-enlisting last October, and because he waited so long to re-enlist he had last pick for orders. Subsequently he was stationed in the same same environment with the same work stress.~ ~Frequency of symptoms: Symptoms occur every day.~ ~Severity of symptoms: Depression symptoms from PHQ-9 are in the mild range. Anxiety symptoms from GAD-7 are in the moderate range.~ ~Psychosocial factors: Occupational stress and minimal social support.~ ~Aggravating/alleviating factors: Aggravating factors include occupational stress and feeling disconnected from others. Alleviating factors include cooking and programming.~ ~Current tx: None~ ~Past tx: PT began behavioral health treatment in 2012. ~ ~Functional impact: Symptoms negatively impact PT's functioning at home and work.~.....

Paternal history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Father
Status:	Active		
Comment:	- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model~of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and~short-term intervention focused approach~~ Pt indicated understanding		

Paternal grandfather's history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandfather
Status:	Active		
Comment:	Patient was seen for 30 minute IBHC appointment		

Paternal grandmother's history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandmother
Status:	Active		
Comment:	Patient was seen by a trainee under the supervision of a licensed mental health professional. Patient indicated an understanding of this.~.....		

Family history of test conclusions [Use for free text] on 11 Aug 2015

Date Onset:	18 Aug 2015	Date Reported:	11 Aug 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	A written list of medications was given to the patient		

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Family history of the options include referral on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~[] Physical Activity~[] Safety~[] Diabetes Counseling~[] Cholesterol~[X] Nutrition~[X] Sexuality~[] Other:		

Family history of diabetes mellitus on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	PATERNAL GF and Father		

Family history of patient counseling on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~[] Tobacco Use~[] Alcohol Use~[] Weight Management ~[] Dental Care~[] Mental Health~[] Hypertension ~[X] Other:STRESS MANAGEMENT, SLEEP		

Family history of mental illness (not retardation) on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	MATERNAL		

Fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] on 23 Apr 2015

Date Onset:	23 Apr 2015	Date Reported:	23 Apr 2015
Source:	Clinical Evidence	Relationship:	Brother
Status:	Active		
Comment:	Depression Screening:~ ~[1] 1. Little Interest or pleasure in doing things~[1] 2. Feeling down depressed or hopeless~[0] 3. Trouble sleeping or sleeping too much~[1] 4. Feeling tired or little energy~[0] 5. Poor appetite or overeating~[0] 6. Feeling bad about self~[0] 7. Trouble concentrating on things~[1] 8. Moving or speaking slowly or being restless~[0] 9. Thoughts that you would be better off dead~Add point values from each response. Total (PHQ-9) Score = 4~ ~Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely		

No family history of chronic liver disease on 24 Oct 2012

Date Onset:	24 Oct 2012	Date Reported:	24 Oct 2012
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

***** End of Family History *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Resulted Labs**ETG/ETS, UA (250 Cut-Off) on 07 Nov 2017**

Collection Date:

07 Nov 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	
Interpretation: This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.				

Drug Abuse Screen on 07 Nov 2017

Collection Date:

07 Nov 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Phencyclidine, UA	NEGATIVE		(Negative)	
Interpretation: >25 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Amphetamines	NEGATIVE		(Negative)	
Interpretation: >1000 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Barbiturates	NEGATIVE		(Negative)	
Interpretation: > 200 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Benzodiazepines	NEGATIVE	(Negative)
------------------------	-----------------	-------------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Negative)
------------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
------------------	-----------------	--------------	-------------------

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay**ETG/ETS, UA (250 Cut-Off) on 31 Oct 2017**

Collection Date:

31 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	
Interpretation: This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.				

Drug Abuse Screen on 31 Oct 2017

Collection Date:

31 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Methadone	NEGATIVE		(Negative)	
Interpretation: >300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.				

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine

NEGATIVE

(Negative)

Interpretation:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

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1985

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DoD ID: 1286180538

Created: 13 Nov 2017

>300 ng/mL reported as positive**For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Opiates****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Oxycodone****NEGATIVE****ng/mL****(Negative)****Interpretation:****Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****Comment on 30 Oct 2017**

Collection Date:

30 Oct 2017

Site/Specimen:

SERUM

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Comment 15	COMMENT			
Interpretation: A Carbohydrate Deficient Transferrin (CDT) result <1.4% is considered to be normal and is consistent with low or no alcohol use during the				

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1985

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

previous two weeks.

Transferrin Carbohydrate Deficient on 30 Oct 2017

Collection Date: 30 Oct 2017

Site/Specimen: SERUM

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Transferrin Carbohydrate Deficient/Transferrin Total	0.7	%	0.0-1.3	

Interpretation:

Normal <1.4
 Inconclusive 1.4 - 1.6
 Elevated >1.6

Clinical use only. Not specific for medico-legal purposes.

This test is not suitable for the evaluation of patients suspected of having congenital glycosylation disorders.

Gamma Glutamyl Transferase on 30 Oct 2017

Collection Date: 30 Oct 2017

Site/Specimen: SERUM

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Gamma-Glutamyl Transferase	80	U/L	(10.0-71.0)	Higher Than Normal

Lipid Panel on 30 Oct 2017

Collection Date: 30 Oct 2017

Site/Specimen: SERUM

Ordering Clinician: RODAK, COLLEEN M

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cholesterol	235	mg/dL		

Interpretation:**Adults: ages 18 and up****Desirable: <200 mg/dL****Borderline High: 200-239 mg/dL****High: > or = 240 mg/dL****Pediatric: ages 2-17****Acceptable: <170 mg/dL**

Anderson, Daniel Dennis

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1985 SSN: ***-**-****

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Borderline High: 170-199 mg/dL
High > or = 200 mg/dL

Triglyceride 128 mg/dL

Interpretation:**Adults: ages 18 and up****Desirable: <150 mg/dL****Borderline High: 150-199 mg/dL****High: 200-499 mg/dL****Very High: > or = 500 mg/dL****Pediatric: ages 2-9****Acceptable: <75 mg/dL****Borderline High: 75-99 mg/dL****High: > or = 100 mg/dL****Pediatric: ages 10-17****Acceptable: <90 mg/dL****Borderline High: 90-129 mg/dL****High: > or = 130 mg/dL**

HDL Cholesterol 62 mg/dL

Interpretation:**Adults: ages 18 and up****Desirable: > or = 60 mg/dL****Low: <40 mg/dL**

An HDL cholesterol less than 40 mg/dL is low and constitutes a coronary heart disease risk factor. An HDL cholesterol greater than 60 mg/dL is a negative risk factor for coronary heart disease.

Pediatric: ages 2-17**Acceptable: >45 mg/dL****Borderline Low: 40-45 mg/dL****Low: <40 mg/dL**

Cholesterol/HDL 3.8 ratio

Cholesterol

LDL Cholesterol Direct 161 mg/dL

Interpretation:**Adults: ages 18 and up****Optimal: <100 mg/dL****Near Optimal: 100-129 mg/dL****Borderline High: 130-159 mg/dL****High: 160-189 mg/dL****Very High: > or = 190 mg/dL****Pediatric: ages 2-17****Acceptable: <110 mg/dL****Borderline High: 110-129 mg/dL****High: > or = 130 mg/dL**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Cholesterol Non-HDL 173 mg/dL**Interpretation:****Adults: ages 18 and up****Desirable:** <130 mg/dL**Above Desirable:** 130-159 mg/dL**Borderline High:** 160-189 mg/dL**High:** 190-219**Very High:** > or = 220 mg/dL

Non-HDL cholesterol is a secondary target of therapy in persons with high serum triglycerides (greater than 199 mg/dL). The goal for non-HDL cholesterol in persons with high triglycerides is 30 mg/dL higher than their LDL cholesterol goal.

Pediatric: ages 2-17**Acceptable:** <120 mg/dL**Borderline High:** 120-144 mg/dL**High:** > or = 145 mg/dL**Source:**

-Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report. Circulation 2002 Dec 17;106(25):3143-421.

-National Lipid Association Recommendations for Patient-Centered Management of Dyslipidemia: Part 1-Full Report. Journal of Clinical Lipidology 2015; In Press.

-Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents; National Heart, Lung, and Blood Institute. Pediatrics. 2011 Dec;128 Suppl 5:S213-56.

-NCEP Expert Panel of Blood Cholesterol Levels in Children and Adolescents. National Cholesterol Education Program (NCEP): Highlights of the Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents. Pediatrics 1992;89:495-501.

-Srinivasan SR, Myers L, Berenson GS. Distribution and correlates of non-high-density lipoprotein cholesterol in children: the Bogalusa Heart Study. Pediatrics 2002;110(3):e29.

ETG/ETS, UA (250 Cut-Off) on 17 Oct 2017

Collection Date: 17 Oct 2017

Site/Specimen: URINE

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	
Interpretation: This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved				

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

by the Food and Drug Administration.

Drug Abuse Screen on 17 Oct 2017

Collection Date: 17 Oct 2017
 Ordering Clinician: LANDE, RAYMOND G.
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Amphetamines	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Barbiturates	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Benzodiazepines	NEGATIVE	(Negative)
-----------------	----------	------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Opiates	NEGATIVE	(Negative)
---------	----------	------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Phencyclidine, UA	NEGATIVE	(Negative)
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Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Negative)
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Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
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Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay**ETG/ETS, UA (250 Cut-Off) on 10 Oct 2017**

Collection Date:

10 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 10 Oct 2017

Collection Date:

10 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA

NEGATIVE

(Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Cannabinoids NEGATIVE (Negative)

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Methadone NEGATIVE (Negative)

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.**

Oxycodone NEGATIVE ng/mL (Negative)

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 03 Oct 2017**

Collection Date:

03 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.****Drug Abuse Screen on 03 Oct 2017**

Collection Date:

03 Oct 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Methadone	NEGATIVE		(Negative)	

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Amphetamines NEGATIVE (Negative)**Interpretation:**

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates NEGATIVE (Negative)**Interpretation:**

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines NEGATIVE (Negative)**Interpretation:**

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine NEGATIVE (Negative)**Interpretation:**

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates NEGATIVE (Negative)**Interpretation:**

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA NEGATIVE (Negative)**Interpretation:**

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids NEGATIVE (Negative)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Oxycodone**

NEGATIVE

ng/mL

(Negative)

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 26 Sep 2017**

Collection Date:

26 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.****Drug Abuse Screen on 26 Sep 2017**

Collection Date:

26 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Amphetamines	NEGATIVE		(Negative)	

Interpretation:**>1000 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Barbiturates**

NEGATIVE

(Negative)

Interpretation:**> 200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 13 Nov 2017

for non-medical purposes.

Benzodiazepines	NEGATIVE	(Negative)
------------------------	-----------------	-------------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA	NEGATIVE	(Negative)
--------------------------	-----------------	-------------------

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Negative)
------------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
------------------	-----------------	--------------	-------------------

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 22 Sep 2017**

Collection Date:

22 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 22 Sep 2017

Collection Date:

22 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Phencyclidine, UA	NEGATIVE		(Negative)	

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

for non-medical purposes.
-----**Benzodiazepines** **NEGATIVE** (Negative)**Interpretation:**

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
for non-medical purposes.
-----**Cocaine** **NEGATIVE** (Negative)**Interpretation:**

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
for non-medical purposes.
-----**Opiates** **NEGATIVE** (Negative)**Interpretation:**

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
for non-medical purposes.
-----**Cannabinoids** **NEGATIVE** (Negative)**Interpretation:**

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
for non-medical purposes.
-----**Methadone** **NEGATIVE** (Negative)**Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be
used for non-medical purposes.**Oxycodone** **NEGATIVE** ng/mL (Negative)**Interpretation:**

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used
for non-medical purposes.**Methodology:** Immunoassay

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

ETG/ETS, UA (250 Cut-Off) on 19 Sep 2017

Collection Date:

19 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 19 Sep 2017

Collection Date:

19 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

>200 ng/mL reported as positive**For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cocaine****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methadone****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.****Oxycodone****NEGATIVE****ng/mL****(Negative)****Interpretation:****Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 12 Sep 2017**

Collection Date:

12 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Ethyl Glucuronide	Negative	ng/mL	Cutoff=250
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Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 12 Sep 2017

Collection Date:

12 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine

NEGATIVE

(Negative)

Interpretation:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

>300 ng/mL reported as positive**For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methadone****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.****Oxycodone****NEGATIVE****ng/mL****(Negative)****Interpretation:****Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 05 Sep 2017**

Collection Date:

05 Sep 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Drug Abuse Screen on 05 Sep 2017

Collection Date: 05 Sep 2017
 Ordering Clinician: LANDE, RAYMOND G.
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Amphetamines	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Barbiturates	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Benzodiazepines	NEGATIVE	(Negative)
-----------------	----------	------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Methadone	NEGATIVE	(Negative)
-----------	----------	------------

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be
 used for non-medical purposes.

Opiates	NEGATIVE	(Negative)
---------	----------	------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used
 for non-medical purposes.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Phencyclidine, UA **NEGATIVE** (Negative)

Interpretation:**>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Cannabinoids **NEGATIVE** (Negative)

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Oxycodone **NEGATIVE** ng/mL (Negative)

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 29 Aug 2017**

Collection Date:

29 Aug 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.****Drug Abuse Screen on 29 Aug 2017**

Collection Date:

29 Aug 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Interpretation:**>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Amphetamines****NEGATIVE****(Negative)****Interpretation:****>1000 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Barbiturates****NEGATIVE****(Negative)****Interpretation:****> 200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Benzodiazepines****NEGATIVE****(Negative)****Interpretation:****>200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Opiates****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone **NEGATIVE** (Negative)

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone **NEGATIVE** **ng/mL** (Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

ETG/ETS, UA (250 Cut-Off) on 22 Aug 2017

Collection Date:

22 Aug 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 22 Aug 2017

Collection Date:

22 Aug 2017

Site/Specimen:

URINE

Ordering Clinician:

LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines **NEGATIVE** (Negative)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Barbiturates**

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Benzodiazepines**

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Opiates**

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Phencyclidine, UA**

NEGATIVE

(Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Cannabinoids**

NEGATIVE

(Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**Methadone**

NEGATIVE

(Negative)

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Oxycodone NEGATIVE ng/mL (Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

***** End of Resulted Labs *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Radiology

***** End of Radiology *****

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Immunizations

Vaccine	Series	VISVersion	Date	Manufacturer	Lot No.	Dose/Site	Exemption	Administered By
Influenza Seasonal, injectable quadrivalent - preservative free	1	8/7/2015	16 Oct 2017	SmithKline	P5472	.5 mL/Right Arm	None	AGUGLIARO, ANTHONY J

***** End of Immunizations *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Previous Encounters**08 Nov 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J**

Encounter ID: BETH-30260377 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Nov 2017 1026 EST**
 Clinic: **PAIN MGMT CL BE**

Appt Type: **FTR**
 Provider: **SPEVAK, CHRISTOPHER J**

AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 08 Nov 2017 1027 EST**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
ESZOPICLONE, 2 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY	NR	02 Nov 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		MOUTH EVERY NIGHT *TAKE FOR TWO WEEKS WHEN YOU START CPAP *		
		#0 RF0		
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Active	TAKE ONE CAPSULE BY	0 of 1	02 Nov 2017
		MOUTH EVERY DAY #0 RF1		
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY	1 of 1	16 Oct 2017
		MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY		
		#0 RF1		
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH	2 of 2	27 Sep 2017
		EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0		
		RF2		
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY	2 of 3	06 Sep 2017
		DAY #0 RF3		
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017
		MOUTH EVERY DAY #0 RF1		
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017
		FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017
		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0		
		RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY	3 of 3	10 May 2017
		DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE		
		EVERY DAY #0 RF3		
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG)	1 of 1	28 Apr 2017
		EVERY FOUR HOURS FOR BASELINE PAIN CONTROL		
		#0 RF1		
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

A/P Written by SPEVAK,CHRISTOHER J @ 08 Nov 2017 1027 EST

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Disposition Written by SPEVAK,CHRISTOHER J @ 08 Nov 2017 1027 EST

Released w/o Limitations

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By SPEVAK, CHRISTOHER J (Physician) @ 08 Nov 2017 1027

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Nov 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-30278125 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Nov 2017 0900 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 09 Nov 2017 1129 EST

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Anderson (previously Merwin)
 Patient last 4: 0538
 Appt #: Intake + 16
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used:** CBT**Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He stated that he missed his last appointment due to complications with GI issues. Patient reported that he is feeling less depressed this week. He attributes this to positive interactions with dating partner and developing new interests. Patient stated that he and his dating partner have been spending a lot of time together and she plans to move in with him. Therapist and patient discussed impulsive decision making but patient feels that this is a positive thought out direction forward. He stated that it helps him socialize and is a source of emotional support. Patient expressed interest in gardening and identified wanting to develop a hydroponic system for growing plants indoors. Patient has also been pursuing treatment with medical marijuana for anxiety and GI issues.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No suicidal/homicidal thought/intent/plan reported.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	No
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017

Reviewed with patient on: 27 September 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient does not report any suicidal ideation.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors. He reports less depressive symptoms.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.

A/P Written by PAUL, SHERIN @ 09 Nov 2017 1129 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 09 Nov 2017 1130 EST

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 09 Nov 2017 1130

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Nov 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY

Encounter ID: BETH-30265161 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **08 Nov 2017 0730 EST**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **RAGLAND, MARY****Reason for Appointment:**

IOP

Appointment Comments:

ctc

S/O Note Written by DAVIS, KRISTEN KATHLEEN @ 08 Nov 2017 1418 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group (0730-0845)

S: Topics discussed: Introductions; differences between military branches, communities and commands; the impact of alcohol use on stress. SM discussed with other group members the differences between their commands and feelings of frustration regarding administrative procedures. SM shared in detail what brought him to ATS this time and the first time. SM acknowledged that his alcohol use contributed to the work stress he experienced prior to entering treatment. The session ended with group members sharing their plans for the holiday weekend and if they had concerns to present to the group. SM stated that he is having friends over this weekend and identified grilling as one of his triggers. He reported that his house is dry and that his girlfriend is no longer drinking.

O: SM arrived late to group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM is sharing openly and honestly with the group. SM provides appropriate feedback and appears committed to his recovery.

P: SM will continue with group as assigned.

S/O Note Written by HANGEMANOLE, DESPINA C @ 09 Nov 2017 0834 EST**History of present illness**

The Patient is a 32 year old male.

SM was not present for Finding Meaning group 1000-1045.

Note Written by RAGLAND, MARY @ 08 Nov 2017 1326 EST**Mind-Body Group, Session #1: Meditation 1100-1155**

S: Psychoeducation re: meditation. This therapist taught definition and principles of meditation. Facilitator instructed participants in three basic sitting postures with variations. Practiced 20 minutes of sitting meditation, participants instructed to focus on counting their breath while maintaining erect yet relaxed posture. Discussed this experience.

O: Ct arrived on time for group. Alert/oriented x 3.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Insight: Good
SI/Hi: None

Judgment: Good
Med/Pain Issues: None

A: Ct participated appropriately in discussion and activity.

P: Ct will attend next group as scheduled.

A/P Written by RAGLAND,MARY @ 13 Nov 2017 0949 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by RAGLAND,MARY @ 13 Nov 2017 0950 EST

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic.

Signed By RAGLAND, MARY (Physician) @ 13 Nov 2017 0950

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

06 Nov 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-30228910 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Nov 2017 1300 EST**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 06 Nov 2017 1352 EST**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Judgement & Fellowship

S) SM stated he had been thinking about a gardening invention and planned to spend some time working on this in the future. SM stated he has found himself being more productive and distracted by healthy hobbies recently. SM reported that he doesn't feel he's getting as much out of IOP due to the redundancy. SM and this writer discussed ways to reframe this thought as to stay as engaged as possible. SM acknowledged that redundancy is necessary for learning and that something was missing from his first effort at recovery which is why he was unable to sustain it. SM identified that missing piece as support and stated that he now has support from his family, girlfriend and a couple friends. SM reported that he was unsure as to why sober support specifically is important in recovery but agreed to think about it and have some thoughts to discuss next session. SM denied any alcohol use or thoughts about drinking. SM denied SI/HI.

O) SM reported to session on time and was dressed casually. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM is thoughtful when discussing his support system and relationships. SM demonstrates a lack of knowledge of parts of recovery as evidenced by his inability to identify why sober support is necessary in recovery, however, SM demonstrates good judgement in offering to brainstorm on this for homework.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin continue with ATS groups as scheduled.

A/P Written by HANGEMANOLE, DESPINA C @ 06 Nov 2017 1340 EST**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 06 Nov 2017 1342 EST**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 06 Nov 2017 1352

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

06 Nov 2017 at WRNMMC, ATS Adult BE by BURTON, CARA N

Encounter ID: BETH-30222571 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Nov 2017 0730 EST**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **BURTON, CARA N**

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by BURTON, CARA N @ 06 Nov 2017 1021 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Morning Process Group (0730-0845):

S: Today's session was begun by completing introductions as there were two new group members beginning the IOP Program today. Each group member took turns sharing their names, military history as well as what led to their engagement in substance abuse treatment. Additional time was spent discussing attendance at meetings, including both AA and SMART Recovery. Group members also spent some time sharing how their mental health symptoms (such as PTSD, depression and anxiety) have increased in early sobriety. Group members engaged easily with one another and appeared to relate well and share spontaneously throughout the session. This SM shared openly about his titration off his medicine and also shared about potential triggers with drinking. He was actively engaged throughout the session.

O: SM arrived on time for group and was oriented x3.

Appearance: Neat, clean, dressed appropriately to season in civilian clothing

Behavior: Appropriate, engaged, talkative

Speech: WNL

Thoughts: WNL

Mood: Euthymic, stable

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/Hi: None reported

Med/Pain Issues: None expressed

A: SM is engaged during sessions and can sometimes go off topic for some time but is easily redirected. He appears motivated to maintain abstinence.

P: SM will continue with IOP groups as scheduled.

S/O Note Written by LESKO, STACEY BETH @ 07 Nov 2017 0731 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Risky Drinking Group: 1115-1200

S: The group reviewed the concept of risky drinking and what constitutes 'low risk' drinking vs. 'high risk' drinking. Group members watched the second part of HBO's documentary 'Risky Drinking' that highlighted a man's struggle with excessive drinking and the impact on his family and overall wellbeing. Group members discussed what they viewed in relation to the consequences of high-risk drinking and related it to their own life experiences.

O: SM arrived on time for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Good

Judgment: Good

SI/Hi: None Current

Med/Pain Issues: None expressed

A: SM actively engaged in discussion and provided and received feedback appropriately.

P: SM will continue with IOP as planned.

S/O Note Written by FOBIZSHI, MACANGELO M @ 07 Nov 2017 1146 EST**History of present illness**

The Patient is a 32 year old male.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

He reported: Encounter Background Information: Seeking Safety Group
Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session. Today's group topic was focused identifying healthy and unhealthy relationship beliefs and learning how to cultivate a healthy relationship. The group members reviewed the relationship beliefs listed in the handout and discussed the ones that they could relate to. SM reports poor communication skills in the past. SM states that he never took time to understand situations and make better decisions. SM states that this affected his relationship with his roommate. SM reports effort to improve communication skills and healthy relationship. The group discussed how to change some of the unhealthy belief to improve their relationship and fortify their recovery. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P.

S/O Note Written by HARDIN,JAMES G @ 09 Nov 2017 1009 EST

History of present illness

The Patient is a 32 year old male.

Relapse Prevention Group~Focus of Session: Managing Stress

S) SM participated in the group discussion about stress, coping with stress, and how stress can impact physical/psychological health and decision making. We discussed the idea of having a "background" stress level and how to decrease it. SM talked about past experiences with meditation and how it has helped. We discussed how by making a consistent effort we can improve our stress levels so that we are less likely to experience difficult events as a crisis.~O) Appearance: uniform Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: fair

Affect: Congruent

Insight: Fair/good

Judgment: fair/good

SI/HI: None Current

Med/Pain Issues: None

A) SM seems invested in the group at this time.

P) Next relapse prevention group will discuss effective communication

A/P Last Updated by BURTON,CARA N @ 06 Nov 2017 1028 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by BURTON,CARA N @ 06 Nov 2017 1028 EST

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue attending groups.

Signed By BURTON, CARA N (Licensed Clinical Social Worker) @ 09 Nov 2017 1102

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

03 Nov 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B

Encounter ID: BETH-30204077 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **03 Nov 2017 0730 EST**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **LESKO, STACEY BETH**

AutoCites Refreshed by LESKO, STACEY B @ 03 Nov 2017 1024 EST**Allergies**

•No Known Allergies

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by LESKO, STACEY BETH @ 03 Nov 2017 1024 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group: 0730-0845

S: The group discussed several topics today to include job challenges, incorporating a community program into one's recovery, and the impact of a life changing event (suicide attempt and car accident) on their thinking moving forward. Lastly, some discussion around the idea of putting oneself in high risk situations and how eventually the ability to abstain may get harder and harder.

O: SM arrived on time for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM participated appropriately in group today, both giving and receiving feedback.

P: SM will continue with IOP groups as planned.

S/O Note Written by LESKO, STACEY BETH @ 03 Nov 2017 1024 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Educational Group: Recovery Toolbox 0900-0945

Session #1: Types of Community Recovery Support Meetings

S: Psychoeducation re: what are Community Recovery Support Group meetings, types of 12-step groups, SMART Recovery and Celebrate Recovery. Lists of available meetings provided, as well as how to locate meetings. Discussed purpose of Community Recovery Support Groups, differences between treatment and Community Recovery Support Groups, and members' prior experiences with Community Recovery Support Groups.

O: SM arrived on time for group.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None

Med/Pain Issues: None

A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.

P: SM will attend next group as scheduled.

S/O Note Written by FOBIZSHI, MACANGELO M @ 06 Nov 2017 0654 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background Information: Creative Art Therapy Group

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was painting. The Instructor explained how painting could be used as therapeutic recreation to release emotions and tension. The instructor provided art material and allowed the group member time to paint. The group discussed their individual paintings and its significance.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/Hi: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/Hi.P: SM will continue group next week.

S/O Note Written by DELEON,PATRICK D. @ 08 Nov 2017 1156 EST

History of present illness

The Patient is a 32 year old male.

S: Intensive Outpatient Program Seeking Safety group, topic "Healing from Anger." Time 1000-1100. Discussion of constructive vs. destructive forms of anger, unmet needs that often/usually underlie anger, skills and strategies for managing anger without acting out in ways that make it worse. SM reports ongoing sobriety, identifies himself as having a significant anger problem both towards others and towards himself. SM discussed manageable level of stress with girlfriend moving into his apartment, communication about potential issues, set commitment to cook, plan meals for the week, finish painting rooms in his house over the weekend.

O: Client arrived on time to session. Alert and oriented x 3.

Appearance: Appropriate

Behavior: Appropriate

Speech: Within Normal Limits

Thoughts: Logical, linear, goal-directed

Mood: Anxious

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/Hi: None reported

Med/Pain Issues: Irritable Bowel Syndrome

A: SM actively engaged in group discussion, thoughtful about larger causes of anger and childhood experiences and trauma that influence him today, as well as specific strategies to address present.

P: Continue in Intensive Outpatient Program, next Seeking Safety group 6 Nov.

A/P Last Updated by LESKO,STACEY B @ 03 Nov 2017 1027 EST

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by LESKO,STACEY B @ 08 Nov 2017 1346 EST

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 08 Nov 2017 1346

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

02 Nov 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E

Encounter ID: BETH-30188360 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **02 Nov 2017 1040 EST**
Clinic: **GI CL BE**Appt Type: **T-CON***
Provider: **BRIDGES, EDWARD E**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by KIRBY, JAMAYA K @ 02 Nov 2017 1040 EST
Patient would like you to call him about medication.**A/P** Written by BRIDGES, EDWARD E @ 03 Nov 2017 1843 EST**1. Irritable bowel syndrome with diarrhea:** 32M with history of IBS-D. He reports his psychiatrist is taking him off all medications now and is requesting marinol for his diarrhea based off his review of research. I told him to send me his research and we would re-assess.**Disposition** Written by BRIDGES, EDWARD E @ 03 Nov 2017 1843 EST

Signed By BRIDGES, EDWARD E (Physician) @ 03 Nov 2017 1843

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

02 Nov 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A

Encounter ID: BETH-30189154 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **02 Nov 2017 0900 EST**
 Clinic: **OCCUP THERAP TBI BE**

Appt Type: **PROC**
 Provider: **NAVARRO, CARA A**

AutoCites Refreshed by NAVARRO, CARA A @ 02 Nov 2017 1105 EST

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

rec therapy

Appointment Comments:

can

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 02 Nov 2017 1105 EST
Questionnaires

A/P Written by NAVARRO,CARA A @ 02 Nov 2017 1122 EST

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x 2

Disposition Written by NAVARRO,CARA A @ 02 Nov 2017 1125 EST

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by NAVARRO,CARA A @ 02 Nov 2017 1122 EST

Recreational Therapy

Recreational Therapy Program

Name: Anderson, Daniel P02

Date: 02 Nov 2017

Time: 97537 x 30 MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building positive monitored socialization skills

Phone: [REDACTED]
Email: [REDACTED]@gmail.com
Branch / Rank: Navy/ P02

SM arrives on time, groomed well and presents in a pleasant mood.

SM discusses current stressors and strategies he is using for managing himself. SM declines Recreational Therapy services at this time due to the stress of travel and trying to implement lifestyle changes on his own. SM was provided with community recommendations and mindfulness app to try on his phone. SM appreciated resources and has Rec Therapist contact information if needing services in the future.

PLAN:

1. Patient will not receive Recreational Therapy services at this time.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 13 Nov 2017

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 02 Nov 2017
1126

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

01 Nov 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-30174458 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **01 Nov 2017 1300 EST**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T****AutoCites** Refreshed by TOBAR,EDEN @ 01 Nov 2017 1322 EST**Allergies**

•No Known Allergies

Vitals**Vitals** Written by LO,BAO-KHANG CONG @ 01 Nov 2017 1239 EDT

BP: 132/70, HR: 82, RR: 16, HT: 70 in, WT: 200 lbs, BMI: 28.7, BSA: 2.087 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by LO,BAO-KHANG C @ 01 Nov 2017 1239 EDT

BP: 132/70, HR: 82, RR: 16, HT: 70 in, WT: 200 lbs, BMI: 28.7, BSA: 2.087 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 01 Nov 2017 1652 EST**Followup Note**Patient: Daniel Anderson (previously Merwin) Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #14

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. We last met five weeks ago, at which time we initiated a cross-taper of Effexor xr 225 mg po qam to Cymbalta 60 mg po daily as pt didn't think Effexor was helpful and GI had suggested he try Cymbalta to also help his IBS instead. Two weeks ago pt called this provider and stated he was having withdrawal symptoms from coming off of Effexor after taper so we restarted Effexor xr 37.5 mg po qam. Today pt states the withdrawal brain zaps went away after he resumed the 37.5 mg daily but he started taking it every other day on 29OCT and the zaps have returned. He doesn't think Cymbalta 60 mg has been helpful, though he continues to take it. He had TMS and completed his course of treatment with it at IOP. HE is not sure if it was helpful. Reviewed phq9 and gad7 scores which are virtually unchanged from last visit. HE does think he is feeling a little better since starting a romantic relationship with a woman about 10 years older than him who has a 16 year old daughter. He finds spending time with them enjoyable and helps his mood. He has not drank since we last met and hasnot been taking naltrexone. He denies cravings. HE tried hydroxyzine 10 mg prn anxiety and didn't find it helpful for acute anxiety. He denies suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

06SEP17 phq9= 19 (#9=1); gad7= 19

27SEP17 phq9= 18 (#9=0); gad7= 17

01NOV17 phq9= 18 (#9=0); gad7= 16

Risk Assessment:**C-SSRS Baseline** (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present

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[] Faith/religion commitment

[] Positive future orientation

Allergies: nkda**Medications:**

HYDROXYZINE HCL, 10 MG, TABLET, ORAL TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY
AS NEEDED NAUSEA/ANXIETY 1 Active 16 Oct 2017@0001

DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL TAKE ONE CAPSULE BY MOUTH EVERY DAY 1 Ordered

Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic INSTILL 1 DROP IN EACH EYE FOUR
TIMES A DAY AS NEEDED FOR DRYNESS 2 Ordered 27 Sep 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 2 Active

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
Active 06 Jun 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY
AS NEEDED FOR GAS 2 Active 18 May 2017@0001

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL DISSOLVE 1 TABLET UNDER
TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN 3 Active
10 May 2017@0001

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED
IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May
2017@0001

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL DRINK 20ML (400MG) EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL 1 Active 28 Apr 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt

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states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in casual clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:fair

Speech:talkative

Mood:dysphoric

Affect:full

Thought Process: circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase SERUM 49		U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin SERUM 4.9	g/dL (3.5-5.2)			
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin SERUM 0.3	mg/dL (0.15-1.2)			
Bilirubin Direct SERUM <0.2	mg/dL (0.0-0.3)			
Protein SERUM 7.6	g/dL (6.6-8.7)			

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen SERUM 14.8	mg/dL (6-20)			

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Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)

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Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

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Goal:pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Interventions: Stop taking Effexor XR 37.5 mg po qam. Continue Cymbalta 60 mg daily. Consider taper off at next visit if it still is not helpful. May increase hydroxyzine to 20 mg po daily prn anxiety since he has not tried this dose yet, though I told him he could .

Measure:gad7, pcl, phq9

Problem #2: safety

Goal:pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm-met

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal:pt will abstain from drinking

Objective: pt will refrain from alcohol use

Intervention: discontinue naltrexone 50 mg po daily, which he has already stopped taking a month ago.

Normal b12 panel drawn after July 2017 visit. He continues with ATS.

Measure:self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of medication plan with patient who stated understanding and agreement with plan.

Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Follow-up: one month

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR,EDEN @ 02 Nov 2017 1011 EST

1. **Generalized anxiety disorder:** Med management 25 minutes; supportive therapy 25 minutes

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by TOBAR,EDEN @ 02 Nov 2017 1011 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR,EDEN @ 01 Nov 2017 1359 EST

Additional A/P Information:

Discontinued NALTREXONE--PO 50MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY

Note Written by TOBAR,EDEN @ 01 Nov 2017 1359 EST

Additional A/P Information:

Discontinued VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING

Signed By TOBAR, EDEN (Physician/Workstation) @ 02 Nov 2017 1012

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DoD ID: 1286180538

Created: 13 Nov 2017

01 Nov 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J

Encounter ID: BETH-30172775 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **01 Nov 2017 1115 EST**
 Clinic: **PAIN MGMT CL BE**

Appt Type: **FTR**
 Provider: **SPEVAK, CHRISTOPHER J**

AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 01 Nov 2017 1116 EST**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING	NR	16 Oct 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	#0 RF0 TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

A/P Written by SPEVAK,CHRISTOHER J @ 01 Nov 2017 1116 EST

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Disposition Written by SPEVAK,CHRISTOHER J @ 01 Nov 2017 1117 EST**Released w/o Limitations**

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Signed By SPEVAK, CHRISTOHER J (Physician) @ 01 Nov 2017 1117

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

01 Nov 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-30175360 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Nov 2017 0730 EST**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **DELEON,PATRICK D.**

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by DAVIS,KRISTEN KATHLEEN @ 03 Nov 2017 0756 EST**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group (0730-0845)

S: Topics discussed: Introductions, recovery programs and goals for recovery. Group members discussed the different aspects of their recovery programs, if they are currently being developed or goals they have regarding recovery. SM arrived late to group and stated it was because of health reasons. SM was engaged in the group for the remainder of the session, offering constructive feedback to other group members. SM stated that right now in his recovery process, he is looking to deepen his relationships and is working to prevent opportunities of isolation.

O: SM arrived 30 minutes late for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM arrived late for group and was engaged in the group for the remainder of the session. SM is sharing openly and honestly with the group. SM gives appropriate feedback and appears dedicated to his recovery.

P: SM will continue with group as assigned.

S/O Note Written by HANGEMANOLE,DESPINA C @ 03 Nov 2017 0844 EST**History of present illness**

The Patient is a 32 year old male.

Educational Group: Finding Meaning 1000-1045

Focus of Session: Defining Spirituality~S: The group discussed what spirituality means to them. SM explored basic issues of spirituality and how addiction affects spirituality. He shared that his definition of spirituality are similar to military values such as honesty and integrity. SM explored the practical applications of spirituality and acknowledged that practicing spirituality may be beneficial for recovery.

O: SM arrived on time for group.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None

Med/Pain Issues: None~A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.~P: SM will attend next group as scheduled.

Note Written by RAGLAND,MARY @ 01 Nov 2017 1306 EST**Mind-Body Group, Session #6: Walking Meditation 1100-1145**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S: Psychoeducation re: purposes of walking meditation, how walking and sitting meditation differ and compare. Watched video of Thich Nhat Hanh describing walking meditation. Group then went to lawn north of America Building to practice walking meditation for 20 min. Group discussed experience of walking meditation.

O: SM arrived on time for session. SM alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: SM participated in exercise and discussion.

P: SM to continue with group/IOP Tx.

A/P Written by DELEON, PATRICK D. @ 03 Nov 2017 1509 EST

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON, PATRICK D. @ 03 Nov 2017 1509 EST

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive Outpatient Program, next groups 3 Nov

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 03 Nov 2017 1509

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

30 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by BILODEAU, NATALIE C

Encounter ID: BETH-30146266 Primary Dx: Obstructive sleep apnea (adult) (pediatric)

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Oct 2017 1556 EDT**
 Clinic: **SLEEP (PULM) CL BE**

Appt Type: **T-CON***
 Provider: **BILODEAU, NATALIE C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by BILODEAU, NATALIE C @ 30 Oct 2017 1556 EDT

Called with results of sleep study

Telephone Consult Comments: Written by BILODEAU, NATALIE C @ 30 Oct 2017 1556 EDT

Very mild osa hx depression would like to try cpap

A/P Last Updated by BILODEAU, NATALIE C @ 30 Oct 2017 1609 EDT**1. Obstructive sleep apnea (adult) (pediatric):** Pt aware of sleep study results very mild OSA overall.

Reviewed treatment therapy OA vs CPAP He would like to try cpap. For excessive daytime sleepiness

Advised not to drive if sleepy.

Medication(s):

-ESZOPICLONE--PO 2MG TAB - TAKE ONE TABLET BY MOUTH EVERY NIGHT TAKE FOR TWO WEEKS WHEN YOU START CPAP #14 RF0

Consult(s):

-Referred To: DME & MEDICAL SUPPLIES NET BE (Routine) Specialty: FAMILY PRACTICE/PRIMARY CARE Clinic: REFERRAL MGMT CTR BE Provisional Diagnosis: Obstructive sleep apnea (adult) (pediatric)

Disposition Last Updated by BILODEAU, NATALIE C @ 03 Nov 2017 1507 EST**Administrative Options:** Consultation requested**Note** Written by BILODEAU, NATALIE C @ 30 Oct 2017 1605 EDT

:

VENDOR BP GAMMA

You have been diagnosed with obstructive sleep apnea (OSA). Treating your OSA with continuous positive airway pressure (CPAP) will improve your quality of sleep. You will need to combine the use of your CPAP with at least 7-8 of sleep 7 nights a week.

Treating your sleep apnea will improve: Memory, blood pressure, blood sugar, mood, daytime sleepiness, heartburn and erectile dysfunction.

1. How to get your CPAP machine

1. Your provider has placed a DME order (Durable Medical Equipment) for a CPAP and supplies.
2. In 3 business days BP GAMMA, your DME Vendor, will contact you. If they have not contacted you, you can call **their office at 301 874 3390 or 1 800 624 4134 to confirm that this CPAP order was approved and to coordinate pick up and/or delivery of this device.** The Walter Reed CPAP Concierge office (301 400 1412) will fax over needed paper work.
3. Once you have a confirmed date for pick up, contact the clinic to schedule an appointment for a CPAP start up class.

1. CPAP START UP CLASS

A 2-3 hour group session held once a week where will receive education on your new diagnosis of sleep apnea and go over general information about CPAP while addressing issues you may have encountered. We encourage you to bring your CPAP machine to class.

To schedule this appt: Call 301 400 1412 or contact us via our website: Internet search >Sleep Disorder Walter Reed> Contact Sleep Medicine Staff located on the right side of webpage> Enter your contact info> Type of appointment CPAP START UP”.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Begin using your CPAP a few days before this scheduled class.

The use of a sleep aid, such as Ambien (zolpidem) or Lunesta (eszopiclone), is usually recommended for the first two weeks of CPAP use. It is recommended that you treat any nasal congestion. If you have chronic nasal congestion from allergies, use Flonase (fluticasone nasal spray). If you have acute nasal congestion from a cold, over the counter Afrin (oxymetazoline nasal spray) for a few night can be helpful.

2. Schedule follow-up

After the CPAP start up class, you will be scheduled into a CPAP follow appointment to evaluate CPAP data after 4-6 weeks of use.

*If you will **NOT** be attending this class, we recommend you call 301 295 6289 and schedule a CPAP follow up with CPAP follow up provider.*

Other important information:

- Bring you CPAP data card to all CPAP appointments.
- CPAP therapy is recommended as a lifetime treatment unless otherwise changed by your sleep provider.
- An annual follow up is recommended to renew CPAP supplies for all patients.

Signed By BILODEAU, NATALIE C (Physician/Workstation) @ 03 Nov 2017 1507

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

30 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-30142543 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Oct 2017 1200 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

jbf

Note Written by HANGEMANOLE, DESPINA C @ 31 Oct 2017 1204 EDT**Focus Of Session: Work Stress/Risky Behaviors**

S) SM stated that he completed TAPS last week and continues to experience stress related to work. SM stated he is experiencing conflict with his chain of command as they are requiring that he drive back and forth between WR and Ft. Meade between appointments. SM stated that he hopes to get transferred to WR to eliminate this stress. SM reported that he has been diagnosed with sleep apnea, which is relieving for him as he has been struggling with sleep issues for years. SM reported that he has moved in with his girlfriend of a few months, who also has an alcohol problem. SM described his relationship as supportive and stated that they have already agreed on a plan if their relationship doesn't work out. SM reported that she has self identified an alcohol problem but has been abstinent from alcohol for an extended time and plans to continue abstinence. SM reported an increased in anxiety related to work stress but a decrease in depressive symptoms since dating this person. SM reported that once IOP is over he will begin taking leave as to avoid having to be at work during his MEB process. SM stated that he will be speaking with a GI provider regarding possibly starting Marinol. SM acknowledged the risks of relapse and cross addiction. SM stated that he continues to have flare ups and nothing he has tried so far has worked to alleviate his discomfort. SM reported his pain as a 4/10 from his IBS. SM reported he attended one AA meeting this week and plans to return to Smart Recovery meetings now that he is back in the Glen Burnie area. SM denied any alcohol use or thoughts about drinking. SM denied SI/HI.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM is thoughtful when discussing his support system and relationships. SM demonstrates good judgement by attending all appointments and participating appropriately. SM lacks insight in some of his decisions around his relationship and his IBS treatment. SM will be at greater risk of relapse if he begins taking Marinol, and given that SM was unable to sustain sobriety after his last treatment this appears to be high risk behavior.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin continue with ATS groups as scheduled.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 30 Oct 2017 1357 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 30 Oct 2017 1357 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 31 Oct 2017 1204

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

30 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-30133906 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by FOBIZSHI, MACANGELO M @ 31 Oct 2017 0628 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session.

Today's group topic was "signs of danger versus safety". The group session was focused identifying red flags during their recovery process, as well as, green flags that will further their recovery. The group members selected both red and green flags from the handout that they could relate to. The provider asked the group members to create a safety plan for the red flags they selected. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P.

S/O Note Written by HANGEMANOLE, DESPINA C @ 31 Oct 2017 0712 EDT**History of present illness**

The Patient is a 32 year old male.

S: The group discussed drinking history and meetings. SM introduced himself to the group stating that he has finally been diagnosed with sleep apnea, after years of having sleep problems. SM gave a brief but detailed history of his alcohol use over his lifetime, sharing that his alcohol use became out of control when he moved to the area a few years ago secondary to depression and anxiety. SM discussed his MEB starting, and the some of the decisions he's made regarding his career thus far. SM reported that he enjoys SMART recovery meetings more than AA meetings but does relate to the 12 Step philosophy as a whole. ~O: SM arrived on time for group. SM was oriented x3. ~Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Fair

Judgment: Good

SI/HI: None Current

Med/Pain Issues: None expressed ~A: SM is sharing openly and honestly with the group. SM gave appropriate feedback and asked thoughtful questions of other group members. SM is open to community recovery, though it is not clear why SM does not enjoy AA meetings. ~P: SM will continue with IOP groups as scheduled.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 30 Oct 2017 0955 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 30 Oct 2017 0956 EDT**Released w/o Limitations**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue with groups as scheduled.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 03 Nov 2017 0732

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

24 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N

Encounter ID: BETH-30067722 Primary Dx: Obstructive sleep apnea (adult) (pediatric)

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **24 Oct 2017 1021 EDT**
 Clinic: **SLEEP (PULM) CL BE**

Appt Type: **PROC**
 Provider: **KHRAMTSOV, ANDREI N.**

Reason for Appointment: Written by ANDRADA, TEOTIMO F @ 24 Oct 2017 1021 EDT
 psg interpretation

A/P Last Updated by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT

1. Obstructive sleep apnea (adult) (pediatric)

Procedure(s): -Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older x 1 (26-PROFESSIONAL COMPONENT)

Disposition Last Updated by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT

Released w/o Limitations

Follow up: as needed .

Note Written by ANDRADA, TEOTIMO F @ 24 Oct 2017 1022 EDT

Walter Reed National Military Medical Center**Sleep Disorders Center**

8901 Rockville Pike

Bethesda, MD 20889

Phone: 301-295-4547 Fax: 301-319-8197

Patient Name: Anderson, Daniel

SSN: [REDACTED]

Study Date: 10/4/2017

Scorer: L. Davis, RPSGT

Referring Provider: Dr. Khramtsov

POLYSOMNOGRAM REPORT**Technical Description:**

Physiologic data were collected using a computerized Sensormedics polygraph interfaced with Somnostar Z4 amplifiers. The recording montage consisted of central, frontal and occipital EEG, EOG, chin EMG, thermocouple and pressure transducer airflow, chest and diaphragmatic movement, combined leg EMG, tracheal sounds and pulse oximetry. The patient was monitored throughout the study via infrared CCTV and recorded for review. Respiratory events and limb movements were scored according to *The AASM Manual for the Scoring of Sleep and Associated Events, Version 2.3*.

Polysomnographic Data:

The patient took 3mgs Eszopiclone prior to the study. The study duration was 419.5 minutes. The recorded total sleep time was 367.5 minutes with a sleep efficiency of 87.6%. The patient's latency to sleep was 16.5 minutes. The REM latency was 174.5 minutes. Sleep stage distribution revealed 12.9% Stage N1, 58.1% Stage N2, 16.1% Stage N3, 12.9% Stage REM and wake after sleep onset was 35 minutes. There were 100 arousals and 0 awakenings resulting in a total arousal index (TAI) of 16.3/hour of sleep.

There were 0 apneas (0 obstructive, 0 centrals, 0 mixed) and 37 hypopneas with **an apnea hypopnea index(AHI) of 6./hour**. The apnea hypopnea index during supine sleep(88 minutes) was 19/hour and 2/hour during non-supine sleep(280 minutes). The hypopnea index was 6./hour. The Central apnea index was 0/hour. Hypopneas were scored using nasal pressure signal drop by at least 30% followed by arousal or 3% oxygen desaturation..

Oxygen saturation was normal at baseline. Oxygen saturation remained between 86% and 97% with mean value of 95% throughout the study. During the study the oxygen saturation was below 90% for 1 percent of the total sleep time. The average heart rate was 73 beats per minute. There were 0 PLMS and

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

0 PLMS with arousals with a PLMS index of 0/hour and a PLMS arousal index of 0/hour.

Medical Interpretation:

The patient underwent a Diagnostic PSG: Epworth Sleepiness Scale was 20/24. Sleep efficiency was good and there was adequate total sleep time to establish a diagnosis. Sleep architecture was disrupted. The patient had an AHI consistent with mild sleep apnea. The EKG did not demonstrate arrhythmias.

Diagnosis:

1. Obstructive Sleep Apnea(G47.33)

Suggestions for Clinical Care:

1. AutoPAP titration with pressures of 6-15 cm H2O and close clinical follow up.
2. Recommend sleeping in the lateral position, obtaining 7-8 hours of sleep per night, avoid of alcohol or other sedatives and maintaining an ideal body weight as these can improve sleep quality.
3. The patient should be counseled- as is done with all patients directly seen at this SDC- not to engage in any hazardous activities (such as driving) if excessively sleepy. Such sleepiness is to be reported to their physicians for further evaluation and treatment.

Interpreted by:

Andrei Khramtsov, MD
Diplomate, Sleep Medicine
Staff Physician, Sleep Disorders Center
WS#:5

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 24 Oct 2017 1042

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-30033585 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **20 Oct 2017 1237 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE,RAYMOND G.****AutoCites** Refreshed by LANDE,RAYMOND G. @ 20 Oct 2017 1245 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Oct 2017 1237 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 20 Oct 2017 1239 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #13 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 13 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided today will be SM last TMS appointment, as SM will be away on training for some time. ZUNG depression = 45, PHQ 9 = 13.

S/O Note Written by LANDE, RAYMOND G. @ 20 Oct 2017 1245 EDT

Reason for Visit

Visit for: Attending Note: A procedural time out was done during which settings and patient was re-identified.

45 minutes

Purpose of visit was for session of Transcranial Magnetic Stimulation. SM is receiving treatment for depression.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS without evidence of distress. Confirmed that there was no metal above the neck. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes. WRNMMC PAO with SM's permission in room.

Objective

Plan: SM next session scheduled.

A/P Last Updated by LANDE, RAYMOND G. @ 20 Oct 2017 1247 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Last Updated by LANDE, RAYMOND G. @ 20 Oct 2017 1248 EDT**Released w/o Limitations****Follow up:** in the PSYCH DAY HOSP BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By** LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 20 Oct 2017 1248**Note** Written by BRAGGS, DEBORAH C. @ 20 Oct 2017 1333 EDT**(Added after encounter was signed.)****nursing note**

SM enrolled for TMS for anxiety due to reports of reoccurrence of panic attacks. SM enrolled in TMS due to treatment resistant depression. SM start date for TMS was 9/12/17. SM end date for TMS 10/20/17. SM had #13 treatments for depression with at therapeutic level. SM had #10 for anxiety. SM will continue to follow up with outpatient behavioral health for behavioral health care. SM offers no c/o pain and no distress note.

PHQ 9=scores	GAD 7=scores	ZUND depression=scores	ZUNG anxiety=scores
	9/15=18		9/15=4
	9/22=15		9/22=50
10/6=15		10/6=51	
10/13=16		10/13=56	
10/20=13		1/20=45	

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G

Encounter ID: BETH-30033488 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **20 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **HARDIN, JAMES G**

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by FOBIZSHI, MACANGELO M @ 23 Oct 2017 0621 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background Information: Creative Art Therapy Group Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The instructor explained how poetry could be used as a platform to express emotions and thoughts. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P: SM will continue group next week.

S/O Note Written by HARDIN, JAMES G @ 25 Oct 2017 1015 EDT**History of present illness**

The Patient is a 32 year old male.

Process group: 0730-0845

Focus of Session: weekend planning, role of sponsors

S) The group discussed their plans for the weekend and the need to keep their time structured. We talked about the dangers of boredom and too much free time. Members talked about their relationships with others in the self-help community and the role of sponsors. SM fully participated in the discussion.

O) Appearance: normal

Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: calm

Affect: consistent

Insight: fair

Judgment: fair

SI/HI: None Current

Med/Pain Issues: None

A) SM was invested in group today.

P) Next process group will be same time Monday.

Note Written by RAGLAND, MARY @ 24 Oct 2017 0725 EDT**Educational Group: Recovery Toolbox****Session #5: Sponsorship in Community Recovery Support Groups**

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S: Psychoeducation re: what is sponsorship, how does one obtain a sponsor, ways to work with a sponsor for recovery. Participants discussed prior experiences with sponsors.

O: SM arrived on time for group.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None

Med/Pain Issues: None

A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.

P: SM will attend next group as scheduled.

A/P Last Updated by HARDIN, JAMES G @ 25 Oct 2017 1016 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HARDIN, JAMES G @ 25 Oct 2017 1016 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse Program, WRAMC) @ 25 Oct 2017 1016

Note Written by DELEON, PATRICK D. @ 25 Oct 2017 1042 EDT

(Added after encounter was signed.)

S: Intensive Outpatient Program Seeking Safety group, topic "Honesty." Time 1000-1100. Discussion of the role of honesty in recovery, ways in which honesty gets impacted in active substance abuse, and situations which make honesty more difficult. Particular discussion of honesty with children and with therapists, and both the difficulties and benefits of open direct communication when emotions are high. SM actively engaged in group discussion, processed difficulties with AA, spoke about feeling judged and that things get oversimplified in AA. Peers and this SW acknowledging 'absolute' talk in AA while also reframing that as having basic principles which are helpful in time of crisis, and that can be explored more fully and individually in treatment and/or with sponsor.~

O: Client arrived on time to session. Alert and oriented x 3.~

Appearance: Appropriate~

Behavior: Appropriate~

Speech: Within Normal Limits~

Thoughts: Logical, linear, goal-directed~

Mood: Depressed~

Affect: Congruent~

Insight: Fair~

Judgment: Fair~

SI/HI: None reported~

Med/Pain Issues: Irritable Bowel Syndrome~

A: SM active participant in group, open to feedback~

P: Continue in Intensive Outpatient Program, next Seeking Safety group 23 Oct

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

19 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-30017293 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **19 Oct 2017 1158 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 19 Oct 2017 1321 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Oct 2017 1158 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 19 Oct 2017 1223 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #12 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 12 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 19 Oct 2017 1318 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:35-13:20).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 22/ # 12 at 120% MT.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Written by LANDE,RAYMOND G. @ 19 Oct 2017 1325 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 19 Oct 2017 1326

CHANGE HISTORY

The following Disposition Note Was Overwritten by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT:

The Disposition section was last updated by BAHROO,BHAGWAN A @ 19 Oct 2017 1322 EDT - see above.Previous Version of Disposition section was entered/updated by LANDE,RAYMOND G. @ 19 Oct 2017 1321 EDT.

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J

Encounter ID: BETH-30002526 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **18 Oct 2017 1325 EDT**
 Clinic: **PAIN MGMT CL BE**

Appt Type: **FTR**
 Provider: **SPEVAK, CHRISTOPHER J**

AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 18 Oct 2017 1325 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING	NR	16 Oct 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	#0 RF0 TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

A/P Written by SPEVAK,CHRISTOHER J @ 18 Oct 2017 1326 EDT

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Disposition Written by SPEVAK,CHRISTOHER J @ 18 Oct 2017 1327 EDT**Released w/o Limitations**

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Signed By SPEVAK, CHRISTOHER J (Physician) @ 18 Oct 2017 1327

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-29999838 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **18 Oct 2017 0730 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **DELEON, PATRICK D.****Reason for Appointment:**

IOp

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 18 Oct 2017 1146 EDT**History of present illness**The Patient is a 32 year old male.
SM was not in Finding Meaning Group 1000-1045.**S/O Note** Written by DAVIS, KRISTEN KATHLEEN @ 18 Oct 2017 1338 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group 0730 - 0845

S: Topics discussed: Introductions, feeling words, and six categories of emotion. Group members described how they are feeling and where these feelings would fall in the six categories (mad, glad, sad, hurt, afraid and guilt/shame). SM identified feeling mad/sad for having to work last night and glad that the process is moving along for him to sell his house. SM helped orient new members when making introductions.

O: SM arrived late to group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Stable

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None Current

Med/Pain Issues: None expressed

A: SM participated appropriately in discussion. SM demonstrates commitment to sobriety/recovery.

P: SM will continue with groups as assigned.

Note Written by RAGLAND, MARY @ 19 Oct 2017 0959 EDT**Mind-Body Group, Session #4: Yoga 1100-1155****SM did not attend this group.****A/P** Written by DELEON, PATRICK D. @ 23 Oct 2017 0729 EDT**1. Alcohol dependence, uncomplicated F10.20**

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON, PATRICK D. @ 23 Oct 2017 0730 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic. - Comments: Continue in Intensive Outpatient Program, next groups 20 Oct**Signed By DELEON, PATRICK D.** (Social Work Case Manager) @ 23 Oct 2017 0730

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Oct 2017 at WRNMMC, Psychiatry Be by TEKELENBURG, JAAP

Encounter ID: BETH-29990523 Primary Dx: Encounter for other administrative examinations

Patient: **ANDERSON, DANIEL DENNIS** Date: **18 Oct 2017 0627 EDT** Appt Type: **T-CON***
Treatment Facility: **WALTER REED** Clinic: **PSYCHIATRY BE** Provider: **TEKELENBURG,JAAP**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient** Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by TEKELENBURG,JAAP @ 18 Oct 2017 0627 EDT
Care coordination

S/O Note Written by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT

Subjective

L/m at 0625 to notify of facility cancelled appointment for today at 0900 with Dr. Paul. Next scheduled appointment is 25 October at 0800. Please call for additional assistance 301-295-0500.

A/P Last Updated by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT

1. Encounter for other administrative examinations

Disposition Last Updated by TEKELENBURG,JAAP @ 18 Oct 2017 0629 EDT

Referred for Appointment

Signed By TEKELENBURG, JAAP (Nurse) @ 18 Oct 2017 0629

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

17 Oct 2017 at WRNMMC, Int Med CL E Medical Home BE by MEYERS, NANCY

Encounter ID: BETH-29976219 Primary Dx: Unspecified asthma, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **17 Oct 2017 0915 EDT**
 Clinic: **INT MED CL E MEDICAL HOME**
BE

Appt Type: **FTR**
 Provider: **MEYERS,NANCY NMN**

Reason for Appointment:

Cats Allergies, Asthma

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by TASHU,BIRTUKA A @ 17 Oct 2017 0937 EDT

BP: 141/93 Right Arm, HR: 98, RR: 18, T: 99.6 °F, HT: 69 in, WT: 78.6 kg, SpO₂: 96%, BMI: 25.59,
 BSA: 1.944 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 3/10 Mild,
 Pain Scale Comments: Pt stated that he has asthma/ cat allergies & irritable bowel pain. repat b/p on left arm 131/93

Comments: + Depression / Anxiety

Neg suicidal.

S/O Note Written by TASHU,BIRTUKA A @ 17 Oct 2017 0919 EDT**Chief complaint**

The Chief Complaint is: Asthma/ cat allergies & irritable bowel pain.

History of present illness

The Patient is a 32 year old male.

Pain Severity 3 / 10.

Pain assessment

Location: irritable bowel pain

Duration: chronic

Quality: 3/10

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

Allergies

Allergies Verified and Updated on 17 Oct 2017

NKDA

Current medication

Medication Review on 17 Oct 2017

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Photorefractive keratectomy
Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

S/O Note Written by MEYERS,NANCY NMN @ 17 Oct 2017 0957 EDT

Chief complaint

The Chief Complaint is: Abdominal discomfort, request pulmonary referral.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Presents for referral pumony. VA has requested pt document allergy to cats as manifest by wheezing, and difficulty breathing.

Treated effectively with albuterol

Presently with and pain and bloating related to IBS

Notes from GI, lab and rad studies reviewed.

Last colo 2012.

Pt currently drinking a cup coffee which he stated he needed to drive

Had formed BM this morning

Denies nausea

Has used Levsin without improvement, attempts to maintain FODMAP diet.

Recently started on cymbalta.

Pain Severity 3 / 10.

Pain assessment

Location: abdominal

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

What makes it worse:

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Cymbalta 60 qd
 Probiotic one packet po daily
 Simethicone 80 mg po qid prn
 Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history
 IBS-D
 Generalized anxiety disorder
 Major depressive disorder
 ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 Photorefractive keratectomy
 Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2.

Abdomen:

Visual Inspection: • Abdomen was distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: • Abdominal tenderness tenderness with palpation. ° No abdominal guarding. ° No mass was palpated in the abdomen.

Test conclusions

Medication list was updated at the beginning of the visit.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Lab Result Cited by MEYERS,NANCY @ 17 Oct 2017 0952 EDT

Comprehensive Metabolic Panel	Site/Specimen	06 Jul 2017 1520
Albumin	SERUM	5.0
Alkaline Phosphatase	SERUM	61
Alanine Aminotransferase	SERUM	39
Bilirubin	SERUM	0.5
Urea Nitrogen	SERUM	9.0
Calcium	SERUM	10.5 (H)
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.96
Glucose	SERUM	87
Potassium	SERUM	4.3
Protein	SERUM	7.8
Sodium	SERUM	141
Anion Gap	SERUM	14
GFR Calculated Non-Black	SERUM	104.2
GFR Calculated Black	SERUM	120.4 <i>
Aspartate Aminotransferase	SERUM	26

Lab Result Cited by MEYERS,NANCY @ 17 Oct 2017 0951 EDT

CBC W/Diff	Site/Specimen	06 Jul 2017 1520
WBC	BLOOD	6.6
RBC	BLOOD	4.53
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	41.9
MCV	BLOOD	92.5
MCH	BLOOD	31.8
MCHC	BLOOD	34.4
RDW CV	BLOOD	12.3
Platelets	BLOOD	284
MPV	BLOOD	10.5
Neutrophils	BLOOD	63.3
Lymphocytes	BLOOD	26.9
Monocytes	BLOOD	8.3
Eosinophils	BLOOD	0.5
Basophils	BLOOD	0.5
ABS Neutrophils	BLOOD	4.2
ABS Lymphocytes	BLOOD	1.8
ABS Monocytes	BLOOD	0.6
ABS Eosinophils	BLOOD	0.0
ABS Basophils	BLOOD	0.0
Nucleated RBC/100 WBC	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED
Granulocytes Immature	BLOOD	0.5
Absolute Immature Granulocytes	BLOOD	0.03

Rad Result Cited by MEYERS,NANCY @ 17 Oct 2017 0948 EDT**ANDERSON, DANIEL DENNIS** 20/ [REDACTED] **DoD ID: 1286180538 32yo** [REDACTED] **1985 M**

***** MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Event Date: 23-Oct-2012 15:54:00
Exam #: 12359730
Exam Date/Time: 02-Nov-2012 07:18:00
Transcription Date/Time: 05-Nov-2012 09:56:00
Provider: COPSEY, HELEN C
Requesting Location:
GSURG GI APU BE WRNMMC BETHESDA, MD
Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G
Supervised By: MARCIA JAVITT, MD
Approved By: JAVITT, MARCIA C
Approved Date: 05-Nov-2012 09:48:00
Supervised By: 115455 MARCIA JAVITT, MD
Supervised By Date: 05-Nov-2012 09:48:00

Amended Report Text:

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

A/P Written by MEYERS,NANCY @ 17 Oct 2017 1002 EDT

1. Unspecified asthma, uncomplicated: Related to exposure cats. Pt request referral pulmonary per VA for documentation. Sxs are managed with albuterol

Consult(s): -Referred To: PULMONARY DISEASE NCR (Routine) Specialty: PULMONARY DISEASE Clinic: RM
PULMONARY IR Provisional Diagnosis: Unspecified asthma, uncomplicated

2. Irritable bowel syndrome with diarrhea: Referred back to GI. Diarrhea predominant. Consider nortriptyline if Cymbalta not effective in managing pain and sxs

Disposition Written by MEYERS,NANCY @ 17 Oct 2017 1002 EDT

Released w/o Limitations

Follow up: as needed .

Administrative Options: Consultation requested

Signed By MEYERS, NANCY (Physician) @ 17 Oct 2017 1003

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

16 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29962066 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **16 Oct 2017 1114 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 16 Oct 2017 1249 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #0 RF1	1 of 1	16 Oct 2017
VENLAFAXINE HCL, 37.5 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF0	NR	16 Oct 2017
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 16 Oct 2017 1114 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 16 Oct 2017 1150 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #11 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 11 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Thursday.

S/O Note Written by LANDE, RAYMOND G. @ 16 Oct 2017 1249 EDT

Reason for Visit

Visit for: Attending Note: A procedural time out was done during which settings and patient was re-identified.

45 minutes

Purpose of visit was for another session of Transcranial Magnetic Stimulation for depression.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS without evidence of significant distress. Confirmed that there was no metal above the neck. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Objective

Plan: SM scheduled for next session.

A/P Written by LANDE, RAYMOND G. @ 16 Oct 2017 1251 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Disposition Written by LANDE, RAYMOND G. @ 16 Oct 2017 1251 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 16 Oct 2017 1251

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

16 Oct 2017 at WRNMMC, Immunization Clinic Be by AGUGLIARO, ANTHONY J

Encounter ID: BETH-29961946 Primary Dx: Encounter for immunization

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 Oct 2017 1110 EDT**
 Clinic: **IMMUNIZATION CLINIC BE**

Appt Type: **PROC**
 Provider: **AGUGLIARO, ANTHONY JOHN**

Reason for Appointment: Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1110 EDT
 flu shot

S/O Note Written by AGUGLIARO, ANTHONY JOHN @ 16 Oct 2017 1112 EDT

Reason for Visit

Visit for: immunization.

History of present illness

The Patient is a 32 year old male.

He reported: Previous history of Encounter Background Information:

Vaccinations

• Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Personal history

Patient to be vaccinated for influenza is older than 6 months of age. Patient is not sick today and has no allergies to eggs or any component of the vaccine. Patient has not had serious reaction to influenza in the past. Patient has no history of Guillain-Barre syndrome.

Therapy

• The drug reactions/side effects are being monitored: Details -- Patient tolerated vaccinations without significant side effects discharged 15 minutes after administered and no adverse reactions noted.

Practice Management

Patient information sheet: Given to ___Patient___Parent___Guardian on Vaccination Information Statement(s). Risks, benefits and limitations discussed and understood

A/P Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1113 EDT

1. Encounter for immunization

Procedure(s):

-Influenza Split Virus Vaccine 0.5mL Dosage IM Preserv Free Quadrivalent x 1 - Influenza Seasonal, injectable quadrivalent - preservative free; Series #: 1; .5 mL; IM; Right Arm; Mfg: SmithKline; Lot: P5472.

-Immunization Administration One Vaccine x 1

Disposition Written by AGUGLIARO, ANTHONY J @ 16 Oct 2017 1113 EDT

Released w/o Limitations

Signed By AGUGLIARO, ANTHONY J (Physician) @ 16 Oct 2017 1113

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

16 Oct 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29961116 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **16 Oct 2017 1047 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **TOBAR, EDEN T**

Call Back Phone: [REDACTED]

AutoCites Refreshed by TOBAR, EDEN @ 16 Oct 2017 1047 EDT**Allergies**

•No Known Allergies

Vitals

No Vitals Found.

Reason for Telephone Consult: Written by TOBAR, EDEN @ 16 Oct 2017 1047 EDT
meds**S/O Note** Written by TOBAR, EDEN T @ 18 Oct 2017 0852 EDT**Subjective**

Received call from pt stating he has been on cymbalta 60 mg for five days after stopping effexor xr 75 mg every morning as per our taper plan prior to that. Pt states the day before his call, he began experiencing brain zaps, was finding it hard to concentrate, and has felt nausea for the two days prior to his call. He finds it hard to focus on driving. He asks what he can do about his effexor withdrawal and about being put on quarters. He is currently attending ATS IOP. Returned pt's call. We discussed adding back effexor xr 37.5 mg po qam to counteract his effexor withdrawal. Discussed taking it in the morning and his cymbalta at night to minimize drug interaction and potential for serotonin syndrome. Also prescribed hydroxyzine 10 mg, up to two tabs daily for agitation/nausea. Agreed to leave quarters slip at front desk for him to pick up, putting him on quarters until the morning of 18OCT. He has follow up with this provider the week of Oct 30th as he is in transition class next week.

A/P Last Updated by TOBAR, EDEN @ 18 Oct 2017 0853 EDT**1. Generalized anxiety disorder****--> Unassociated Orders, Procedures and Injuries/Accidents <--**

VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING #30 RF0 Ordered By:

TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

hydroxyzine HCL--PO 10MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH TWICE A DAY AS NEEDED NAUSEA/ANXIETY #30 RF1

Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR, EDEN @ 18 Oct 2017 0853 EDT**Discussed:** Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By TOBAR, EDEN** (Physician/Workstation) @ 18 Oct 2017 0853

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29960995 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 Oct 2017 1044 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **ACUT**
 Provider: **HANGEMANOLE, DESPINA C**

S/O Note Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1101 EDT**History of present illness**

The Patient is a 32 year old male.

SM asked to speak with this writer as he is feeling 'out of it' due to withdrawal from his psychotropic medication Effexor. SM reported having 'brain zaps' in which he forgets his train of thought and has difficulty communicating. SM stated he's having trouble focusing in group. SM stated he is also feeling stressed regarding the pressures his command is putting on him at work. SM shared that he will ask his PCM for updated limdu paperwork to specify that he cannot be on watch and should not be driving back and forth from WR to Ft. Meade unless he has adequate time to do so. SM stated he would call Dr. Tobar for guidance. SM reported he spoke with Dr. Tobar and she put him on 48 hours SIQ and is re-prescribing a low dose of Effexor. SM stated he will attend TMS appointments and his PCM appointment tomorrow but would otherwise not be at appointments until Wednesday. SM appeared anxious and presented as tearful. SM will reschedule individual appointment for Wednesday.

A/P Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1109 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1109 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will report for groups on Wednesday and reschedule individual appointments.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 16 Oct 2017 1110

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

16 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29961906 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 16 Oct 2017 1113 EDT**History of present illness**

The Patient is a 32 year old male.

S: The group discussed addictive behaviors, meetings and relationship with command. SM reported that he does not interact as regularly with his command as many others in group but mostly does not get adverse reactions from them about his need for treatment. SM stated that he could understand how many in leadership may not understand addiction or the need for treatment just based on their lack of life experience with it. SM reported that he could understand how people may engage in addictive behaviors other than substance abuse and acknowledged that it's likely an outward manifestation of something going on internally with that person. ~O: SM arrived on time for group. SM was oriented x3. ~Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Anxious

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None Current

Med/Pain Issues: None expressed ~A: SM is sharing openly and honestly with the group. SM gives appropriate feedback and appears engaged in group. SM can be tangential but is conscious of this and appears to be actively working to be more concise. ~P: SM will continue with IOP groups as scheduled.

S/O Note Written by FOBIZSHI, MACANGELO M @ 17 Oct 2017 0630 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session. The group topic was "Safety". The group focused on learning healthy safe coping skills. The group members identified safe and unsafe coping skills they have been using. The provider explained the three stages of healing from PTSD and substance abuse; safety, mourning and reconnection. The group members discussed what safety means to them and the signs of recovery. The group reviewed the examples of safe coping skills in the handout and identified some safe coping skills to practice. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI. P: SM will continue group next week.

S/O Note Written by HARDIN, JAMES G @ 17 Oct 2017 1026 EDT**History of present illness**

The Patient is a 32 year old male.

Relapse Prevention Group (0900-0945)

Focus of Session: Identifying Triggers

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

S) SM participated in a group discussion about identifying triggers. SM reported that both internal and external factors can be triggers, with negative emotions being among the main triggers. SM listened as other suggested ways to cope and identified attending meetings and therapy appointments as his best ways to cope with triggers. SM participated actively in the group process.

O) SM arrived on time for group. SM was dressed casually. SM's mood was calm and affect was congruent.

A) SM seems invested in group at this time.

P) Next relapse prevention group: Managing thoughts

S/O Note Written by HANGEMANOLE,DESPINA C @ 17 Oct 2017 1202 EDT**History of present illness**

The Patient is a 32 year old male.

SM did not attend service dog training as he was put on SIQ orders for symptoms related to withdrawal from his psychotropic medication.

A/P Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1113 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1114 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic. - Comments: SM will continue with groups as scheduled.**Signed By** HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 17 Oct 2017 1203

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

13 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29945631 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **13 Oct 2017 1213 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 13 Oct 2017 1336 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Oct 2017 1213 EDT
TMS

S/O Note Written by POURZAND, MIRIAM @ 13 Oct 2017 1216 EDT

History of present illness

The Patient is a 32 year old male.

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression 45 minute session.

Subjective

TMS Session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 20/ #10 at 120% MT.

Objective

SM next session scheduled.

.....

S/O Note Written by BLOBERG, BRIAN @ 13 Oct 2017 1232 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #10 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #10 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Monday 16OCT2017.

A/P Written by LANDE, RAYMOND G. @ 13 Oct 2017 1337 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Written by LANDE, RAYMOND G. @ 13 Oct 2017 1338 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 13 Oct 2017 1338

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

13 Oct 2017 at WRNMMC, ATS Adult BE by HARDIN, JAMES G

Encounter ID: BETH-29946680 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **HARDIN, JAMES G**

Reason for Appointment:

IOP

Appointment Comments:

jbf

S/O Note Written by FOBIZSHI,MACANGELO M @ 13 Oct 2017 1303 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. Patient reviewed the "check in" handout at the start of the session. Patient shared all coping skills, and commitments completed since the previous group meeting. Patient denies any alcohol or substance use and any unsafe behaviors since the last group. Today's group today focused on harshness versus compassion. The group reviewed the handout provided by the therapist. The group members reviewed the examples of harsh self-talk and compassionate self-talk in the handout and discussed the ones they related to. The therapist discussed how harshness relates to PTSD and substance abuse. The group collectively talked about how compassion promotes growth and harshness prevents growth. The patient discussed ways to increase compassion in sobriety. At the end of the group session, the group members filled out a commitment sheet to be reviewed at the next group session: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/Hi: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/Hi.P: SM will continue group next week.

S/O Note Written by FOBIZSHI,MACANGELO M @ 13 Oct 2017 1342 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Creative Art Therapy Group

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The group members discussed the "What secret we keep" and "Kintsugi" poems. The Instructor explained how creative writing could be used as a platform to express emotions and thoughts. The group member discussed the poems provided and what it meant to them. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/Hi: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/Hi.P: SM will continue group next week.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by HARDIN,JAMES G @ 17 Oct 2017 1021 EDT**History of present illness**

The Patient is a 32 year old male.

Process group: 0730-0845

Focus of Session: motivation, "nature vs nurture" re substance abuse

S) The group discussed their past experiences in treatment, mostly inpatient treatment, and what worked for them. We discussed "getting serious" about recovery as opposed to simply sitting in meetings, not paying attention. We talked about "identifying in" vs. "identifying out". Members talked about the moment when they realized they truly had an alcohol/drug problem. SM fully participated in the discussion.

O) Appearance: normal

Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: calm

Affect: consistent

Insight: fair

Judgment: fair

SI/HI: None Current

Med/Pain Issues: None

A) SM was invested in group today.

P) Next process group will be same time next week.

A/P Written by HARDIN,JAMES G @ 19 Oct 2017 0751 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by HARDIN,JAMES G @ 19 Oct 2017 0751 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic.**Signed By** HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse Program, WRAMC) @ 19 Oct 2017 0751

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

12 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29939825 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **12 Oct 2017 1500 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

f/u

Appointment Comments:

dei

Note Written by PAUL, SHERIN @ 13 Oct 2017 0851 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Anderson (previously Merwin)
Patient last 4: 0538
Appt #: Intake + 15
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: CBT****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Therapist and patient discussed recent events in his life. Patient continues to endorse significant frustration related to his interactions with his command. Therapist and patient processed his frustration and problem solved potential solutions. Patient stated that he was able to effectively end interaction with a female he was interested in after recognizing that they were not on the same page about what they wanted. Therapist provided positive reinforcement for this as this is different than his previous behavior. Patient also discussed initial interest in a new romantic partner. Patient is working to identify reasonable next steps for his future.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017*Reviewed with patient on:* 27 September 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.

A/P Written by PAUL, SHERIN @ 13 Oct 2017 0852 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 13 Oct 2017 0853 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 13 Oct 2017 0853

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

12 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29929434 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **12 Oct 2017 1204 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 12 Oct 2017 1309 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Oct 2017 1204 EDT
TMS**S/O Note** Written by POURZAND, MIRIAM @ 12 Oct 2017 1209 EDT**History of present illness**

The Patient is a 32 year old male.

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression 45 minute session.

Subjective

TMS Session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 19/ #9 at 120% MT.

Objective

SM next session scheduled.

S/O Note Written by BLOBERG,BRIAN @ 12 Oct 2017 1229 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #9 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #9 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Written by LANDE,RAYMOND G. @ 12 Oct 2017 1310 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Written by LANDE,RAYMOND G. @ 12 Oct 2017 1310 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 12 Oct 2017 1310

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

11 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A

Encounter ID: BETH-29912121 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 Oct 2017 1400 EDT**
 Clinic: **OCCUP THERAP TBI BE**

Appt Type: **PROC**
 Provider: **NAVARRO, CARA A**

AutoCites Refreshed by NAVARRO, CARA A @ 12 Oct 2017 1517 EDT

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

Major depressive disorder, recurrent, moderate

Appointment Comments:

can

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 12 Oct 2017 1517 EDT
Questionnaires

A/P Written by NAVARRO,CARA A @ 12 Oct 2017 1518 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x 2

Disposition Written by NAVARRO,CARA A @ 12 Oct 2017 1525 EDT

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by PALAD,NOLAN @ 11 Oct 2017 1247 EDT

Consult Order

Referring Provider: PAUL, SHERIN

Date of Request: 27 Sep 2017

Priority: Routine

Provisional Diagnosis:

Major depressive disorder, recurrent, moderate

Reason for Request:

Rec Therapy: Patient would benefit from additional coping skills and building positive monitored socialization skills.

Note Written by NAVARRO,CARA A @ 12 Oct 2017 1524 EDT

Recreational Therapy

Recreational Therapy Program

Name: Anderson, Daniel P02

Date: 11 Oct 2017

Time: 97537 x 30 MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

SM arrives on time, groomed well and tired, stating he has not been sleeping well.

SM completed homework and reported goals he has to improve interpersonal relationships, decrease isolation and tolerate the community without being overwhelmed. Due to SM schedule he will not participate in Recreational Therapy programs till November.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Pending Appointments: 02 Nov 2017

PLAN:

1. Patient will attend follow up session on 02 Nov to set POC

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 12 Oct 2017 1525

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

11 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29910949 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **11 Oct 2017 1158 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE,RAYMOND G.****AutoCites** Refreshed by LANDE,RAYMOND G. @ 11 Oct 2017 1448 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment:Written by CHELLAPPA,MARY R @ 11 Oct 2017 1158 EDT
TMS**S/O Note** Written by POURZAND,MIRIAM @ 11 Oct 2017 1226 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #8 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #7 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 11 Oct 2017 1416 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:05-12:50).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 18/ #8 at 120% MT.

Objective

SM next session scheduled.

A/P Last Updated by BAHROO,BHAGWAN A @ 11 Oct 2017 1418 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; POURZAND,MIRIAM

Disposition Last updated by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 11 Oct 2017 1449

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 11 Oct 2017 1449 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 11 Oct 2017 1418 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

11 Oct 2017 at WRNMMC, Pain Mgmt Clinic Bethesda by SPEVAK, CHRISTOHER J

Encounter ID: BETH-29908707 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 Oct 2017 1044 EDT**
 Clinic: **PAIN MGMT CL BE**

Appt Type: **FTR**
 Provider: **SPEVAK, CHRISTOPHER J**

AutoCites Refreshed by SPEVAK, CHRISTOHER J @ 11 Oct 2017 1044 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit
[use for free text] (Paternal Aunt)
- not maternal uncle's history of referred
here (Maternal Uncle)
- family history of supplemental HPI [use
for free text] (General FHx)
- no family history of malignant melanoma
of the skin (General FHx)
- family history of father is alive (General
FHx)
- family history of heart disease (General
FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General
FHx)
- no family history of malignant neoplasm of
large intestine (General FHx)
- no family history of malignant neoplasm of
the gastrointestinal tract (General FHx)
- paternal grandfather's history of
preliminary background HPI [use for
free text] (Paternal Grandfather)
- paternal grandmother's history of
preliminary background HPI [use for
free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use
for free text] (Paternal Grandmother)
- paternal history of preliminary background
HPI [use for free text] (Father)
- family history of test conclusions [Use for
free text] (General FHx)
- family history of diabetes mellitus
(General FHx)
- family history of mental illness (not
retardation) (General FHx)
- family history of the options include
referral (General FHx)
- family history of patient counseling
(General FHx)
- fraternal history of SUBJECTIVE [Use for
s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease
(General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

A/P Written by SPEVAK,CHRISTOHER J @ 11 Oct 2017 1045 EDT

1. Alcohol dependence, uncomplicated: S: The SM participated in a weekly group discussion about medical perspectives on substance use disorders. Topics of this group range from the history of substance use, psychoeducation on substance use disorders, recent medical advances in understanding substance use disorders and treatments. Participants were also encouraged to discuss their own personal perspectives on the topics discussed.

O: SM arrived on time for group and was dressed appropriately for the setting. The SM was oriented x3

Appearance: neat and clean Behavior: Appropriate, engaged in group

Speech: WNL Thoughts: WNL

Mood: Good Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI/AVH: None Reported Med/Pain Issues: None Reported

A: SM actively participated in group. Participants were respectful of each other's perspectives and exhibited understanding of the topic as evidenced by group discussions. Participants were encouraged to ask questions and were answered accordingly.

P: Next medical group to will continue to build upon the topics already discussed and explore new approaches to treatment. Participants will follow up with their primary psychiatric/medical providers with any specific concerns about their personalized treatment plans.

Disposition Written by SPEVAK,CHRISTOHER J @ 11 Oct 2017 1045 EDT**Released w/o Limitations**

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By SPEVAK, CHRISTOHER J (Physician) @ 11 Oct 2017 1045

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

11 Oct 2017 at WRNMMC, ATS Adult BE by DELEON, PATRICK D.

Encounter ID: BETH-29910492 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **DELEON,PATRICK D.**

Reason for Appointment:

IOP

Appointment Comments:

jbf

S/O Note Written by BURTON,CARA N @ 11 Oct 2017 1217 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Educational Group: Finding Meaning (1000-1100): Spirituality and Personality
 S: The focus of today's session was the connection between personality and spirituality. Group members were encouraged to assess their personalities during active substance use and at the current point of their recovery. They also reflected on how their personalities have changed since being sober. This SM shared openly about the ways in which substance use allowed him a release from his cares or ongoing frustrations. He engaged actively throughout the session and commented on what others shared appropriately.

O: SM arrived on time for group, was oriented x4 and engaged actively during the group exercises and discussion.

Appearance: Neat, clean, dressed appropriately to season

Behavior: Appropriate, engaged

Speech: WNL

Thoughts: Logical, WNL

Mood: Stable

Affect: Congruent, full range

Insight: Fair

Judgment: Fair

SI/HI: None reported

Med/Pain Issues: None reported

A: SM interacted with group members and facilitators. He demonstrated an understanding of the concepts presented.

P: SM will attend the next group as scheduled.

Note Written by RAGLAND,MARY @ 16 Oct 2017 0952 EDT**Process Group 0730-0845**

S: Topics discussed: Introductions (Name, relationship to the military, substance of choice, sobriety date, and what brought Ct to ATS), Review of Group Rules/Expectations. Demonstrated understanding of Group Rules and assisted in explaining to new group members. Ct again spoke of his father's emotional abandonment of him and it's impact on his emotions--did not connect this to his substance use..

O: Ct arrived over 30 minutes late for group. Ct alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

Note Written by RAGLAND,MARY @ 16 Oct 2017 1156 EDT

Mind-Body Group, Session #3: Breath Work 1100-1150

S: Psychoeducation re: purposes of using breath work (slowing thought process, slowing physiological processes, increase focus and concentration relaxation, linking body and mind), types of breath work (Counting, Mantras, Body focus, Guided/Imagery, Breathing while moving intentionally). Practiced several different types of breath work chosen by participants.

O: SM arrived on time for group. Alert/oriented x 3.

Appearance: Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/HI: None

Med/Pain Issues: None

A: SM participated appropriately in discussion and activity.

P: SM will attend next group as scheduled.

A/P Written by DELEON,PATRICK D. @ 17 Oct 2017 0921 EDT

1. Alcohol dependence, uncomplicated F10.20

Procedure(s):

-(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON,PATRICK D. @ 17 Oct 2017 0921 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive Outpatient Program, next groups 13 Oct

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 17 Oct 2017 0922

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

10 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A

Encounter ID: BETH-29890663 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **10 Oct 2017 1059 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **BAHROO, BHAGWAN A**AutoCites Refreshed by BAHROO, BHAGWAN A @ 10 Oct 2017 1231 EDT**Allergies**

•No Known Allergies

Reason for Appointment:Written by CHELLAPPA, MARY R @ 10 Oct 2017 1059 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 10 Oct 2017 1130 EDTHistory of present illness

The Patient is a 32 year old male.

Visit for: Transcranial magnetic Stimulation for Depression (1100-1135).

Subjective

TMS session: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes.

Adjustments were made to accommodate comfort.

This session number #7 at 120% MT.

Objective

Next session was scheduled.

S/O Note Written by BLOBERG, BRIAN @ 10 Oct 2017 1133 EDTHistory of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre Procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #7 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS: This is session #7 for depression with MT level at therapeutic treatment level for entire session.

Post procedure: SM monitored briefly. SM had no reports of distress associated with TMS.

PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Written by BAHROO, BHAGWAN A @ 10 Oct 2017 1232 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): POURZAND,MIRIAM; BLOBERG,BRIAN

Disposition Written by BAHROO,BHAGWAN A @ 10 Oct 2017 1232 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BAHROO, BHAGWAN A (MD, Staff Psychiatrist, WRAMC) @ 10 Oct 2017 1232

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Oct 2017 at WRNMMC, Psych Day Hosp Be by BAHROO, BHAGWAN A

Encounter ID: BETH-29871173 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **06 Oct 2017 0854 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **BAHROO, BHAGWAN A**AutoCites Refreshed by BAHROO, BHAGWAN A @ 06 Oct 2017 1201 EDT**Allergies**

•No Known Allergies

Reason for Appointment: Written by BLOBERG, BRIAN @ 06 Oct 2017 0854 EDT
TMSS/O Note Written by POURZAND, MIRIAM @ 06 Oct 2017 0946 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (0900-0935).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 20.09 minutes.

Adjustments were made to accommodate comfort.

This session number #6 at 120% MT.

Objective

Next session was scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 06 Oct 2017 0955 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.

Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #6; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 6 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Tuesday. ZUNG depression=51, PHQ 9=15.

A/P Written by BAHROO, BHAGWAN A @ 06 Oct 2017 1202 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

PROVIDER(S): POURZAND,MIRIAM; BRAGGS,DEBORAH C

Disposition Written by BAHROO,BHAGWAN A @ 06 Oct 2017 1203 EDT

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BAHROO, BHAGWAN A (MD, Staff Psychiatrist, WRAMC) @ 06 Oct 2017 1203

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

06 Oct 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B

Encounter ID: BETH-29877815 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **LESKO, STACEY BETH**

AutoCites Refreshed by LESKO, STACEY B @ 06 Oct 2017 1330 EDT**Allergies**

•No Known Allergies

Reason for Appointment:

process grou

Appointment Comments:

ctc

S/O Note Written by LESKO, STACEY BETH @ 06 Oct 2017 1330 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: S: The group discussed several topics today to include the how childhood family dynamics has impacted their addiction and recovery. Group members talked about trying new community support meetings and what they liked/didn't like about them. Lastly, members shared what they were doing over the 3-day weekend to stay safe and support their sobriety.

O: SM arrived on time for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Good

Judgment: Good

SI/Hi: None Current

Med/Pain Issues: None expressed

A: SM participated appropriately in group today, both giving and receiving feedback.

P: SM will continue with process groups as planned.

A/P Written by LESKO, STACEY B @ 06 Oct 2017 1332 EDT**1. Alcohol dependence, uncomplicated F10.20**

Procedure(s): -(90853) Psychiatric Therapy Group Interactive x 1

Disposition Written by LESKO, STACEY B @ 06 Oct 2017 1333 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic.Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 06 Oct 2017 1333

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE

Encounter ID: BETH-29863837 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **05 Oct 2017 1349 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **ABRAHAM, FENOTE**

AutoCites Refreshed by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Reason for Appointment: Written by ABRAHAM, FENOTE @ 05 Oct 2017 1349 EDT

Medical Record Release

Appointment Comments: Written by ABRAHAM, FENOTE @ 05 Oct 2017 1349 EDT

per medical records office AKA Merwin, Daniel D

Questionnaire AutoCites Refreshed by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT**Questionnaires****Note** Written by ABRAHAM, FENOTE @ 05 Oct 2017 1407 EDT

Medical record screened IAW the signed authorization of patient submitted through Medical Correspondence office. Patient not present.

Psychiatry records are sensitive, and screening was done diagnostically to determine whether it is appropriate to release this sensitive information to the patient as requested. In certain circumstances it can be unsafe for patient to read sensitive psychiatry notes. Record was carefully screened. Patient noted to have been diagnosed with MDD recurrent Moderate and GAD

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

No concerns arose during this screening about patient safety or the safety of others should patient read these records. Patient psychiatry records for ABHC clinic WR-Bethesda written by Paul, Tobar, Wise, Zembrzuska, Melton and Nilsen are authorized to be released as requested.

A/P Written by ABRAHAM, FENOTE @ 05 Oct 2017 1408 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by ABRAHAM, FENOTE @ 05 Oct 2017 1411 EDT

Released w/o Limitations

Signed By ABRAHAM, FENOTE (Psychiatrist, WNMMC) @ 05 Oct 2017 1411

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Oct 2017 at WRNMMC, Occup Therap TBI Be by NAVARRO, CARA A

Encounter ID: BETH-29868902 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **05 Oct 2017 1300 EDT**
Clinic: **OCCUP THERAP TBI BE**Appt Type: **SPEC**
Provider: **NAVARRO, CARA A****AutoCites** Refreshed by NAVARRO, CARA A @ 06 Oct 2017 0732 EDT**Family History**

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

Generalized anxiety disorder

Appointment Comments:

can

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT
Questionnaires

A/P Last Updated by NAVARRO,CARA A @ 06 Oct 2017 0753 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x 6

Disposition Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT

Consult Order

Referring Provider: POURZAND, MIRIAM

Date of Request: 13 Sep 2017

Priority: Routine

Provisional Diagnosis:

Generalized anxiety disorder

Reason for Request:

SM suffers from significant anxiety with avodiance would benefit from recreation therapy program please evaluate. sm cell [REDACTED]

Note Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT

Recreational Therapy

SUBJECT

Recreational Therapy Program

Name: Anderson, Daniel P02

Last 4: [REDACTED]

Date: 05 Oct 2017

Time: 97537 x 90MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

OBJECTIVE

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Patient was seen today for education, planning and training in prep for participation in Recreational Therapy programs.

ACTION

Patient was educated on application, agenda, safety, and program expectations for participation in upcoming Recreational Therapy programs. SM's homework is to write goals for Recreational therapy and what programs he can use to best practice the skills he is developing/learning. Patient was receptive to education and motivated with TX. Patient is in agreement with plan.

Assessment: Alert and oriented x 4. Presents to be in a pleasant mood although displayed signs of anxiety as evidenced by excessive talking and having scattered thoughts. SM was not able to identify personal goals for post military and has homework to complete prior to next session. SM relates challenges back to his childhood and contradicts self with what does and does not matter to him. SM was educated on what the scope of practice is for Recreational Therapy and how writer is not able to change or help SM with certain areas of his life. During conversation SM requires redirection to answer questions. Learning style- Combined Patient tolerated session well.

Barriers to learning: none

Community Reintegration: **Isolates self in his home, refuses to go to a gym because "it's dirty"**

Leisure Barriers: **social avoidance due to indifference towards others, IBS challenges**

Pending Appointments: 11 Oct 2017

Leisure interests include: cooking, video games, movies, TV shows

Learning Style: combined

Precautions: pain

Interventions Recommended:

<input checked="" type="checkbox"/> Aquatic	<input checked="" type="checkbox"/> Relaxation	<input type="checkbox"/> Physical conditioning	<input type="checkbox"/>
Horticulture			
<input type="checkbox"/> Arts & Craft	<input type="checkbox"/> Adaptive Sports	<input type="checkbox"/> 1:1 session	
<input checked="" type="checkbox"/> Social Activities			
<input checked="" type="checkbox"/> Outdoor Activities	<input checked="" type="checkbox"/> Leisure counseling	<input type="checkbox"/> Cognitive	
Activities	<input type="checkbox"/> Paddling		
<input checked="" type="checkbox"/> Yoga	<input type="checkbox"/> Archery	<input checked="" type="checkbox"/> Community	
Reintegration			
<input type="checkbox"/> Hunting/Fishing	<input type="checkbox"/> Cooking Group	<input type="checkbox"/> Therapeutic Riding	

Adaptive Equipment Utilized and/or recommended:

<input type="checkbox"/> Scissors (loop)	<input type="checkbox"/> Pencil Grip	<input type="checkbox"/> Knives/spoons/fork
<input type="checkbox"/> Cookware		
<input type="checkbox"/> Magnifying glass	<input type="checkbox"/> Talking books	<input type="checkbox"/> Ski/snowboard
<input type="checkbox"/> Bicycle		
<input type="checkbox"/> Prosthetics	<input type="checkbox"/> W/C, Rollator	<input type="checkbox"/> Assistive Tech
<input type="checkbox"/> Vehicle		
<input type="checkbox"/> Lift Systems(s)	<input type="checkbox"/> IDEO Brace	

Leisure & Community Reintegration Barriers:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 13 Nov 2017

<input type="checkbox"/> Cognitive Skills	<input checked="" type="checkbox"/> Social Skills	<input type="checkbox"/> Communication
<input type="checkbox"/> Paralysis		
<input type="checkbox"/> Financial	<input type="checkbox"/> General Weakness	<input type="checkbox"/> ROM limitations
<input type="checkbox"/> Mobility		
<input type="checkbox"/> Perceptual Prob	<input type="checkbox"/> Grasp / Release	<input checked="" type="checkbox"/> Fears / Phobias
<input type="checkbox"/> Hearing Deficits		
<input type="checkbox"/> Visual Acuity	<input checked="" type="checkbox"/> Motivation	<input type="checkbox"/> Spasticity
<input checked="" type="checkbox"/> Pain		
<input checked="" type="checkbox"/> Attitude	<input checked="" type="checkbox"/> Self-confidence	<input type="checkbox"/> Transportation

PLAN:

1. Patient will attend follow up session on 11 Oct with completed homework and set POC

Discharge Recommendations:

☐ Utilization of Community Resources
☐ Adaptive equipment requested
☐ Continue program at home
☒ Encouragement of social / leisure participation

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 06 Oct 2017 0815

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29861230 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **05 Oct 2017 1158 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 05 Oct 2017 1314 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Oct 2017 1158 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 05 Oct 2017 1242 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #5 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 5 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 05 Oct 2017 1301 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:05-12:50).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 15/ #5 at 120% MT.

Objective

Next session was scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 05 Oct 2017 1303 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Disposition Last updated by LANDE,RAYMOND G. @ 05 Oct 2017 1314 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 05 Oct 2017 1315

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 05 Oct 2017 1314 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 05 Oct 2017 1314 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 05 Oct 2017 1304 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N

Encounter ID: BETH-29852335 Primary Dx: Sleep disorder, unspecified

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **04 Oct 2017 2000 EDT**
Clinic: **SLEEP (PULM) CL BE**Appt Type: **PROC**
Provider: **KHRAMTSOV, ANDREI N.****Reason for Appointment:**

split w 3% per Dr. K

A/P Last Updated by IRVINE, RAYMOND W @ 05 Oct 2017 0423 EDT**1. Sleep disorder, unspecified**

Procedure(s): -Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older x 1 (TC-TECHNICAL COMPONENT) ADDITIONAL PROVIDER(S): PETRI, ROEL - This note pertains to polysomnography data collection only. The physician interpretation is appended to a separate procedure note. If there are no additional procedure notes visible within the electronic medical record, please call 301-295-4547 and ask to speak with one of the physician staff.

Disposition Last Updated by IRVINE, RAYMOND W @ 05 Oct 2017 0423 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: Please don't drive if sleepy.Note Written by IRVINE, RAYMOND W @ 05 Oct 2017 0419 EDT**Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 27 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

R/o obstructive sleep apnea

Reason for Request:

32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 05 Oct 2017 0826

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29846543 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **04 Oct 2017 1235 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 05 Oct 2017 0703 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by POURZAND, MIRIAM @ 04 Oct 2017 1235 EDT
TMS

S/O Note Written by POURZAND, MIRIAM @ 04 Oct 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

TMS session: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #4 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20:10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 4 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

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S/O Note Written by BAHROO, BHAGWAN A @ 04 Oct 2017 1334 EDT

Reason for Visit

Visit for: Transcranial magnetic Stimulation for Depression (12:01-12:45).

Subjective

Attending Note: A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Adjustments were made to accommodate comfort.
This session number 14/ #4 at 120% MT.

Objective

Next session was scheduled

A/P Last Updated by BAHROO,BHAGWAN A @ 04 Oct 2017 1341 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; POURZAND,MIRIAM

Disposition Last updated by LANDE,RAYMOND G. @ 05 Oct 2017 0704 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 05 Oct 2017 0704

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 05 Oct 2017 0704 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 05 Oct 2017 0704 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 04 Oct 2017 1341 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29846244 Primary Dx:

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 1217 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 04 Oct 2017 1341 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

			EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active		TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active		DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active			NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active			NR	05 Oct 2015

Reason for Appointment: Written by GARDINER, DELACIE E @ 04 Oct 2017 1217 EDT
LST

Appointment Cancelled by Facility

Encounter Cancelled by POURZAND, MIRIAM @ 04 Oct 2017 1341 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29847918 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 1100 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

F/U

Appointment Comments:

CTC

S/O Note Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1324 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: CBT/Work Stress

S) SM reported that he has been feeling bad the last two days due to some stress with his direct supervisor. SM stated that he feels angry but was able to identify feeling disrespected as the main reason for his anger. SM and this writer used CBT techniques to work through the beliefs and emotional consequences of the conflict at work. SM explored how he can use cognitive reframing and expectation adjustment to reduce the stress around this conflict. SM stated that he had forgotten to do his gratitude list for the last couple days until his family reminded him to do it and stated he was happy for the accountability. SM reported group went well and he attended one SMART recovery meeting last week which he enjoyed. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to be thinking critically about his recovery and is open to feedback. SM seems to be open minded to using concrete techniques to address his depression and anxiety and is reflective and thoughtful in session. Alcohol Use D/O, Severe

P) SM will follow up with social worker in two weeks. SM will begin continue with ATS groups as scheduled.

A/P Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1325 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 04 Oct 2017 1325 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 04 Oct 2017 1326

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29868491 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 06 Oct 2017 0704 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Anderson (previously Merwin)
 Patient last 4: 0538
 Appt #: Intake + 14
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used:** CBT**Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Therapist and patient discussed recent events in his life. He identified positive changes he was attempting to make. Therapist worked with patient to identify small concrete steps toward these changes. Therapist reminded patient not to shift from extremes. For example, patient, typically rigid, expressed a desire to sell his house and have no attachments to anything. Therapist worked with patient on reasonable changes. Further conversation focused on patient's interactional style with people.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Major Depressive Disorder, Single Episode, Moderate
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support, occupational/legal stressors
 Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017

Reviewed with patient on: 27 September 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.

2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.

A/P Written by PAUL, SHERIN @ 06 Oct 2017 0705 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 06 Oct 2017 0705 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Oct 2017 0706

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

04 Oct 2017 at WRNMMC, ATS Adult BE by RAGLAND, MARY

Encounter ID: BETH-29842898 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2017 0730 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **GRP**
 Provider: **RAGLAND, MARY**

Reason for Appointment:

process group

Appointment Comments:

ctc

Note Written by RAGLAND, MARY @ 04 Oct 2017 1007 EDT**Process Group 0730-0845**

S: Topics discussed: Introductions, stressors which impacted drinking and/or recovery. Ct shared openly about his prior treatment experiences for alcohol, his recent relapse episode which led to this ATS referral. Ct shared very openly about negative childhood experiences related to being the child of divorced parents. Ct described recent trouble for "sexual harrassment" presented in a way as warning the other group members not to "post photos of yourself on social media" or "ask a civilian to speak outside of work". Ct related to another peer about SMART Recovey and they determined they lived near each other. Ct suggested they carpool to meetings.

O: Ct arrived on time for group SM alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

A/P Written by RAGLAND, MARY @ 05 Oct 2017 0847 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by RAGLAND, MARY @ 05 Oct 2017 0847 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Signed By RAGLAND, MARY (Physician) @ 05 Oct 2017 0847

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

03 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29829383 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **03 Oct 2017 1147 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE,RAYMOND G.****AutoCites** Refreshed by LANDE,RAYMOND G. @ 03 Oct 2017 1403 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment:Written by CHELLAPPA,MARY R @ 03 Oct 2017 1147 EDT
TMS**S/O Note** Written by BAHROO,BHAGWAN A @ 03 Oct 2017 1221 EDT**Reason for Visit**

Visit for: TransCranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

This session number 13/ #3 at 120% MT.

Objective

Plan: SM next session scheduled.

S/O Note Written by BRAGGS,DEBORAH C @ 03 Oct 2017 1226 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #3 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20:10 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 3 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO,BHAGWAN A @ 03 Oct 2017 1223 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 03 Oct 2017 1403 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 03 Oct 2017 1403

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 03 Oct 2017 1403 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 03 Oct 2017 1403 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 03 Oct 2017 1223 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

03 Oct 2017 at WRNMMC, Psychiatry Be by ABRAHAM, FENOTE

Encounter ID: BETH-29826711 Primary Dx:

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **03 Oct 2017 1014 EDT**
Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
Provider: **ABRAHAM, FENOTE**

Reason for Appointment: Written by ABRAHAM, FENOTE @ 03 Oct 2017 1014 EDT
Medical Record Release

Appointment Cancelled by Facility

Encounter Cancelled by ABRAHAM, FENOTE @ 03 Oct 2017 1745 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

02 Oct 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29812077 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **02 Oct 2017 1146 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 02 Oct 2017 1146 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 02 Oct 2017 1248 EDT

Reason for Visit

Visit for: Transcranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 12/ #2 at 120% MT.

Objective

Plan: SM next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 02 Oct 2017 1250 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for depression session #2 at therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 20.09 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 2 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO, BHAGWAN A @ 02 Oct 2017 1252 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Disposition Last updated by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 02 Oct 2017 1414

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 02 Oct 2017 1413 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 02 Oct 2017 1252 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

02 Oct 2017 at WRNMMC, Sleep (Pulm) Cl Be by KHRAMTSOV, ANDREI N

Encounter ID: BETH-29807781 Primary Dx: Sleep disorder, unspecified

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **02 Oct 2017 1000 EDT**
 Clinic: **SLEEP (PULM) CL BE**

Appt Type: **SPEC**
 Provider: **KHRAMTSOV, ANDREI N.**

AutoCites Refreshed by KHRAMTSOV, ANDREI N @ 02 Oct 2017 1019 EDT**Problems**

Loading...

Family History

- family medical history (General FHx)
- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

Loading...

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Labs

26 Sep 2017 0736

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site Specimen
URINEResult
negative <i>Units
ng/mLRef Range
Cutoff=250

26 Sep 2017 0736

Drug Abuse Screen

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Opiates

Phencyclidine, UA

Cannabinoids

Methadone

Oxycodone

Site Specimen

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

Result

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

Units

ng/mL

Ref Range

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

22 Sep 2017 0745

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site Specimen
URINEResult
negative <i>Units
ng/mLRef Range
Cutoff=250

22 Sep 2017 0745

Drug Abuse Screen

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Opiates

Phencyclidine, UA

Cannabinoids

Methadone

Oxycodone

Site Specimen

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

Result

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

Units

ng/mL

Ref Range

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

19 Sep 2017 0720

ETG/ETS, UA (250 Cut-Off)

Site Specimen

Result

Units

Ref Range

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Ethyl Glucuronide	URINE	negative <i>	ng/mL	Cutoff=250
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19 Sep 2017 0720**Drug Abuse Screen**

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	negative <i>		(Negative)
Barbiturates	URINE	negative <i>		(Negative)
Benzodiazepines	URINE	negative <i>		(Negative)
Cocaine	URINE	negative <i>		(Negative)
Opiates	URINE	negative <i>		(Negative)
Phencyclidine, UA	URINE	negative <i>		(Negative)
Cannabinoids	URINE	negative <i>		(Negative)
Methadone	URINE	negative <i>		(Negative)
Oxycodone	URINE	negative <i>	ng/mL	(Negative)

12 Sep 2017 0819**ETG/ETS, UA (250 Cut-Off)**

Ethyl Glucuronide	URINE	negative <i>	ng/mL	Cutoff=250
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12 Sep 2017 0819**Drug Abuse Screen**

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	negative <i>		(Negative)
Barbiturates	URINE	negative <i>		(Negative)
Benzodiazepines	URINE	negative <i>		(Negative)
Cocaine	URINE	negative <i>		(Negative)
Opiates	URINE	negative <i>		(Negative)
Phencyclidine, UA	URINE	negative <i>		(Negative)
Cannabinoids	URINE	negative <i>		(Negative)
Methadone	URINE	negative <i>		(Negative)
Oxycodone	URINE	negative <i>	ng/mL	(Negative)

05 Sep 2017 0915**ETG/ETS, UA (250 Cut-Off)**

Ethyl Glucuronide	URINE	negative <i>	ng/mL	Cutoff=250
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05 Sep 2017 0915**Drug Abuse Screen**

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	negative <i>		(Negative)
Barbiturates	URINE	negative <i>		(Negative)
Benzodiazepines	URINE	negative <i>		(Negative)
Cocaine	URINE	negative <i>		(Negative)
Opiates	URINE	negative <i>		(Negative)
Phencyclidine, UA	URINE	negative <i>		(Negative)
Cannabinoids	URINE	negative <i>		(Negative)
Methadone	URINE	negative <i>		(Negative)
Oxycodone	URINE	negative <i>	ng/mL	(Negative)

Vitals**Vitals** Written by VELMA,SHEDRICK D @ 02 Oct 2017 0940 EDTBP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO₂: 95%, BMI: 23.63, BSA: 1.879 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats**Vitals** Written by MARCIULIONIS,MANTAS @ 29 Sep 2017 0958 EDTBP: 133/94, HR: 72, T: 97.5 °F, HT: 69 in, WT: 163 lbs, SpO₂: 96%, BMI: 24.07, BSA: 1.894 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Vitals Written by NDEGWAH,DOROTHY J @ 27 Sep 2017 1054 EDT

BP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters, Tobacco Use: No, Alcohol

Use: No,

Pain Scale: 0 Pain Free

Vitals Written by WESLEY,LATASHA @ 26 Sep 2017 0859 EDTBP: 135/94, HR: 79, RR: 18, T: 97.9 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,

BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10 Severe, Pain Scale Comments: headache- dull

Reason for Appointment:

R/o obstructive sleep apnea

Appointment Comments:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

dttp/irmac pt waived atc

Vitals**Vitals** Written by VELMA,SHEDRICK D @ 02 Oct 2017 0940 EDTBP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO₂: 95%, BMI: 23.63, BSA: 1.879 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats**S/O Note** Written by KHRAMTSOV,ANDREI N. @ 12 Oct 2017 1254 EDT**Chief complaint**

The Chief Complaint is:

Difficulty staying asleep.

History of present illness

The Patient is a 32 year old male.

He reported: Military service in the Navy and currently on active duty.

Patient reports gasping , witnessed apnea, difficulty staying asleep , non refreshing sleep, hypersomnia, feeling tired, See paper note .

Past medical/surgical history**Diagnoses:**

No coronary artery disease

No congestive heart failure.

No hypertension

No pulmonary hypertension.

No diabetes mellitus.

Cerebral artery thrombosis - without cerebral infarction.

Depression Anxiety, Patient denies suicidal or homicidal ideation

Personal history

Behavioral: No caffeine use mild excessive and not a current smoker.

Alcohol: Alcohol use H/o EOH abuse.

Review of systems**Encounter Background Information:** Medication list reviewed.**Otolaryngeal:** No nasal passage blockage (stiffness), no snoring, and snoring not exacerbated by nasal congestion.**Gastrointestinal:** Heartburn.**Genitourinary:** Nocturia.**Endocrine:** Decreased libido.**Musculoskeletal:** The legs do not feel restless.**Psychological:** Total Epworth Sleepiness score for likelihood of falling asleep during the day 19/24 Driving problems secondary

EDS.- yes and middle-night awakening with a choking sensation.

See paper note.

Physical findings**Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Awake. ° Alert. ° In no acute distress.

Neck:

Appearance: • Neck circumference 38 cm.

Obstructions:

Obstructions: • Airway was partially obstructed Mallampati class 2.

Lungs:

° Clear to auscultation is without wheezes, rales or ronchi.

Cardiovascular:

Heart Rate And Rhythm: ° Normal are normal, no murmurs, gallops or rubs appreciated.

Edema: ° Pretibial pitting edema not bilateral.

Neurological:

• Not oriented to time, place, and person. ° System: normal is grossly normal. Normal gait.

Objective

Assessment/Plan: The patient presents with some symptoms suggestive of Obstructive Sleep Apnea. y. Polysomnography/split has been ordered. Discussed with patient OSA, Insufficient Sleep Syndrome (ISS) and nasal congestion. The patient was counseled to maintain an ideal body weight to reduce the severity of the disease and related complications. The risks of alcohol and other sedatives were discussed. The patient was educated on positional therapy. The patient was counseled to avoid driving while excessively sleepy.(was stressed to patient with hypersomnia) !!!

A/P Written by KHRAMTSOV,ANDREI N @ 02 Oct 2017 1033 EDT**1. Sleep disorder, unspecified**

Medication(s): -ESZOPICLONE--PO 3MG TAB - TAKE ONE TABLET BY MOUTH EVERY NIGHT AS NEEDED FOR

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

SLEEP #1 RF0

Disposition Written by KHRAMTSOV,ANDREI N @ 12 Oct 2017 1302 EDT**Released w/o Limitations****Follow up:** as needed in the SLEEP (PULM) CL BE clinic. - Comments: meds. recon/immun.add

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Given the multidisciplinary variables that have been considered in the evaluation and management of this patient's sleep complaints the medical decision making is of moderate to high complexity. The diagnostic procedures and therapeutic interventions are of high technical complexity thereby the overall data complexity for this patient's evaluation is moderate to high. At least 30 minutes were spent face to face with this patient (10 minutes reviewing questionnaire and history, 5 minutes reviewing medical record, 10 minutes educating and counseling on good sleep practices and strategies and 5 minutes coordinating care). PATIENT COUNSELED NOT TO OPERATE MOTOR VEHICLES IF FEELING TIRED.

Note Written by WILLIAMS,FELICIA P @ 02 Oct 2017 0928 EDT**Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 27 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

R/o obstructive sleep apnea

Reason for Request:

32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.

Note Written by TERRY,SETH M @ 12 Oct 2017 1100 EDT**Questionnaire**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017



WALTER REED NATIONAL MILITARY MEDICAL CENTER
SLEEP DISORDERS CENTER
Building 9, 2nd Floor, Arrowhead Zone
8901 Wisconsin Ave, Bethesda, MD 20889
PHONE: 301-295-4547 FAX: 301-319-8187



See DD FORM 2005 for Privacy Act Statement

General Information

Patient Name: DANIEL ANDERSON SSN: [REDACTED]
Age: 32 Gender: M Height: 6'9" Weight: 160 lbs.
Status: ☒ Active Duty ☐ Retired ☐ Dependant ☐ National Guard/Reserve
Branch of Service: ☐ Army ☐ Air Force ☒ Navy ☐ Marine Corps ☐ Other: _____

Chief Complaint

Please briefly describe the reason for your Sleep Medicine evaluation

NOT SLEEPING / REM.
INITIAL SLEEP STUDY WAS 11 AWAKE 2 REM.
ALWAYS TIRED

Medical History

1. Do you have any of the following medical conditions? (select all that apply)

- ☐ High Blood pressure ☐ Diabetes ☐ Depression ☐ Fibromyalgia
☐ Heart failure ☐ Stroke ☐ Hypothyroidism ☐ High cholesterol
☐ GERD (heartburn/reflux) ☐ COPD ☐ Asthma ☐ Erectile Dysfunction
☐ Chronic Sinus Disease ☐ Peripheral vascular disease ☐ Heart Disease/heart attack

2. Please list any additional current or past medical problems

MAJOR DEPRESSION / ANXIETY / DISORDERS
CHRONIC IBS-D (IRRITABLE BOWEL SYNDROME) PARENT

3. Please list any medications you take on a regular basis:

Name	Dose (if known)	Reason for Taking
<u>EFFEXOR</u>	<u>150 MG</u>	<u>DEPRESSION</u>
<u>NALTREXON</u>	<u>COMB</u>	<u>ALCOHOL - SON TO BED</u>

4. Have you ever smoked cigarettes? ☒ No ☐ Yes

• At what age did you start: _____ Number of Packs/day: _____ Number of years: _____

5. As a child, did you have any of the following? (select all that apply)

- ☐ Chronic sinus congestion/nasal allergies ☐ Tonsillectomy/Adenoidectomy
☐ Parents that smoked cigarettes ☐ Overweight

CHRONIC ASTHMA

6. Do you have any family members with a sleep disorder (i.e. obstructive sleep apnea, narcolepsy)

DO NOT KNOW

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

7. Do you experience the following (select all that apply)

- ☐ Heartburn/Reflux Disease ☒ Headaches ☐ Sinus congestion/nasal allergies
☐ Shortness of breath ☐ Erectile dysfunction ☒ Decreased libido (sex drive)
☒ Irritability or moodiness ☒ Urinating more than once per night

8. Have you had surgery on your upper airway? (tonsillectomy, septoplasty, UPPP, sinuses, etc)

Type of Operation

Year

Tonsillectomy

2002

Septoplasty

2017

Sleep-Related Symptoms

Symptom Yes No

Difficulty falling asleep ☐ ☒Difficulty staying asleep ☒ ☐Wake up frequently at night ☐ ☐Snoring ☐ ☒Non-refreshing sleep ☐ ☒Daytime sleepiness ☒ ☐Stop breathing at night ☐ ☒Urinating frequently at night ☒ ☐Waking up short of breath ☐ ☒Waking up choking/gasping ☒ ☐Heartburn at night ☐ ☒Nasal congestion disrupts sleep ☐ ☒Sweaty at night ☐ ☒Dry mouth in the morning ☐ ☒Restless sleep ☒ ☐

Symptom Yes No

Uncontrollable urge to sleep ☒ ☐Muscle weakness w/ emotional experience ☐ ☒Sleep paralysis (can't move on awakening) ☒ ☐Sleep attacks (fall asleep unexpectedly) ☐ ☒Dreaming/hallucinations at sleep onset ☒ ☐Legs feel restless ☐ ☒Unpleasant sensation in legs ☐ ☒Sensation is worse at night ☐ ☒Sensation worse with inactivity ☐ ☒Sensation improves with movement ☐ ☒Sleep walking ☐ ☒Sleep talking ☐ ☒Unusual movements during sleep ☐ ☒Dream enacting behavior ☐ ☒

Sleep Hygiene

1. What is your typical sleep period?

Weekdays - Average Bedtime: 10 PM Average Wake Time: 6 AM Average Duration: 8

Weekends - Average Bedtime: 10 PM Average Wake Time: 7 AM Average Duration: 9

2. How long does it usually take you to fall asleep? 5-15 minutes

3. Do you take naps during the day? ☐ Yes ☒ No

If yes: How many days/week? ___ How long? ___ minutes

4. Do you routinely exercise each day? ☒ Yes ☐ No

If yes, at what time: 3 PM

5. Do you do any of the following?

• Drink caffeine (coffee, tea, soda) within 2-3 hours of bedtime?

☐ Yes ☒ No

• Drink alcohol within 2-3 hours of bedtime?

☐ Yes ☒ No

• Watch TV or read in bed?

☐ Yes ☒ No

• Take prescription or over the counter stimulants?

☐ Yes ☒ No

• Do you try to go to bed and wake up at the same time every day?

☒ Yes ☐ No

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

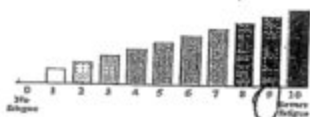
DoD ID: 1286180538

Created: 13 Nov 2017

Epworth Sleepiness Scale:*How likely are you to fall asleep in the following situations.*

0 = never 1 = slight chance 2 = moderate chance 3 = high chance

Situation	Chance of Dozing
Sitting and reading	2
Watching TV	2
Sitting, inactive in a public place (e.g. theater or a meeting)	2
As a passenger in a car for an hour without a break	3
Lying down to rest in the afternoon when circumstances permit	3
Sitting and talking to someone	1
Sitting quietly after a lunch without alcohol	3
In a car, while stopped for a few minutes in the traffic	2

TOTAL: 19**Fatigue***Please circle the number below that describes your fatigue over the past 2 weeks.***FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)**

1. Do you have difficulty concentrating because you are sleepy or tired?
2. Do you have difficulty remembering things because you are sleepy or tired?
3. Do you have difficulty driving short distances (<100 miles) because you're tired?
4. Do you have difficulty driving long distances (>100 miles) because you're tired?
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?

(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 12 Oct 2017 1302

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

29 Sep 2017 at WRNMMC, GI Clinic Bethesda by BRIDGES, EDWARD E

Encounter ID: BETH-29797254 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Sep 2017 1149 EDT**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **BRIDGES, EDWARD E**

Call Back Phone: [REDACTED]

A/P Written by BRIDGES, EDWARD E @ 29 Sep 2017 1153 EDT

1. Irritable bowel syndrome with diarrhea: 32M with history of IBS-D, now with more formed stools since starting Effexor 3 months ago but persistent abdominal cramping.

-Will retreat peppermint oil 200mg daily for his abdominal cramping, with concurrent 4 week trial of protonix 40 mg daily to offset heartburn risk. We may increase peppermint oil to twice daily if clinically effective and tolerated. The patient will also continue to avoid heartburn triggers, including fatty meals, ETOH, coffee, spicy foods, and late night meals.

-Regarding other spasmodics: (1) He has previously failed hyocyanine, (2) He is a poor candidate for dicyclomine given its CNS effects, which may exacerbate his underlying psychiatric condition and pharmacotherapy

-Continue Effexor or transition to cymbalta per psychiatry

-Continue low fodmap diet, including no beer, no wine, no rum, no broccoli, no lettuce, no onions, no garlic, no beans, no spinach, no cabbage, no asparagus, no fruits, no sausage, no chorizo, no eggs, no polyols, and no dairy

-Additional recommendations to follow final anorectal manometry testing today.

Disposition Written by BRIDGES, EDWARD E @ 29 Sep 2017 1153 EDTSigned By **BRIDGES, EDWARD E** (Physician) @ 29 Sep 2017 1154

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

29 Sep 2017 at WRNMMC, GI Proc CL BE by DAMIANO, MARK N

Encounter ID: BETH-29794499 Primary Dx: Fecal urgency

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Sep 2017 1000 EDT**
 Clinic: **GI PROC CL BE**

Appt Type: **PROC**
 Provider: **DAMIANO, MARK N**

Reason for Appointment:

ANORECTAL MANOMETRY/BALLOON EXPULSION STUDY

Appointment Comments:

CGBM

Vitals**Vitals** Written by MARCIULIONIS, MANTAS @ 29 Sep 2017 0958 EDT

BP: 133/94, HR: 72, T: 97.5 °F, HT: 69 in, WT: 163 lbs, SpO₂: 96%, BMI: 24.07, BSA: 1.894 square meters,
 Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

A/P Last Updated by BRIDGES, EDWARD E @ 29 Sep 2017 1158 EDT**1. Fecal urgency**

Procedure(s):

-Rectal Balloon Distension Test x 1
 ADDITIONAL PROVIDER(S): BRIDGES, EDWARD E;
 BELLE, LAVERN S

-Manometry Rectal x 1
 ADDITIONAL PROVIDER(S): BRIDGES, EDWARD E; BELLE, LAVERN S

2. Fecal smearing**Disposition** Last Updated by BRIDGES, EDWARD E @ 29 Sep 2017 1158 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** DAMIANO, MARK N (Gastroenterology Staff, Walter Reed NMMC Bethesda) @ 29 Sep 2017 1211**Note** Written by BRIDGES, EDWARD E @ 26 Oct 2017 1232 EDT

(Added after encounter was signed.)

Walter Reed National Military Medical Center

Gastroenterology

Rectal Manometry Report

Patient Name: Daniel Dennis Anderson **SSN:** [REDACTED] **Date:** 9/29/2017**Age:** 32 **Sex:** Male **Race:** Caucasian **Phone #:** 4105625345 **Referring****Provider:** Bridges, Edward

Reason for study: The patient is a 32 y/o active duty male, with a history of substance abuse, anxiety, and depression, referred for rectal manometry in evaluation of fecal urgency and rare fecal smearing. He also reports a history of IBS-D dating to childhood, with daily abdominal cramping that peaks prior to defecation and is relieved after bowel movements. Historically, he has experienced 1 large volume liquid brown stool (BSS#7) per day, however, his stools have become more formed (BSS#4) over the past 3 months since starting Effexor and continuing a low FODMAP diet. Unfortunately, there has been no concurrent resolution of his abdominal cramps, which continue to be triggered by physical activity, anxiety, and stress. Peppermint oil was previously trialed for his cramps but discontinued shortly after starting due to heartburn, which resolved with peppermint oil cessation. He reports 5 to 15 minute urgency before

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

defecating on every occasion and 2 episodes of trace fecal smearing in the setting diarrhea within the last year. He denies post stool leakage. His psychiatrist is currently considering transition to Cymbalta from Effexor.

CT A&P 2012 (evaluation of abdominal pain): Focal wall-thickening at the hepatic flexure with proximal stool retention.

Colonoscopy (McNally) in 2012: Mild congestion in the sigmoid but no masses or polyps; biopsies were unremarkable.

MRE 2012: Normal.

1. Physical Exam:

- a. **Appearance:** No internal/external hemorrhoids. Normal surrounding skin. No anal fissure.
- b. **Neurological exam:** Normal sensation to sharp/dull with cutaneous sphincter reflex not elicited.
- c. **DRE resting internal sphincter tone:** Normal
- d. **DRE pubo-rectalis sling:** Normal descent **with paradoxical squeeze of external sphincter.**
- e. **DRE external sphincter squeeze press:** Normal

2. Manometry findings:

- a. **Sensory threshold to rectal distention:** 15 ml (*NL* \leq 20ml)
- b. **Internal/External Resting Pressure (IAS):** 81 mmHg (*NL*= 59-74 mmHg)
- c. **External Sphincter Contractile Pressure (EAS):** 318 mmHg (*NL* > 100 mmHg)
- d. **Internal Sphincter relaxation with rectal distention:** Normal
- e. **Graduated relaxation:**

Bolus (ml)	Relaxation (mmHg)
15	10
20	18
30	34
40	33
50	54

3. Findings:

- Normal external sphincter squeeze pressure and normal descent of pubo-rectalis on DRE.
- Normal internal sphincter relaxation with balloon distension.
- Manometric evidence of elevated internal anal sphincter resting and normal external sphincter contractile pressure.
- Normal sensory threshold.
- Normal balloon expulsion test (able to expel 60mL water filled balloon within 60 seconds).

4. Impression:

- The patient's normal anorectal manometry is not consistent with a defacatory disorder.

5. Recommendations :

- Treat for IBS-D.
- Follow up with referring provider, Dr Bridges.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

RVU code – 91120, 91122
Damiano

Reporting Dr. Bridges /Dr.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

29 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29792215 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Sep 2017 0800 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE, DESPINA C @ 29 Sep 2017 1133 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Treatment Planning

S) SM reported that he has been busy with appointments and will be finishing up with the VA this week. SM stated he had a sleep study on Monday and acknowledged he will be starting IOP process groups on Wednesday and then full IOP on 11 October. SM stated that he went to an AA meeting but walked out and spent time in his car trying to figure out why he had such a problem with AA. SM expressed that he felt the people in AA were of lower intelligence and didn't have much motivation to work on their problems behaviorally, though they verbalized a desire to change. SM stated he then went to a SMART recovery meeting and felt much more engaged there. SM stated he appreciates the CBT focus. SM was encouraged to keep an open mind about AA and he acknowledged there were many things about AA philosophy that he agreed with but that the meetings just didn't resonate with him. SM stated that he would need to be vigilant regarding the tendency to rationalize a return to drinking when he is "feeling better". SM stated that he feels he is working on the spiritual bankruptcy of addiction by connecting with his family and trying to connect more with friends. SM and this writer reviewed treatment planning goals. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed casually. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM was insightful in developing his treatment plan. SM appears to be thinking critically about his recovery and is open to feedback.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin ATS groups on 4 October.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 29 Sep 2017 0842 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 29 Sep 2017 0843 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 29 Sep 2017 1133

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

28 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29784961 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **28 Sep 2017 1304 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **LANDE, RAYMOND G.****AutoCites** Refreshed by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	27 Sep 2017
Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic	Ordered	INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2	2 of 2	27 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by SANTIAGO, HANNAH L @ 28 Sep 2017 1304 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 28 Sep 2017 1333 EDT

Reason for Visit

Visit for: TransCranial Magnetic Stimulation for depression (12:05-12:50).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 11/ #1 at 120% MT.

Objective

Plan: SM next session scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 28 Sep 2017 1335 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; SANTIAGO, HANNAH L

Disposition Last updated by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 28 Sep 2017 1419

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 28 Sep 2017 1419 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 28 Sep 2017 1336 EDT.

Released w/o Limitations

Follow up: as needed in 4 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

27 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29768079 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **27 Sep 2017 1144 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 27 Sep 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 27 Sep 2017 1144 EDT
 TMS

S/O Note Written by BRAGGS, DEBORAH C @ 27 Sep 2017 1216 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 80% up to 120%. TMS Treatment for depression session #1 at non therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total of stimulation time of 21.21 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 1 with MT level at non- therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 27 Sep 2017 1241 EDT

Reason for Visit

Visit for: Initial session for TransCranial Magnetic Stimulation for depression (11:50-12:30)

Motor threshold was determined on 12 September 2017 and SM has so far received a total of 9 sessions for Anxiety.

Subjective

A procedural time out was done during which settings and patient was re-identified.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS mildly anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was not anxious at start of procedure. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

After finding level and location the first treatment was administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 26 second intervals for a total stimulation time of 37.5 minutes.

Adjustments were made to accommodate comfort.

This session number 10/initial session started at 80% and ended with 120% MT.

Objective

Plan: SM next session scheduled.

A/P Last Updated by BAHROO,BHAGWAN A @ 27 Sep 2017 1253 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 27 Sep 2017 1355

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 27 Sep 2017 1354 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 27 Sep 2017 1253 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

27 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29765423 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **27 Sep 2017 1100 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T****AutoCites** Refreshed by TOBAR,EDEN @ 27 Sep 2017 1120 EDT**Allergies**

•No Known Allergies

Vitals**Vitals** Written by NDEGWAH,DOROTHY J @ 27 Sep 2017 1054 EDTBP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No,
Pain Scale: 0 Pain Free**Appointment Comments:**

ett/phq9/gad7

Vitals**Vitals** Written by NDEGWAH,DOROTHY J @ 27 Sep 2017 1054 EDTBP: 137/93, HR: 82, RR: 16, T: 97.9 °F, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters,
Tobacco Use: No, Alcohol Use: No,
Pain Scale: 0 Pain Free**Note** Written by TOBAR,EDEN @ 27 Sep 2017 1543 EDT**Followup Note**Patient: Daniel Anderson (previously Merwin) Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #13

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. We last met three weeks ago, at which time we increased his Effexor xr to 225 mg po qam. Today pt states he doesn't think it has been helpful. He completed IOP last Thursday. He is going through the MEB process, getting his VA appts done. He is starting TMS with IOP today. He has a sleep study coming up. He was prescribed ramelteon during IOP which he didn't think was helpful. He has tried taking melatonin 10 mg OTC which is more helpful. He officially had his name changed and is working with his therapist on trying to figure out what he wants from here. He states he forgot to ask her about being referred to a sexual trauma group as he discusses a male cousin tried to force himself on pt when pt was age five but pt says he was able to get away. He describes another incident when he was older and at a sleepover at a friend's and the friend tried to force himself sexually on pt so pt fled. We discussed he should bring this up with his individual therapist before considering pursuing group therapy. He continues to take naltrexone but admits he did drink half a beer once. He is still in ATS and told them. He continues to have IBS symptoms and states GI suggested discussing switching his SNRI to Cymbalta with me. He denies suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

06SEP17 phq9= 19 (#9=1); gad7= 19

27SEP17 phq9= 18 (#9=0); gad7= 17

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement

Anderson, Daniel Dennis

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1985

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1985

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DoD ID: 1286180538

Created: 13 Nov 2017

[] Good coping/problem solving skills [x] Hopefulness present
 [] Faith/religion commitment [] Positive future orientation

Allergies:nkda**Medications:**

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING 3 Ordered 06 Sep 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 0 Refill
 VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY DAY 0 Active 06 Sep 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 2 Active
 Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. 0 Active 09 Aug 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS 2 Active 18 May 2017@0001

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his

Anderson, Daniel Dennis

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1985

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Created: 13 Nov 2017

'uncle's son" when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in casual clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:fair

Speech:talkative

Mood:stable

Affect:full

Thought Process: circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Test	Site/Specimen	Date	Time	Units	Ref Rng
Gamma Glutamyl Transferase	SERUM 49	04 Jan 2017	1232	U/L	(10.0-71.0)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Hepatic Function Panel	SERUM	04 Jan 2017	1232		
Albumin	4.9 g/dL				(3.5-5.2)
Alkaline Phosphatase	58 U/L				(40-129)
Alanine Aminotransferase	34 U/L				(0-41)
Aspartate Aminotransferase	24 U/L				(0-40)
Bilirubin	0.3 mg/dL				(0.15-1.2)
Bilirubin Direct	<0.2 mg/dL				(0.0-0.3)
Protein	7.6 g/dL				(6.6-8.7)

Test	Site/Specimen	Date	Time	Units	Ref Rng
Basic Metabolic Panel	SERUM	22 Jun 2016	1240		
Urea Nitrogen	14.8 mg/dL				(6-20)
Carbon Dioxide	28 mmol/L				(22-29)
Chloride	98 mmol/L				(98-107)
Creatinine	1.00 mg/dL				(0.7-1.2)

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1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: since pt is not finding Effexor helpful, agreed to cross taper of Effexor to Cymbalta as

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DoD ID: 1286180538

Created: 13 Nov 2017

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

follows:

Week 1: Decrease Effexor XR from 225 mg to 150 mg every day.

Week 2: Decrease Effexor XR from 150 mg to 75 mg every day.

Week 3: Stop taking Effexor XR 75 mg. In its place, start Cymbalta 60 mg daily.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will abstain from drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Normal b12 panel drawn after July 2017 visit.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of medication plan with patient who stated understanding and agreement with plan.

Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 27 Sep 2017 1544 EDT**1. Generalized anxiety disorder**

Medication(s):

-DULoxetine--po 60MG CPDR - TAKE ONE CAPSULE BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR, EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR, EDEN @ 27 Sep 2017 1544 EDT**Released w/o Limitations****Follow up:** 1 month(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 75MG CPSR 24H - TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT**Additional A/P Information:**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Discontinued RAMELTEON--PO 8MG TAB -

Note Written by TOBAR, EDEN @ 27 Sep 2017 1130 EDT

Additional A/P Information:

Discontinued PSEUDOEPHEDRINE--PO 30MG/5ML SOLN -

Signed By TOBAR, EDEN (Physician/Workstation) @ 27 Sep 2017 1544

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

27 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29771713 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Sep 2017 1000 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

IOP Discharge

Appointment Comments:

bsd

Note Written by PAUL, SHERIN @ 27 Sep 2017 1404 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Anderson (previously Merwin)
 Patient last 4: 0538
 Appt #: Intake + 13
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Anderson, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. Patient was last seen 14 August 2017. Patient recently completed IOP. He stated that he learned a lot of new tools from IOP and had things he knew refreshed. Patient is hopeful about the future and the potential options he has about paths. Patient relayed his ideas to the therapist. Therapist encouraged patient to work on breaking down larger goals into small concrete goals. This includes personal well-being and mental health. Patient will be referred to OT and Rec Therapy to work on coping and increasing life functioning. Therapist and patient discussed next steps in MEB. He is almost complete with VA appointments. Therapist and patient discussed patient's schedule and appointment load.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

Anderson, Daniel Dennis

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Created: 13 Nov 2017

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Created: 13 Nov 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes

Medical Record

Anderson, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 27 September 2017

Reviewed with patient on: 27 September 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Anderson, Daniel Dennis

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1985

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Patient going through MEB.A/P Last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT**1. Generalized anxiety disorder**

Consult(s):

-Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL
Clinic: OCCUP THERAP BE Provisional Diagnosis: Major depressive disorder, recurrent, moderate**2. Major depressive disorder, recurrent, moderate**

Procedure(s):

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT**Released w/o Limitations****Follow up:** 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Administrative Options:** Consultation requested

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 27 Sep 2017 1420

CHANGE HISTORY**The following Disposition Note Was Overwritten by PAUL, SHERIN @ 27 Sep 2017 1420 EDT:**

The Disposition section was last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT - see above. Previous Version of Disposition section was entered/updated by PAUL, SHERIN @ 27 Sep 2017 1405 EDT.

Released w/o Limitations**Follow up:** 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following A/P Note Was Overwritten by PAUL, SHERIN @ 27 Sep 2017 1420 EDT:

The A/P section was last updated by PAUL, SHERIN @ 27 Sep 2017 1420 EDT - see above. Previous Version of A/P section was entered/updated by PAUL, SHERIN @ 27 Sep 2017 1405 EDT.

1. Generalized anxiety disorder**2. Major depressive disorder, recurrent, moderate**

Procedure(s):

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PAUL, SHERIN @ 27 Sep 2017 1417 EDT:**Signed PAUL, SHERIN (Clinical Psychologist) @ 27 Sep 2017 1405**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

26 Sep 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29747424 Primary Dx: Encounter for other administrative examinations

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **26 Sep 2017 1000 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **GRP**
Provider: **DELSESTO, BARBARA SUE****AutoCites** Refreshed by DELSESTO, BARBARA S @ 26 Sep 2017 1127 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

IOP Discharge

Appointment Comments:

bsd

S/O Note Written by DELSESTO, BARBARA SUE @ 26 Sep 2017 1127 EDT**Reason for Visit**

Visit for: Case Management. Patient came in to meet with CM about his plan ahead after discharge from IOP. He will see Dr. Paul 27 Sep at 1000 and Dr Tobar at 1100. He interested in an occupational therapy consult for more group activity and support dogs information. We discussed his duty assignment and a possible PCS LIMDU. CM to contact Command about a possible reassignment and a fresh start after the IOP.

History of present illness

The Patient is a 32 year old male.

He reported: Military service Profile Type: LIMDU permanent

MEB status: Patient has been assigned to a PEBLO and has started his VA appointments.

Not thinking about suicide. Patient reports no S.I/H.I or any safety issues. CM information provided to him for any further questions or issues.

CM to work on a plan of care to include his Commander's input for a new duty assignment. SM seems hopeful about his future plans to include going back to school and voc rehab upon transition from the NAVY.

A/P Written by DELSESTO, BARBARA S @ 26 Sep 2017 1135 EDT**1. Encounter for other administrative examinations****Disposition** Written by DELSESTO, BARBARA S @ 26 Sep 2017 1136 EDT**Released w/o Limitations**

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DELSESTO, BARBARA S (Nurse Case Manager, Walter Reed National Military Medical Center) @ 26 Sep 2017 1136

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

26 Sep 2017 at WRNMMC, Int Med CL F Medical Home BE by ROBINSON, TYRONE L

Encounter ID: BETH-29745556 Primary Dx: Ingrowing nail

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **26 Sep 2017 0845 EDT**
 Clinic: **INT MED CL F MEDICAL HOME
 BE**

Appt Type: **FTR**
 Provider: **ROBINSON, TYRONE
 LEHMON**

Reason for Appointment:

f/u eye surgery/wrist pain

Appointment Comments:

jsn

Vitals**Vitals** Written by WESLEY, LATASHA @ 26 Sep 2017 0859 EDT

BP: 135/94, HR: 79, RR: 18, T: 97.9 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,
 BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10 Severe, Pain Scale Comments:
 headache- dull

S/O Note Written by ROBINSON, TYRONE LEHMON @ 27 Sep 2017 1535 EDT**Chief complaint**

The Chief Complaint is: PRT waiver- Sore Rt wrist, Dry eyes.

History of present illness

The Patient is a 32 year old male.
 32 year old male pt, here today for PTR waiver-sore Rt wrist, and continous dry eyes- corrective surgery 2011. Doing well today.
 See depression screen.

Right wrist pain: occurs multiple times a week, lasts for several minutes while typing on computer, no specific prior injury or trauma.
 No numbness or tingling, no weakness. No morning pains.

IBS-D: currently on limdu, unable to participate in physical activity due to IBS symptoms, LIMDU/med board initiated Jul2017.

Dry eyes, also reports vision worsening.

Ingrown toenail: recurrent infections approx 3-4 times past year. Currently no signs of infection.

Good general overall feeling /health.

Pain assessment 9/26/17

Location: Headache

Duration: intermittent

Quality: moderate

Factors that correlate with onset: unknown

Frequency: intermittent

Average level:

Worst level: 10/10

Least level:

What makes it better: unknown

What makes it worse:

Pain Severity 7/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Probiotic one packet po daily
 Simethicone 80 mg po qid prn

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 Naltrexone 50 mg po daily
 Venlafaxine XR 150 mg po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history
 IBS-D
 Generalized anxiety disorder
 Major depressive disorder
 ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 Photorefractive keratectomy
 Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.
 ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Nails:

• Nails: 1st toe nail with erythema lateral edge, mild swelling, no pus or drainage.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Written by ROBINSON, TYRONE L @ 27 Sep 2017 1542 EDT**1. Ingrowing nail:** Recurrent left 1st toe ingrowing and paronychia, currently no indication for abx or drainage, will refer to podiatry for permanent removalConsult(s): -Referred To: PODIATRY NCR (Routine) Specialty: PODIATRY Clinic: RM PODIATRY IR Provisional
Diagnosis: Ingrowing nail**2. Dry eye syndrome of bilateral lacrimal glands**

Medication(s): -CARBOXYMETHYLCELLULOSE--OPT 0.5% SOLN - INSTILL 1 DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #1 RF2 Ordered By: ROBINSON, TYRONE L Ordering Provider: ROBINSON, TYRONE LEHMON

3. Pain in right wrist: No paresthesias or tenderness, no signs of nerve impingement or ganglion, advised using hand pad while using computer and moving hands frequently.**Disposition** Written by ROBINSON, TYRONE L @ 27 Sep 2017 1543 EDT**Released w/ Work/Duty Limitations:** Profile: Ingrowing nail L60.0 from 27 Sep 2017 to 27 Sep 2017; Comment: updated PRT waiver for IBS-D issue and toenail**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By ROBINSON, TYRONE L (Physician) @ 27 Sep 2017 1544**CHANGE HISTORY***The following S/O Note Was Overwritten by ROBINSON, TYRONE L @ 26 Sep 2017 0925 EDT:**S/O Note Written by WESLEY, LATASHA @ 26 Sep 2017 0848 EDT***Chief complaint**

The Chief Complaint is: PRT waiver- Sore Rt wrist, Dry eyes.

History of present illness

The Patient is a 32 year old male.

32 year old male pt, here today for PTR waiver-sore Rt wrist, and continous dry eyes- corrective surgery 2011. Doing well today. See depression screen.

<<Note accomplished in TSWF-CORE>>

Good general overall feeling /health.

Pain Severity 7/ 10.

Pain assessment 9/26/17

Location: Headache

Duration: intermittent

Quality: moderate

Factors that correlate with onset: unknown

Frequency: intermittent

Average level:

Worst level: 10/10

Least level:

What makes it better: unknown

What makes it worse:

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 9/26/17 - NKDA

Current medication

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

.....

Annual Questions Date: 9/26/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

25 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29733883 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **25 Sep 2017 1105 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT
Discharge Summary

S/O Note Written by POURZAND, MIRIAM @ 25 Sep 2017 1105 EDT

History of present illness

The Patient is a 32 year old male.

S/O Note Written by DONKIN, LAURA G @ 22 Sep 2017 1122 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Social Work Discharge Summary

Admission Date: 29 August, 2017

Discharge Date: 22 September, 2017

While at Psychiatry Continuity Services (PCS), in the Intensive Outpatient Program (IOP) and the Comprehensive Recovery Program (CRP), patient PO2, has been involved in psycho-educational groups and individual therapy. He was compliant with his medication management. He also has been receiving TMS treatments for anxiety, and may continue with TMS to treat his depression post discharge.

PO2 will return to duty at Ft Meade, but will attend medical/mental health appointments most days. SM is to start the IOP at Addictions Treatment Service (ATS) on Monday. This program is 3 days per week. SM will also return to the care of Dr. Paul and Dr. Tobar, both at WRNMMC Outpatient Behavioral Health. PO2 has made progress in his treatment and reports a reduction in anxiety. In his future mental health treatment, he would like to move forward from processing his childhood trauma and accept who he is. PO2 has also focused on learning about his personality traits and how to form meaningful relationships. No SI/HI plan or intent present.

S/O Note Written by POURZAND, MIRIAM @ 25 Sep 2017 1320 EDT

Chief complaint

The Chief Complaint is: Met with SM for 30 minutes for discharge meeting.

History of present illness

The Patient is a 32 year old male.

He reported: Feeling tired (fatigue).

Sleep disturbances.

<<Note accomplished in the TSWF BH Spec AIM form>>

HISTORY OF PRESENT ILLNESS: adapted from intake note from 8/29/17: Pt is a 32 y/o single Caucasian male ADN E5 with

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

almost 12 years TIS, HDS: Ft. Meade, MOS: Network Intelligence, referred to PCS by outpatient provider at WRNMMC d/t continued symptoms of anxiety and depression. SM reports he has not worked in one month, has lost access to the building, and was demoted from E6 to E5 in 7/2017 d/t social media sexual harassment sent to a female co-worker. SM reports having anxiety symptoms as far back as childhood d/t his father. In 2008, SM started picking his scalp (neurotic excoriation) while deployed aboard a ship d/t stress and anxiety. SM also developed MRSA. SM reports in 2010 he had a bad 2 year relationship breakup with a woman whom was an alcoholic and taking medication. SM states in 2012 he started seeing behavioral health d/t having suicidal ideation, being discontent with life, and the bad breakup. SM endorses guilt, decreased appetite and fear of gaining weight and losing 10 lbs. in the last month (stating he does not want to look like his father as well as end up with diabetes as he has), states feels as though he has sleep paralysis and at times sleeps too much but other times difficulty falling and staying asleep, +anxiety and worrying, reports being hypersexual stating he could have intercourse daily as well as ejaculate three times a day, +anger/irritability, +isolation, states does not like sun exposure, fantasizes about life-space things, watches television a lot which in turn creates increased anxiety (example: watches Game of Thrones and Walking dead but does not look at it as just a TV show, fantasizes that it is real). SM states he works on computer gaming and enjoys cooking. Reports he was in debt for \$35,000 but sold one of his homes and now debt has decreased to \$19,000. States his debt was from buying his brother a car and giving his family money.

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Personal history**PAST MEDICAL HISTORY**

IBS; PRK; tonsillectomy; childhood asthma; neurotic excoriation (scalp picking);

...

PSYCHIATRIC HISTORY

Suicide attempt as a child by taking bottle of aspirin d/t conflict with father, vomited but no treatment; age 17 suicide attempt via consuming large quantity of alcohol, no treatment; 6/16/2014 Integrated Health WRNMMC x 2 visits d/t anxiety; 8/2014-10/2014 WRNMMC outpatient BH d/t anxiety; 4/2015-11/2015 WRNMMC outpatient BH d/t depression/anxiety, also attended CBTI group; 8/2016 Integrative Health WRNMMC d/t mood swings/anxiety x 1 visit; 9/2016 started seeing outpatient BH WRNMMC d/t mood swings/anxiety. MEDICATIONS HAVE BEEN RECONCILED to include current medications, OTC, and supplements. Previously trialed meds: Zoloft (increased fatigue), melatonin, lexapro (felt flat), Unisom, Wellbutrin XL (increased anxiety), and Lunesta (ineffective). SM currently taking: Effexor 225 mg daily and Naltrexone 50 mg daily, Rozerem 8 mg qhs.

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SOCIAL / DEVELOPMENTAL / SPIRITUAL HISTORY

Pt is 32 year old single Caucasian male with almost 12 yrs TIS, Navy E-5 (recently demoted from E-6), MOS cyber security. Pt reports that he was born in California to very young, unmarried parents, who later married and then divorced. Pt reports that he has 2 sisters, who are ages 30 and 29. He also has a half brother, and half sister who he does not have contact with. Pt reports that father had custody for most of childhood, and mother had to pay support. Both parents were physically abusive. Father was on welfare and frequently negligent of his parental duties. Pt states that father's excessive discipline was to make them fearful. Pt reports 2 incidents of sexual trauma from unwanted contact. Once by older cousin and another time in middle school with friend grabbing him. Pt was moved numerous times during childhood. Pt said that there were times when he was living in a ghetto due to father living off welfare and spending all their money. Pt appears to currently have emotional support from mother and sisters. He has a very contentious relationship with father, thus recently changing his name. Pt said that he barely passed high school, and had a 2.2 GPA. He attributes this to his struggle with IBS, excessive running schedule and not doing homework. He joined the Navy immediately following high school. He has difficulty with relationships and is not currently in one. He denies religious affiliation.

...

Family history**FAMILY PSYCHIATRIC, SUBSTANCE USE AND MEDICAL HISTORY**

Mother is diagnosed with Bipolar disorder. Younger sister also diagnosed with Bipolar disorder. Youngest sister diagnosed with depression. Both sisters have had multiple suicide attempts. Maternal grandmother also Bipolar.

...

Review of systems

Head: No headache.

Gastrointestinal: No constipation.

Musculoskeletal: No localized joint pain, no localized joint swelling, and no limb pain.

Neurological: No dizziness, no motor disturbances, and no gait abnormality. No sensory disturbances.

Psychological: No social isolation.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal . Full range. stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Plan**TREATMENT GOALS AND OBJECTIVES**

Patients goals

1. Figure out how to cope with prior life events- partially met
2. Move on from things- partially met

Treatment objectives

1. Improve psychological functioning-partially met
2. Decrease number of episodes of trichotillomania- partially met reports for 2 days
3. Reduction in symptoms as evidence by self reported measures BHDP by 20% post completion of program -unmet

DISCHARGE TREATMENT PLAN AND STRATEGY

Medication: Effexor 225 mg daily, naltrexone 50 mg daily, Rozerem 8mg qhs

Psychotherapy: continue in out pt

Referrals: watch pad sleep study-completed, Alpha-Stim-completed, TMS treatment for anxiety completed reports not effective, TMS for depression treatment to start , SM completed extensive psychological testing

Estimated Frequency and Duration of Treatment: sm requires continued BHC

Other:

- [x] Treatment Options and Education: Diagnosis and treatment options - including risks, benefits, side effects, and choice to decline treatment, were discussed with the patient who expressed an understanding of the diagnosis and plan.
- [x] Treatment plan was collaboratively discussed with the patient.

[x] Yes [] No...Patient agrees with plan? If not, what part?

DATE: 9/22/17

Notes**RISK LEVEL**

I assessed warning signs, risk factors, and protective factors. After considering these factors in the context of this patient's clinical presentation, I consider this patient to be a:

- [] High Acute Risk for Suicide
- [] Intermediate Acute Risk Suicide
- [] Low Acute Risk for Suicide
- [X] No Elevated Acute Risk Suicide

[X] Patient is not considered to be a risk of harm toward others.

A/P Written by POURZAND, MIRIAM @ 25 Sep 2017 1320 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms. Sm completed program , discharged today.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1
 -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND, MIRIAM @ 25 Sep 2017 1322 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 25 Sep 2017 1322

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

22 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29717413 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **22 Sep 2017 1020 EDT**
Clinic: **ATS ADULT BE**Appt Type: **ACUT**
Provider: **HANGEMANOLE, DESPINA C****Reason for Appointment:** Written by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1020 EDT
recent slip**S/O Note** Written by HANGEMANOLE, DESPINA C @ 02 Oct 2017 0913 EDT**History of present illness**

The Patient is a 32 year old male.

SM reported to clinic and requested to speak to this writer. SM stated that he had half a beer the other night due to being emotional. SM reported that he is still committed to sobriety. SM acknowledged that a higher level of care would need to be explored if it was determined that SM could not maintain abstinence in an outpatient setting. SM stated he did not feel he needed Level III care at this time. SM agreed to start IOP process groups on 4 October and full IOP on 11 October.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1030 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 22 Sep 2017 1030 EDT**Released w/o Limitations****Follow up:** as needed in the ATS ADULT BE clinic. - Comments: SM will continue with group.
30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By** HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 02 Oct 2017 0942

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

22 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29714923 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Sep 2017 0902 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 22 Sep 2017 0902 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 22 Sep 2017 1257 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #9 and #7 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 9 and # 7 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided today will be SM last appointment for anxiety and SM will begin treatment for depression on return to clinic Wednesday September 27. Next session scheduled for Wednesday. ZUNG anxiety=50, GAD 7=15.

S/O Note Written by BAHROO, BHAGWAN A @ 22 Sep 2017 1332 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 9 was the # 7 session at 120% MT.

Objective

Next session scheduled.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 22 Sep 2017 1334 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT

Released w/o Limitations

Follow up: as needed in 5 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 22 Sep 2017 1401

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 22 Sep 2017 1400 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 22 Sep 2017 1334 EDT.

Released w/o Limitations

Follow up: as needed in 5 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

22 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29714760 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Sep 2017 0857 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 1009 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 22 Sep 2017 0857 EDT
IOP

S/O Note Written by EARLEY, KERRIE GLYN @ 22 Sep 2017 1004 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Mindfulness (0800-0850) Facilitated by Kerrie Earley, LCSW

Purpose: Educate in the practice of Mindfulness, including the rationale for incorporating this as a practice into daily life as a means of improving effectiveness in using other skills and managing difficult situations. Living with awareness in the present moment (neither ruminating on in the past, nor worrying about the future), focusing on one thing at a time in a non-judgmental way and doing what works are some of the core concepts of Mindfulness practice that will be repeated and encouraged throughout the course of treatment.

Today patients discussed what mindfulness is and what it is not- emphasizing the role of practice, its use in understanding emotions and improving memory, how it can be used in different situations, etc. Group members discussed emotion/rational/wise minds to consider how to navigate awareness of thoughts without pushing away emotions. Group then practiced mindfulness activities and discussed their ability to participate in the activities as well as implications for improving daily life.

This patient arrived late in the session, but actively tried each exercise and engaged in discussion about how effective it was in the moment. He was thoughtful about how the skills play out in certain areas of his life.

There was no indication of S/I or H/I present. Next mindfulness group scheduled for 29 September.

S/O Note Written by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Guest Speaker Group 0900-0950: Facilitator: Chaplain Edwards, Dr. Gragnani, and Ms. Buford, RN

PURPOSE: The purpose of this group is to have guest speakers bring various topics that would be relevant to group members and their treatment/recover. Group topics range from finance experts, VA experts, Chaplin, and Med Board experts.

TOPIC: Today, Chaplain Clifton Edwards from the Pastoral Care Department discussed what is Spirituality, what it should be, what is your spirituality/what makes you come alive, then had an open forum discussion. Group members discussed what they consider to be their connection to the spiritual world or what motivates them.

PARTICIPATION: SM attended group, was attentive to facilitator, and participated in group discussion. No evidence of SI/HI. Next group 29Sept2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 22 Sep 2017 1052 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0840 Check in to PCS Team A. Late due to ATS appt this a.m. Denied SI/HI. SM will be discharged from PCS today.

S/O Note Written by SMITH,JESSICA ANN @ 22 Sep 2017 1112 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1518 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check out note: SM was discharged from program today; did not check out with this writer.

A/P Last updated by POURZAND,MIRIAM @ 25 Sep 2017 1103 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms. Sm completed program , discharged today.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): DONKIN,LAURA G

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Disposition Written by POURZAND,MIRIAM @ 25 Sep 2017 1104 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 25 Sep 2017 1105**CHANGE HISTORY****The following S/O Note Was Deleted by POURZAND,MIRIAM @ 25 Sep 2017 1102 EDT:****History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Social Work Discharge Summary

Admission Date: 29 August, 2017

Discharge Date: 22 September, 2017

While at Psychiatry Continuity Services (PCS), in the Intensive Outpatient Program (IOP) and the Comprehensive Recovery Program (CRP), patient PO2, has been involved in psycho-educational groups and individual therapy. He was compliant with his medication management. He also has been receiving TMS treatments for anxiety, and may continue with TMS to treat his depression post discharge.

PO2 will return to duty at Ft Meade, but will attend medical/mental health appointments most days. SM is to start the IOP at Addictions Treatment Service (ATS) on

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Monday. This program is 3 days per week. SM will also return to the care of Dr. Paul and Dr. Tobar, both at WRNMMC Outpatient Behavioral Health. PO2 has made progress in his treatment and reports a reduction in anxiety. In his future mental health treatment, he would like to move forward from processing his childhood trauma and accept who he is. PO2 has also focused on learning about his personality traits and how to form meaningful relationships. No SI/HI plan or intent present.

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 25 Sep 2017 1102 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 25 Sep 2017 1102 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 22 Sep 2017 1124 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): DONKIN,LAURA G
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 22 Sep 2017 1124 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 22 Sep 2017 1124 EDT - see above. Previous Version of A/P section was entered/updated by SMITH,JESSICA ANN @ 22 Sep 2017 1113 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 22 Sep 2017 1113 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 22 Sep 2017 1113 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1053 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

2. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1053 EDT:

The A/P section was last updated by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1053 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 22 Sep 2017 1050 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 22 Sep 2017 1050 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 22 Sep 2017 1010 EDT.

1. Generalized anxiety disorder

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

21 Sep 2017 at WRNMMC, GI Clinic Bethesda by BELLE, LAVERN S

Encounter ID: BETH-29711562 Primary Dx: Other specified counseling

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **21 Sep 2017 1834 EDT**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **BELLE, LAVERN S**

Call Back Phone: [REDACTED]

AutoCites Refreshed by BELLE, LAVERN S @ 21 Sep 2017 1834 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY	3 of 3	06 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

			MOUTH EVERY MORNING #0 RF3		
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill		TAKE ONE TABLET BY	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active		MOUTH EVERY DAY #0 RF1 TAKE ONE CAPSULE BY	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active		MOUTH EVERY DAY #0 RF1 TAKE 2 BY MOUTH EVERY	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active		DAY #0 RF3 TAKE ONE PACKET BY	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active		MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH2	of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active		FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active		TAKE ONE SCOOP EVERY	3 of 3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active		DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
				NR	14 Oct 2016
				NR	05 Oct 2015

Reason for Telephone Consult: Written by BELLE, LAVERN S @ 21 Sep 2017 1834 EDT
Scheduled patient for an Anorectal Manometry Procedure.

S/O Note Written by BELLE, LAVERN S @ 21 Sep 2017 1835 EDT

Subjective

Scheduled patient for an Anorectal Manometry Procedure, to be conducted on 29 September 2017 at 1000 hrs. Patient was educated about pre-procedure details, which includes use of an enema prior to procedure, and what she should expect during the procedure. Patient will be given an enema in clinic 10-45 minutes before procedure. Patient verbalized understanding of all given instructions.

A/P Written by BELLE, LAVERN S @ 21 Sep 2017 1836 EDT

1. Other specified counseling

Procedure(s): -Non-Physician Phone Call To Pt/Provider Lengthy (21-30 min) x 1

Disposition Last Updated by BELLE, LAVERN S @ 21 Sep 2017 1836 EDT

Referred for Appointment

Signed By BELLE, LAVERN S (Physician/Workstation) @ 21 Sep 2017 1836

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29708145 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 1353 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0746 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 21 Sep 2017 1353 EDT
CRP

Appointment Comments: Written by CLOPPER, TAMMY J @ 21 Sep 2017 1353 EDT
TB

S/O Note Written by CLOPPER, TAMMY J @ 21 Sep 2017 1354 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 121200

Afternoon Track: CRP

Appointments Reported this afternoon: 1200 TMS

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 21 Sep 2017 1431 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1423

Afternoon Track: CRP

Appointments Reported for Friday: TMS 1200; Discharging

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1431 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Life Skills Group

1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "Getting Others to Support Your Recovery." After reviewing the hand-out, group members shared

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

who is helpful in their recovery and how to get others to help. This SM actively contributed to group discussion. No SI/HI plan or intent present. The next group will be on 28 September, 2017.

S/O Note Written by GHOLSON,GEORICA K @ 21 Sep 2017 1440 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMUNICATION SKILLS 1330-1430.

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician

Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.

Intervention: Discuss and identify passive, passive aggressive, aggressive, and assertive communication strategies. Discuss impact of each communication style on the listener and when each communication style is appropriate. Group discussed how emotions affect behaviors related to the various communication styles. SM participated in group. SM was able to identify characteristics of all three communication styles. Additionally, he identified his style as passive and discussed how feedback from others has impacted how he communicates with other people.

No indication of SI/HI.

Next group scheduled for October 5, 2017.

A/P Last updated by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 22 Sep 2017 0747 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0747

CHANGE HISTORY

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 21 Sep 2017 1441 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 21 Sep 2017 1432 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 21 Sep 2017 1432 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 21 Sep 2017 1432 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 21 Sep 2017 1355 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29699149 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 0754 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 21 Sep 2017 1409 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0
RF3Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
Oral

TAKE ONE SCOOP EVERY 3 of 3

10 May 2017

DAY MIXED IN LIQUID.
AFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mL

DRINK 10ML EVERY 6 3 of 3

28 Apr 2017

#0 RF3
HOURS FOR CONGESTION
#0 RF3
DRINK 20ML (400MG)
EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL
#0 RF1FLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE

NR

14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

NR

05 Oct 2015

Reason for Appointment:Written by CHELLAPPA,MARY R @ 21 Sep 2017 0754 EDT
TMS**S/O Note** Written by BRAGGS,DEBORAH C @ 21 Sep 2017 1229 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #8 and #6 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 28.52 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 8 and # 6 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and after discussion with the team, it was decided that tomorrow will be service member last TMS appointment as SM has medical appointments next week which will keep him from coming in for treatments. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 21 Sep 2017 1407 EDT**Reason for Visit**

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 8 was the # 6 session at 120% MT.

Objective

Next session scheduled.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT**1. Generalized anxiety disorder**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Disposition Last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT**Released w/o Limitations****Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 21 Sep 2017 1410

CHANGE HISTORY***The following A/P Note Was Overwritten by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT:***

The A/P section was last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1410 EDT - see above. Previous Version of A/P section was entered/updated by BAHROO, BHAGWAN A @ 21 Sep 2017 1407 EDT.

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 21 Sep 2017 1409 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 21 Sep 2017 1409 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 21 Sep 2017 1407 EDT.

Released w/o Limitations**Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

21 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29699044 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **21 Sep 2017 0751 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 21 Sep 2017 1411 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 21 Sep 2017 0751 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1021 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1113 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-In at :0755

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 1114 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-Out at :1055

Immediate Future Plans:

- (x) Comprehensive Recovery Program (CRP) 1230-1430
- () Interpersonal Recovery Program (IRP) 1230-1430
- () Trauma Recovery Program (TRP) 1230-1430
- () Attend IOP Program tomorrow morning

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by MILLER,PENNY E @ 21 Sep 2017 1248 EDT**Reason for Visit**

Visit for: (0915-1050) - Intensive Outpatient Program-"Improv Workshop" (Staff: Penny Miller, recreation therapist, Helen Lowenstein, social worker and Lisa Banks-Williams, advanced practice nurse) -

Objective: To provide an opportunity for creativity, self-expression and socialization through verbal and non-verbal improv activities.

Activity: This workshop was facilitated by Amelia Baine, a special guest, comedian and Seema Reza, WRNMMC hospital recreational arts coordinator. Patients were introduced to the activity of improv, used during this session as the intervention for this session. This session patients learned strategies to and were encouraged to take an active role. Patients were provided with directives in order to participate in several activities. Participation in the provided activities facilitated team work, socialization and an opportunity for enjoyment. A safe supportive environment was provided offering patients a structured experience for exploration and a chance to step out of their comfort zones. This writer served as activity coordinator as well as an emotional support, facilitating the group end of activity processing component.

Participation: This patient willingly participated during the session. He disclosed that he is typically shy and serious, however today he did something out of his comfort zone. He reported that he enjoyed his improv experience and is motivated to participate in the future. Pt was supportive of others and interacted well with staff and peers. A total of 11 patients attended this group. The next creative writing session is scheduled for Thursday September 28, 2017.

This note was written by Penny Miller, recreation therapist.

A/P Last updated by DONKIN,LAURA G @ 21 Sep 2017 1115 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by LANDE,RAYMOND G. @ 21 Sep 2017 1412 EDT**Released w/o Limitations****Follow up:** in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 21 Sep 2017 1412**CHANGE HISTORY***The following A/P Note Was Overwritten by DONKIN,LAURA G @ 21 Sep 2017 1022 EDT:*

The A/P section was last updated by DONKIN,LAURA G @ 21 Sep 2017 1022 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 21 Sep 2017 0754 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29695182 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Sep 2017 1437 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0905 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIODERMA, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by SMITH,JESSICA ANN @ 20 Sep 2017 1437 EDT
LST

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1438 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at:1230

Program Track:

(x) Comprehensive Recovery Program (CRP)

() Interpersonal Recovery Program (IRP)

() Trauma Recovery Program (TRP)

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1507 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by VANFOSSEN,MALLORY B @ 20 Sep 2017 1526 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist; and Maggie Hardy, LCSW-C, Social Worker. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. This session also allowed pts to explore the cycle of an intense emotional experience. Pts were lead in a discussion the wave skill from DBT that describes the means of experiencing emotion, according the symbol of a wave in the sea. Pts were then asked to render their own emotional wave using art media, to show us the experience of an evolving emotional state. 2D materials were used, consisting of pastels, chalks, and various types of paint on large paper. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of: how we can use the art process to understand the wave skill, how the process of art making can engage us to feel emotions as we create them visually, how this process of feeling emotion in real time can be channeled into a "safe" action, such as art making, rather than acting on them through other means, and how the depiction of the wave can be described objectively (or separately from self) to further our understanding of emotional experiences, rather than naming and discussing individual feelings. There was no indication of SI/HI. Next art therapy session will be held Thursday 21 September, 2017.

A/P Last updated by POURZAND,MIRIAM @ 22 Sep 2017 0906 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 22 Sep 2017 0906 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0906**CHANGE HISTORY**

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 22 Sep 2017 0906 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 22 Sep 2017 0906 EDT - see above. Previous Version of A/P section was entered/updated by SMITH,JESSICA ANN @ 20 Sep 2017 1508 EDT.

1. Generalized anxiety disorder**Procedure(s):**

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G

Encounter ID: BETH-29693494 Primary Dx:

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **20 Sep 2017 1338 EDT**
Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
Provider: **DONKIN, LAURA G**

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 20 Sep 2017 1338 EDT
Treatment Plan Review Team A

Appointment Cancelled by Facility

Encounter Cancelled by DEUTSCH, ANNE MARIE @ 20 Sep 2017 1404 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by DONKIN, LAURA G

Encounter ID: BETH-29693459 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Sep 2017 1336 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DONKIN, LAURA G**

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 20 Sep 2017 1336 EDT
 Treatment Plan Review Team A

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 0838 EDT

History of present illness

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Daniel Anderson
 20 SEPT 2017
 Follow-Up Data Only
 Psychological testing - Reviewed and interpreted psychological tests from
 BHDP. These are only one source of data and should be interpreted in the
 context of the patient's entire presentation. The BHDP scales are reported
 and briefly interpreted as follows.
 Behavioral Health Vitals (patient reported):
 Overall health reported as: Good
 Pain Level (0-10): 0 Currently treated: N/A
 Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3
 months: Yes
 # past attempts as of 09/06/2016: 3
 Most recent Suicidal Ideation: 1-2 weeks ago
 Suicidal Ideation Duration: Fleeting - a few seconds or minutes
 Suicidal Ideation Frequency: 2-5 times a week
 Protective Elements Stopping Suicidal Actions: Family, Fear of failing
 Harm Others Risk over next week as of 9/20/2017 - None Active Plan: N/A
 Patient with access to weapons: No
 Recent Outcome Measures (last 30 days)
 BASIS24 - Score: 2.52 - High levels of general distress reported (9/20/2017)
 PHQ9 - Score: 20 - Severe depressive symptoms reported. Evaluation
 indicated. (9/20/2017)
 GAD7 - Score: 17 - Moderate anxiety symptoms reported. Evaluation indicated.
 (9/20/2017)
 PCL-5 - Score: 54 - Moderate PTSD symptoms reported (9/20/2017)
 PCL-C: N/A
 AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP
 referral (8/29/2017)
 CSI - Score: -2 - Pt reports no significant other - no score (9/13/2017)
 ISI - Score: 23 - Clinical insomnia (severe) (9/20/2017)
 BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High
 Protection (8/29/2017).

S/O Note Written by DONKIN, LAURA G @ 21 Sep 2017 0850 EDT

History of present illness

The Patient is a 32 year old male.
 He reported: Encounter Background Information: Treatment Progress/Goals
 problem #1: anxiety
 Goal: reduction
 Objective: sxs reduction by 20% next BHDP screening
 Intervention: TMS
 Measure: GAD score 17 9/20/17 indicating moderate anxiety
 Progress: SM had 15% reduction in anxiety
 Problem #2: depression
 Goal: reduction
 Objective: sxs reduction by 20% next BHDP screening

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Intervention: medication increase Effexor 150 mg to 225 mg on 9/6/17
 Measure: PHQ9 severe 20 depression score 9/20/17
 Progress: sm reports increase severity due to returning to work
 Pt was present () was not present (x) during review of treatment plan. Pt present during review with Dr. Pourzand.

S/O Note Written by POURZAND,MIRIAM @ 22 Sep 2017 1048 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Met with SM to complete BHDP from 940-0950. Sm completed program, discharged today. Returning only for TMS treatment for depression and anxiety.

Note Written by POURZAND,MIRIAM @ 22 Sep 2017 1048 EDT**NOTES FROM TODAY'S SESSION:**

Treatment modality currently used: Not Set

Response to treatment: [] None [x] Some [] Significant [] Marked

RISK ASSESSMENT:

Clinician-determined risk level at start of appointment - No risk level set

MEDICATIONS:

Current side effects: daytime fatigue

Current response: doesn't feel any changes with Effexor, reports rozerem effective

Allergies were reviewed as indicated. Allergic to cats and dogs

OBJECTIVE (O):**MENTAL STATUS EXAM:**

Appearance: well-kept

Behavior/Orientation: x4, appropriate

Abnormal Movements: trichotillomania-back of hair picking- 25% of waking hours-reports less past few days

Rapport: appropriate

Speech: non pressured

Mood: grumpy per report, but presents pleasant

Affect: full ranging

Thought Process: clear, direct, oriented

Thought Content: non delusional

Judgment: good

Insight: good

Impulsivity: none impulse- hx of ETOH

Cognition: Average

Fund of Knowledge: well

OTHER OBJECTIVE FINDINGS/LAB RESULTS:**ASSESSMENT (A):****DIAGNOSIS:** anxiety d/o**SAFETY RISK:**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

LEARNING/NEEDS ASSESSMENT:

Patient would like the following information at this appointment: none

PLAN (P):

Patient was educated about and stated understanding of the diagnosis and treatment options.

Patient collaborated on and agreed to the following treatment plan:

High Interest Case? No

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☒ CBC ☒ LFTs ☒ TSH ☒ Chem 8 ☐ Lipids

☒ Fasting Glucose ☒ HCG ☒ UDS ☒ Vit B12 ☐ _____

Safety Plan:

Patient is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Medication:

Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Patient reports taking medications as prescribed: Yes/No

Patient reports following changes in medication:

MED	SIG	Target Dose	Target Symptoms
Effexor XR	225 mg daily		for depression and anxiety treatment
Rozarem	8 mg qhs		for sleep
Naltrexone	50 mg daily		prevent ETOH cravings

Other Interventions (Social, Occupational, Case Management): recreation therapy referral entered 9/13/17

Prognosis:

☐ Excellent ☐ Good ☐ Fair ☒ Guarded ☐ Poor

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Follow-up: PSYCHIATRY/WRNMMC KEMEZIS,PAT 26Sep2017@1000 GRP/90
PENDING

PSYCHIATRY BE/WRNMMC PAUL,SHERIN 27Sep2017@1000 FTR/60
PSYCHIATRY BE/WRNMMC TOBAR,EDEN 27Sep2017@1100 FTR/30
Sm scheduled to be discharged from PCS 9/21, will continue to present for TMS only

Referrals: recreation therapy, TMS

Occupational:

1. The Command WAS NOT directly notified of the current condition of the patient.
2. Patient HAS NOT granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile HAS NOT been written for patient by this writer today.

Profile:

SM in process of MEB

Is Service Member able to carry and fire weapon, from a Behavioral Health perspective (safety)? No

Is Service Member able to have access to sensitive information (to the level of current clearance)? Yes

Is Service Member able to deploy? No

Can Service Member perform MOS duties? N

A/P Last updated by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT

1. Generalized anxiety disorder

Procedure(s):
-Psychiatric Diagnostic Evaluation Review of Records and Reports x 1
-Psychologic Testing And Report Administered By Computer x 1
-Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by DEUTSCH,ANNE MARIE @ 22 Sep 2017 1056 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Signed By DONKIN, LAURA G (Physician) @ 22 Sep 2017 1056

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 22 Sep 2017 1049 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 21 Sep 2017 0859 EDT.

1. Generalized anxiety disorder

Procedure(s):
-Psychologic Testing And Report Administered By Computer x 1
-Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29690929 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Sep 2017 1142 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Sep 2017 1142 EDT
 CRP

S/O Note Written by HARDY, MARGARET L @ 20 Sep 2017 1451 EDT

History of present illness

The Patient is a 32 year old male.

Art Therapy (1230-1430) Facilitated by: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist;
 Co-facilitated by Margaret Hardy, LCSW-C, Social Worker

This writer co-facilitated art therapy in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations.

OBJECTIVE- This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding.

PROMPT: Create a wave. Name the art and be present mindfully while creating - without judgment.

PARTICIPATION: There was no indication of SI/HI. SM drew to the prompt and participated in group discussion integrating the process of doing the art and the symbolic meanings uncovered.

FOLLOW-UP: Next Art Therapy session will be Tuesday, 26 SEP 2017 at 0900 hours. SM will have safety check-out with their assigned Treatment Team prior to leaving for the day.

Therapy

Intervention: Art Therapy

Group Therapy

A/P Last Updated by HARDY, MARGARET L @ 20 Sep 2017 1458 EDT

1. Generalized anxiety disorder F41.1: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. SM reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. SM presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Procedure(s): -(90853) Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY, MARGARET L; VANFOSSEN, MALLORY B

Disposition Written by POURZAND, MIRIAM @ 22 Sep 2017 1049 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 1050

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29684296 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **20 Sep 2017 0758 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 20 Sep 2017 1441 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

SUBL, SUBLINGUAL

UNDER TONGUE EVERY
EIGHT HOURS AS NEEDED
FOR ABDOMINAL PAIN #0
RF3Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Active
OralTAKE ONE SCOOP EVERY 3 of 3
DAY MIXED IN LIQUID.

10 May 2017

AFTER TWO WEEKS
INCREASE TO TWICE
EVERY DAY #0 RF3Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Active
Oral, 5mLDRINK 10ML EVERY 6 3 of 3
HOURS FOR CONGESTION

28 Apr 2017

#0 RF3
DRINK 20ML (400MG)
EVERY FOUR HOURS FOR
BASELINE PAIN CONTROL
#0 RF1FLUARIX QUAD 2016-2017 (FLU VACC QS2016- Active
17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,
INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml
SYRINGE

NR

14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015- Active
16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

NR

05 Oct 2015

Reason for Appointment:Written by CHELLAPPA,MARY R @ 20 Sep 2017 0758 EDT
TMS**S/O Note** Written by BRAGGS,DEBORAH C @ 20 Sep 2017 1227 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #7 and #5 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 7 and # 5 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO,BHAGWAN A @ 20 Sep 2017 1409 EDT**Reason for Visit**

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 7 was the # 5 session at 120% MT.

Objective

Next session scheduled.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 20 Sep 2017 1411 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 20 Sep 2017 1441 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 20 Sep 2017 1441

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 20 Sep 2017 1441 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 20 Sep 2017 1441 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 20 Sep 2017 1412 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29684270 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Sep 2017 0757 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 22 Sep 2017 0717 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 20 Sep 2017 0757 EDT
IOP

S/O Note Written by GHOLSON, GEORICA K @ 20 Sep 2017 1018 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Finis Taylor, MD, Alex Yilmaz, MS4, and Chelsea Schifferle, MS3. Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored the relation between activating events, beliefs and consequences and how they can dispute their beliefs and adopt effective new beliefs. Intervention: Discussion of the ABCDE model and addressing distressing events in their lives. Group members focused on the ABC portion of the ABCDEF model. Patients discussed a distressing situation, emotions from the situation and the beliefs and thoughts associated with the emotion. Patients also discussed the origin of these thoughts and beliefs. Participation: Patient was attentive throughout psycho education and participated in group discussion. SM was open in discussing a distressing situation related to his military experience. He discussed how his beliefs and automatic thoughts were changed due to life experiences and maturity. He also expressed how challenging it can be to reflect on his emotions and alter his automatic thoughts.

No evidence of SI/HI. Next group session is 27 September 2017.

S/O Note Written by DONKIN, LAURA G @ 20 Sep 2017 1037 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Positive Psychology Group 0800-0900 facilitated by Laura Donkin, LCSW and Dr. Deutsch. The purpose of the group is to assist patients in viewing themselves and their situations based on their strengths, rather than weaknesses or symptoms, with the aim of helping them flourish and live a fulfilling life. Today's group was focused on reviewing the factors identified by Dr. Martin Seligman, which are present in people who describe themselves as happy. The discussion was focused on Engagement. There were 2 hand-outs. One hand-out introduced Dr. Seligman's ideas. Another identified the 10 qualifiers of FLOW by Mihaly Csikszentmihalyi. SM actively contributed to group discussion. The next group will be held @ 0800 on 27 July. No SI/HI plan or intent present.

S/O Note Written by FRIEDLANDER, JOSHUA N. @ 20 Sep 2017 1052 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Group Therapy Grounding 1000-1100: Instructed group in the definition of

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

grounding and identified different types of grounding skills and how to use them. Pts asked to practice at least one grounding skill this week for review at next week's session. Handouts provided. Pt participated actively. No evidence of SI/HI.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1418 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0800

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1422 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 20 Sep 2017 1434 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 22 Sep 2017 0718 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 22 Sep 2017 0718

CHANGE HISTORY

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 20 Sep 2017 1423 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 20 Sep 2017 0800 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

19 Sep 2017 at WRNMMC, GI Clinic Bethesda by BHUSHAN, ANITA

Encounter ID: BETH-29676953 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1530 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **BHUSHAN, ANITA**

Reason for Appointment:

follow up

Appointment Comments:

dtp/irmac pt waived atc

Vitals**Vitals** Written by NG, ANDREW J @ 19 Sep 2017 1515 EDT

BP: 137/87, HR: 76, RR: 14, T: 97.9 °F, HT: 69 in, WT: 164.2 lbs, SpO₂: 95%, BMI: 24.25,
 BSA: 1.9 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

S/O Note Written by BRIDGES, EDWARD E @ 19 Sep 2017 1549 EDT**History of present illness**

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Abdominal pain is worse with intake of insoluble fibers, although, this regimen does resolve his liquid stools producing semi formed stools. Also worse during physical activity and with increased anxiety/stress. He has seen nutrition, adopted a low fodmap diet (no beer, no wine, no rum, no broccoli, no lettuce, no onions, no garlic, no beans, no spinach, no cabbage, no asparagus, no fruits, no sausage, no chorizo, no eggs), and found partial relief in frequency of pain and fecal urgency. He also reports similar relief in symptom frequency with avoiding dairy, caffeine, and sugar-substitutes. He reports reduced stool output with decreased oral intake. He previously tested for celiac serologies and inflammatory markers. Denies EIM's of IBD, as well family h/o IBD. Reports fecal staining twice in the setting of diarrhea. Reports 5-15 minute urgency before defecating on every occasion. Denies post defecatory leakage.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

Allergies

Allergies Verified and Updated

NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.

Effexor - started after previously diagnosed IBS-D (used for Anxiety/Depression)

Naltrexone started after previously diagnosed IBS-D (used for ETOH avoidance)

Simethicone qid.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Anxiety/depression

IBS-D

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

PRK

LaForte 1 May 2017.

Personal history

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Family history

Family medical history
No malignant neoplasm of the gastrointestinal tract.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:
Sclera: ° Normal.

Lymph Nodes:

° Submandibular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Musculoskeletal System:

Functional Exam:
General/bilateral: ° Mobility was not limited.
Other:
General/bilateral: ° No muscle tenderness.

Neurological:

° Oriented to time, place, and person.

Psychiatric:

Mood: ° Euthymic.
Affect: ° Normal.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1611 EDT

Tissue Transglutaminase Ab IgA+IgG Panel		Site/Specimen	06 Oct 2016 1307
Tissue Transglutaminase Ab IgA	SERUM	<2 <i>	
Tissue Transglutaminase Ab IgG	SERUM	<2 <i>	

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT

IgA	Site/Specimen	06 Oct 2016 1307
IgA	SERUM	256

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT**Helicobacter pylori Ag EIA**

Order #	160511-04658 (NNMC Bethesda)
Filler #	160606 NBL 374 (NNMC Bethesda)
Status:	Final
Ordering Provider:	SHAH, NISHA AMISH
Priority:	ROUTINE
Date Ordered:	11 May 2016 0843
Date Resulted:	10 Jun 2016 0857
COLLECT_SAMPLE:	STOOL
Order Comment:	to be done two weeks after stopping protonix
BACTERIOLOGY RESULT:	OBSERVATION: Negative
Specimen:	Feces
Collected:	06 Jun 2016 1312
Results:	Final report

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT

ESR	Site/Specimen	11 Apr 2016 1043
ESR	BLOOD	5

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1300 EDT**Helicobacter pylori Ag EIA**

Order #	160511-04658 (NNMC Bethesda)
Filler #	160606 NBL 374 (NNMC Bethesda)
Status:	Final
Ordering Provider:	SHAH, NISHA AMISH
Priority:	ROUTINE
Date Ordered:	11 May 2016 0843
Date Resulted:	10 Jun 2016 0857
COLLECT_SAMPLE:	STOOL
Order Comment:	to be done two weeks after stopping protonix

BACTERIOLOGY RESULT: OBSERVATION: Negative

Specimen:	Feces
Collected:	06 Jun 2016 1312

Results:	Final report
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A/P Last Updated by BRIDGES,EDWARD E @ 19 Sep 2017 1646 EDT**1. Irritable bowel syndrome with diarrhea:** 32WM with IBS-D predominant symptoms complicated fecal urgency/soiling, with some element of FODMAP associated osmotic diarrhea. Comprehensive evaluation has otherwise been unremarkable.

- Will refer for ARM, possibly followed by biofeedback given reported history of urgency with every bowel movements and occasional fecal soiling (twice)
- Continue dietary modification as noted, including low fodmap and low fructose
- Will trial OTC citrucel to increase stool bulk
- Would suggest Nortryptiline or cymbalta for psychiatry to prescribe to attenuate his IBS related cramping

Disposition Last updated by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT

I saw and evaluated the patient, and agree with the above findings and plan.
Discussed the plan with patient at length. All questions answered. Pt v/u and agrees.

Signed By BHUSHAN, ANITA (Physician) @ 22 Sep 2017 1218**CHANGE HISTORY****The following Disposition Note Was Overwritten by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT:**

The Disposition section was last updated by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT - see above. Previous Version of Disposition section was entered/updated by BRIDGES,EDWARD E @ 19 Sep 2017 1647 EDT.

Released w/o Limitations**Follow up:** with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
40 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29675580 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1154 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 19 Sep 2017 1420 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 1154 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 19 Sep 2017 1230 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified. Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location. Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate. Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins. Adjustments were made to accommodate comfort. This session number 6 was the # 4 session at 120% MT.

Objective

Next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 19 Sep 2017 1232 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session 6 and #4 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.05 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 6 and # 4 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 19 Sep 2017 1233 EDT**1. Generalized anxiety disorder**

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
 PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 19 Sep 2017 1420 EDT**Released w/o Limitations****Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 19 Sep 2017 1420

CHANGE HISTORY**The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT:**

The Disposition section was last updated by LANDE, RAYMOND G. @ 19 Sep 2017 1420 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 19 Sep 2017 1233 EDT.

Released w/o Limitations**Follow up:** as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29675591 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1154 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 20 Sep 2017 1038 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 1154 EDT
CRP

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1448 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1155.
Pt denies SI/HI.
Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1449 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1430.
Pt denies SI/HI.
Pt reports following appts on tomorrow, 20 September: none.
Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by DONKIN, LAURA G @ 19 Sep 2017 1518 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Intensive Anger Management Group 1230-1330. 19 September, 2017.
Facilitators: Laura Donkin, LCSW-C and Ms. Gardiner.
Purpose: The purpose of this group is to help people understand the effect that
anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their
thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the
triggers and precipitants that lead to anger and frustration.
Topic: "What's Your Style?" Members explored where they learned their styles of anger, the consequences, the personal
physical effects, and how others are affected by this style of anger. We also explored various styles of expressing anger. Most
members participated in the exercise. This SM actively contributed to group discussion. The next group will be held on Tuesday,
26 August @ 1230. No indications of suicidal/homicidal ideation, plan or intent.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: (1330-1420) Comprehensive Recovery Program- Emotional Regulation- Crisis Management-

Facilitators: Penny Miller, recreation therapist and Georica Gholson, PhD, psychologist. PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group

focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports. ACTIVITY: Today's group focused on "Who Can You Tell Your Narrative to?" to provide increased awareness about one's social supports and using their supports before, during and after a crisis. The group discussed individuals they felt comfortable talking with and people they do not feel comfortable discussing their issues with. Various perspectives were explored in addition to strengths and challenges for each patient. Each group member was provided with a worksheet to develop a plan to assess who is in their support network.

PARTICIPATION: Patient actively participated in the discussion. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for

Tuesday 8/29/17.

S/O Note Written by MILLER,PENNY E @ 20 Sep 2017 0942 EDT**Reason for Visit**

Visit for: (1330-1420) Comprehensive Recovery Program- Emotional Regulation- Crisis Management- Facilitators: this writer Penny Miller, recreation therapist and Georica Gholson, psychologist.

PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.

ACTIVITY: Today's group focused on

"Who Can You Tell Your Narrative to?" to provide increased awareness about one's social supports and using their supports before, during and after a crisis. The group discussed individuals they felt comfortable talking with and people they do not feel comfortable discussing their issues with. Various perspectives were explored in addition to strengths and challenges for each patient. Each group member was provided with a worksheet to develop a plan to assess who is in their support network.

PARTICIPATION: Patient was alert, attentive and willingly contributed to the group discussion. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 8/29/17.

S/O Note Written by POURZAND,MIRIAM @ 20 Sep 2017 1039 EDT**History of present illness**

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

1200-1220-met with sm for follow up. Sm requesting tms treatment for depression. Sm currently undergoing tms treatment for anxiety reports no results. Reviewed BHDP scores-self report with sm and asked sm his current sxs.reporting fleeting suicidal thoughts (denies at time of assessment) reports no plan.

FOLLOW UP PLANS

discussed with treatment team sm to follow up with tms treatment team. Scheduled discharge from program on 9/21/17

.....

.

Physical findings**General Appearance:**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal. Full range. stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Last updated by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 20 Sep 2017 1249 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 20 Sep 2017 1249**CHANGE HISTORY**The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 19 Sep 2017 1540 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 19 Sep 2017 1519 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

@ 19 Sep 2017 1245 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

19 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29679274 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Sep 2017 1100 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

S/O Note Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1411 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Scheduling

S) SM reported that he continues to have IBS issues. SM and this writer discussed upcoming schedule and SM went over scheduled VA appointments. SM agreed to begin ATS IOP process groups on 4 October and full IOP on 13 October. SM stated he was doing well and had no concerns to discuss. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate. New appointment summary sheet reviewed and signed.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that are being addressed through PCS and BH. SM would benefit from engaging in community recovery.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will work on treatment planning goals as homework. SM will begin ATS groups on 4 October.

A/P Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1409 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 19 Sep 2017 1410 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 19 Sep 2017 1412

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

19 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29668633 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **19 Sep 2017 0805 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM****AutoCites** Refreshed by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3		10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3		28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1		28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 19 Sep 2017 0805 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 19 Sep 2017 0952 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by FRIEDLANDER, JOSHUA N. @ 19 Sep 2017 1056 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Group Therapy Distress Tolerance Skills 1000-1050: Instructed group in how to identify moments of distress, how to build up motivation to improve their coping skills in those moments, and how to develop coping skills to better tolerate those moments. Handouts provided. Pt participated actively. No evidence of SI/HI. '

S/O Note Written by HARDY, MARGARET L @ 19 Sep 2017 1059 EDT

History of present illness

The Patient is a 32 year old male.

Creative Writing group (0900 - 1000) Facilitated by Margaret Hardy, LCSW-C, and Seema Reza, Creative Writer. This group is co-led by two providers to address the high acuity of the group members and to have a staff member available should a group member become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively.

PURPOSE: Introduce patients to writing as a means for self-expression, stress relief, and to increase engagement with treatment. The relationship between writing and healing is evidence-based. Research supports that writing combines the objective (what happened) with the subjective (how you felt about it). Writing helps Patients gain insight and process trauma, life events, and gain understanding of their feelings and behavior. Further, research supports that writing for 20 minutes on a consistent basis results in positive effects on white blood cell counts, reduces sick visits, and reduces blood pressures.

TOPIC: In today's group of 10 patients, MS Reza explained the purpose and benefit of writing including biological and emotional to include learning to use words rather than actions as well as areas for further exploration in mental health therapy. Then MS Reza

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

read Wild Geese, by Mary Oliver followed by group discussed of which lines stood out for them followed by reading of 'Permission Granted', by David Allen Sullivan. Writing prompt was to write from the first few words of each stanza.

PARTICIPATION: Patient participated fully in group. Provider observed no evidence of SI/HI.

FOLLOW-UP: Next Creative Writing Group is scheduled for Thursday, 21 SEP 2017 at 0900 hours. Next IOP group is Distress Tolerance at 1000 hours today.

S/O Note Written by DONKIN, LAURA G @ 19 Sep 2017 1207 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0805-0850. SM presented in positive mood and stated that he had slept well the previous night. We discussed pending discharge on Thursday and SM said that he has outpatient behavioral health appointments scheduled but needs to schedule ATS appointments. SM expressed anxiety about managing multiple appointments and work schedule and seemed especially concerned about all the driving this would entail. We then discussed his current relationships with 2 different women and what he hopes to gain from these relationships. We explored his schizoid traits and his emotional needs. On the one hand he enjoys spending time with women, but then wants no expectations and greatly values his alone time. We also explored what triggered the escalation in his anxiety level, which he now connects with his deployment on a ship for basically 3 years off the coast of Japan. SM had very little privacy or shore leave. SM feels that the military component of his work is especially difficult given his personality traits. We will meet again on Thursday for discharge. No SI/HI plan or intent present.

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0800.

Pt denies SI/HI.

Pt reports following appts this morning: none.

S/O Note Written by VANFOSSEN, MALLORY B @ 19 Sep 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1050.

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by POURZAND, MIRIAM @ 20 Sep 2017 1035 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 20 Sep 2017 1035

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 20 Sep 2017 1034 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 19 Sep 2017 1216 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 19 Sep 2017 0954 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

18 Sep 2017 at WRNMMC, ATS Adult BE by LESKO, STACEY B

Encounter ID: BETH-29670106

Primary Dx:

Encounter for observation for other
suspected diseases and conditions ruled
outPatient: **ANDERSON, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **18 Sep 2017 1300 EDT**
Clinic: **ATS ADULT BE**Appt Type: **GRP**
Provider: **LESKO, STACEY BETH**AutoCites Refreshed by LESKO, STACEY B @ 19 Sep 2017 0854 EDT**Allergies**

•No Known Allergies

Reason for Appointment:

PCS understanding sub abuse

Appointment Comments:

ctc

S/O Note Written by LESKO, STACEY BETH @ 19 Sep 2017 0854 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: TOPIC: Understanding Substance Abuse (1230 - 1320)

S: The group discussed what constitutes low risk drinking vs. high risk drinking (0-1-2-3 rule), standard drink sizes, and national data on adult drinking behaviors. Further discussion had on the risk of mixing medications with alcohol. Group members commented and asked questions on material presented.

O: Appearance: Neat and Clean

Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Mood: Euthymic

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/Hi: Convincingly Denies

A: SM engaged in discussion both providing and receiving feedback appropriately.

P: SM will continue with PCS IOP as scheduled.

A/P Written by LESKO, STACEY B @ 19 Sep 2017 0854 EDT**1. Encounter for observation for other suspected diseases and conditions ruled out Z03.89**

Procedure(s): -(90853) Psychiatric Therapy Group Interactive x 1

Disposition Written by LESKO, STACEY B @ 19 Sep 2017 0855 EDT**Released w/o Limitations****Follow up:** in the ATS ADULT BE clinic.

Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 19 Sep 2017 0855

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29659365 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 Sep 2017 1155 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 1155 EDT
TRP

S/O Note Written by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: UNDERSTANDING SUBSTANCE USE: MONDAY @ 1230-1320. Co-Facilitators: Georica Gholson, PhD and Stacy Lesko, Addictions Counselor

PURPOSE: The purpose of this group is to help patients gain an understanding about substance use. Additionally, the group educates patients about medication interactions with and physiological impact of illicit substance use.

TODAY'S INTERVENTION: Group discussion centered on understanding alcohol use. Patients took a substance use quiz and discussed the legal limits, physiological impact, heredity, interaction effects with different medications, and impact of intoxication of alcohol use.

PARTICIPATION: SM was attentive and actively participated in group. No evidence of SI/HI. Next group session is 2 October 2017.

S/O Note Written by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Symptom Management Group: Facilitated by Dr. Pourzand, psychiatric nurse practitioner 1330-1355

Purpose: Learn to ameliorate and manage symptoms and live a functional and productive life.

Goals/ Objectives: learn resources to manage symptoms, identify personal symptoms, and identify how to manage symptoms.

Activity: Symptom management jeopardy -team exercise

Participation: SM achieved goals/ objectives by participating in activity

Assessment: No indication of distress. No indication of SI/HI

Plan: Next group scheduled for Monday September 25, 2017.

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 1446 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Afternoon Programming 1230-1430

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

5 min Check in at:1155

Program Track:

☒ Comprehensive Recovery Program (CRP)☐ Interpersonal Recovery Program (IRP)☐ Trauma Recovery Program (TRP)☐ Leisure Skills Training (LST)

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations ☐ Yes ☒ No Suicidal Ideation ☐ Yes ☒ No.**S/O Note** Written by DONKIN,LAURA G @ 18 Sep 2017 1449 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

☒ Attend IOP Program tomorrow morning☐ OtherDisposition: ☒ Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations ☐ Yes ☒ No Suicidal Ideation ☐ Yes ☒ No.**A/P** Last updated by DONKIN,LAURA G @ 18 Sep 2017 1450 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): GHOLSON,GEORICA K;
DONKIN,LAURA G

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND,MIRIAM @ 19 Sep 2017 1057 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 19 Sep 2017 1057**CHANGE HISTORY**

The following S/O Note Was Deleted by LOWENSTEIN,HELEN @ 18 Sep 2017 1448 EDT:

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1330-1420 Therapy Interfering Behaviors Group. Led by Helen Lowenstein LCSW.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

PURPOSE: Provide Education on Therapy Interfering Behaviors for TRP patients. To understand how certain behaviors can cause interference with progress.
 TOPIC: Therapy Interfering Behaviors. Hand out had 5 blocks to fill out How did the problem develop, Triggers for the recent episode, the problem, things that kept problem going, and positive things that I've got going for me. This was tied into having patients share what their interfering behaviors have been and what if any are they having now.

PARTICIPATION: SM was an active participant at times throughout the group. SM shared his anger can get in the way of seeking help and the stigma. No evidence of S/I or H/I. Next group to meet 10/02/17 at 1330.

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 1447 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 1447 EDT - see above. Previous Version of A/P section was entered/updated by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): GHOLSON, GEORICA K; LOWENSTEIN, HELEN T

The following A/P Note Was Overwritten by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT:

The A/P section was last updated by LOWENSTEIN, HELEN @ 18 Sep 2017 1435 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

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Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): GHOLSON, GEORICA K

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 18 Sep 2017 1416 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT:

The A/P section was last updated by GHOLSON, GEORICA K @ 18 Sep 2017 1341 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 18 Sep 2017 1220 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29653480 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 Sep 2017 0858 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 18 Sep 2017 1306 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 0858 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 18 Sep 2017 1210 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:00-12:40).

Subjective

A procedural time out was done during which settings and patient was re-identified. Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location. Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate. Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0. Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins. Adjustments were made to accommodate comfort. This session number 5 was the # 3 session at 120% MT.

Objective

Next session scheduled.

S/O Note Written by BRAGGS, DEBORAH C @ 18 Sep 2017 1234 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #5 and #3 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.05 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 5 and # 3 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BAHROO,BHAGWAN A @ 18 Sep 2017 1213 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 18 Sep 2017 1306 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 18 Sep 2017 1306

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 18 Sep 2017 1306 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 18 Sep 2017 1306 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 18 Sep 2017 1213 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

18 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29651041 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **18 Sep 2017 0752 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 19 Sep 2017 1054 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
RAMELTEON, 8 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY NIGHT FOR SLEEP #0 RF2	2 of 2	18 Sep 2017
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 18 Sep 2017 0752 EDT
IOP

S/O Note Written by HARDY, MARGARET L @ 18 Sep 2017 0936 EDT

History of present illness

The Patient is a 32 year old male.

Seeking Safety: (Safety) 0800-0850

Facilitators: This group was co-led by Margaret Hardy, LCSW-C and Penny Miller, CTRS, LCSW-C

This writer co-facilitated Seeking Safety Group in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations.

CHECK-IN - mood today was indifferent. Patient's stated the following about this weekend: good coping was, pretended to like myself and cooking for others; no unsafe behavior; commitment was met - cooked for others. Community resource update was to talk with his Social Worker about Command expectation of work while in the IOP Program. Patient's takeaway was - I need to work on boundaries, saying no and no sharing too much information with everybody.

PARTICIPATION: Patient participated fully. There was no indication of SI/HI.

FOLLOW-UP: Next Seeking Safety Group will be Monday, 25 SEPT 2017. The next group today is Common Concerns at 0900 hours. Please see Penny Miller's note of today for additional information.

Therapy

Intervention This Appointment - Group Therapy - Provider normalized ongoing suicidal ideation which began in childhood with recognition that patient knows what to do when things worsen for him, and has sought help.

S/O Note Written by DONKIN, LAURA G @ 18 Sep 2017 0949 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by MILLER, PENNY E @ 18 Sep 2017 0953 EDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Reason for Visit

Visit for: (0800-0850): IOP Program- Seeking Safety Group: Facilitated by this writer Penny Miller, recreation therapist and Margaret Hardy, social worker.

Purpose: Seeking Safety is a psychoeducational group developed for individuals with co-occurring disorders PTSD and Substance Abuse Disorders based on five central ideas (1) safety as the priority of this first-stage-treatment (2) integrated treatment of PTSD and substance abuse (3) a focus on ideals (4) four content areas: cognitive, behavioral, interpersonal, and case management and (5) attention to the therapist processes.

Activity: "Safety", the topic introduced today is described as the first stage of healing from both PTSD and substance abuse, and the foremost guiding principle throughout this treatment. This session the group reviewed samples of unsafe coping verses safe coping, stages of morning, signs of recovery as well as a list of over 80 safe coping skills were provided. A discussion around the topic was facilitated, providing participants with an opportunity to share their personal experiences.

Participation: Pt was attentive and willingly contributed to the group process. Pt disclosed feelings of guilt and resentment regarding issues of neglect he'd experienced from his father, whom was his primary caretaker as a child. He is reading journals provided to him by his mother, and as a result is still coping with the emotional pain. He also disclosed that he feels that he does not have any boundaries and as a result never set boundaries in past relationships. He stated that he notices that when he does not set boundaries in relationships he ends up regretted not doing so. He was encouraged to meet with his individual therapist to further develop in that area. Next Seeking Safety group is scheduled for Monday 25 September 2017 at 0800. No evidence of SI/HI plan or intent noted.

S/O Note Written by GWIN,KRISTIN MICHELLE @ 18 Sep 2017 0959 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

IOP Common Concerns Group: "Effective Communication" 0900-0950

Facilitator: Kristin Gwin, LCSW-C and Delacie Gardiner

PURPOSE: The purpose of this group is for group members to process role of their symptoms and the impact they may or may not have within the following areas: Marriage and/or Relationship Problems, Parenting Difficulties, Family Function, Social Function. These general areas bring up group discussions centering on the following areas: Fear and Worry, Depression, Family Roles, and Family Dynamics. Discussion also are had on how Family, Financial Difficulties, Avoidance, and Isolation can have an impact on the symptoms that the group members may be experiencing and how that can be communicated to those they are close to. Skills that are reviewed include Effective Communication, Communication Styles, Identifying Family Roles, Coping Skills, and Setting Appropriate Boundaries.

TOPIC: Today, the group topic was the Communication Traps". Group members reviewed 10 of the most common communication traps to include Generalizing, Preaching, Mindreading, Dwelling on the Past, Stomping Out, and Labeling. Group members discussed how they and other around them fall into this trap, and how to negotiate communication in a more effective way by being aware of the traps they most commonly fall into.

PARTICIPATION: SM had no evidence of homicidal/suicidal ideation. SM was quiet in group however appeared to be actively listening to the group content. Next group is scheduled for 09/25/17.

S/O Note Written by DONKIN,LAURA G @ 18 Sep 2017 1443 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0745

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No

S/O Note Written by DONKIN,LAURA G @ 18 Sep 2017 1444 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1055

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND, MIRIAM @ 19 Sep 2017 1055 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 19 Sep 2017 1055**CHANGE HISTORY****The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT:**

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 1445 EDT - see above. Previous Version of A/P section was entered/updated by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

The following A/P Note Was Overwritten by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT:

The A/P section was last updated by GWIN, KRISTIN M @ 18 Sep 2017 0959 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

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Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 18 Sep 2017 0951 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 18 Sep 2017 0936 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29643565 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 1149 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 15 Sep 2017 1346 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 15 Sep 2017 1149 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 15 Sep 2017 1240 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.
Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.
Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.
Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos
SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0
Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.
Adjustments were made to accommodate comfort.
This session number 4 was the # 2 session at 120% MT.

Objective

Next session scheduled

S/O Note Written by BRAGGS, DEBORAH C @ 15 Sep 2017 1251 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #4 and #2 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.04 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 4 and # 2 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for Monday. ZUNG anxiety=54, GAD 7=18.

A/P Last Updated by BAHROO, BHAGWAN A @ 15 Sep 2017 1244 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT

Released w/o Limitations

Follow up: as needed in 3 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 15 Sep 2017 1347

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 15 Sep 2017 1347 EDT - see above.Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 15 Sep 2017 1243 EDT.

Released w/o Limitations

Follow up: as needed in 3 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29643553 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 1148 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 15 Sep 2017 1205 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 15 Sep 2017 1148 EDT
CRP

S/O Note Written by CLOPPER, TAMMY J @ 15 Sep 2017 1259 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 1230

Afternoon Track: CRP

Appointments Reported this afternoon: 1200 TMS

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 15 Sep 2017 1407 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1400

Afternoon Track: CRP

Appointments Reported for Monday: TMS 1200

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by GRAGNANI, CYNTHIA THERESA @ 15 Sep 2017 1507 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1350) Staff present: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist, Dr. Gragnani, Psychologist. Pt attended CRP Art Therapy group. This session provided the patient with opportunity to practice creativity and utilize a new outlet for expression, while focusing on art making as a therapeutic practice. This SM was actively engaged in the activity, openly answered questions, and shared with the group. SM was also able to speak to the art making process and how this informed chosen imagery, as well as the insights that were gained. There was no indication of SI/HI.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by VANFOSSEN,MALLORY B @ 15 Sep 2017 1546 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist, Dr Gragnani, Clinical Psychologist. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. Pts were encouraged to consider topics or lingering thoughts that they may have been introduced to in other groups, images that may have been triggered lately, or using the art to process or explore concepts that they may feel the need to further investigate. Pts were instructed to focus on the topics that may be difficult to express in words. Materials consisted of pastels, pencils, markers, crayons, chalks, acrylic paints, and various sculptural 3D materials. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of coping skills required to focus and allow self to express material visually, persevering through frustration and uncertainty, creating meaning from the process and materials in a way that words alone cannot, the purpose and inclination of self-judgment and criticism related to art making and other activities. There was no indication of SI/HI. Next art therapy session will be held Monday 18 September, 2017.

A/P Last updated by GRAGNANI,CYNTHIA T @ 15 Sep 2017 1508 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 1 ADDITIONAL PROVIDER(S): GRAGNANI,CYNTHIA THERESA

Disposition Written by POURZAND,MIRIAM @ 18 Sep 2017 0944 EDT**Released w/o Limitations**

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 18 Sep 2017 0944**CHANGE HISTORY**

The following A/P Note Was Overwritten by GRAGNANI,CYNTHIA T @ 15 Sep 2017 1508 EDT:

The A/P section was last updated by GRAGNANI,CYNTHIA T @ 15 Sep 2017 1508 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 15 Sep 2017 1207 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

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Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 13 Nov 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

15 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29637426 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Sep 2017 0744 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 15 Sep 2017 1140 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 15 Sep 2017 0744 EDT
IOP

S/O Note Written by EARLEY, KERRIE GLYN @ 15 Sep 2017 1045 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Core Mindfulness Skills: 0800-0850- Facilitated by Kerrie Earley, LCSW

Purpose: Patients will be provided with information regarding the practice of Mindfulness, including the rationale for incorporating this as a practice into daily life. Mindfulness functions as a foundation for being in "Wise Mind"-a state of mind where individuals are more able to engage in skillful behavior and regulate emotions more effectively. Living with awareness in the present moment (neither ruminating on in the past, nor worrying about the future), focusing on one thing at a time in a non-judgmental way and doing what works are some of the core concepts of Mindfulness practice.

Today patients discussed concepts of selective attention, multitasking, and focus in the context of mindfulness. Group members watched two videos and discussed the role of mindfulness in day to day life and in using coping. One group member started speaking at length about a recent accident and his reactions. SW asked follow up questions and redirected him to the topic as he was using graphic and violent language, and patient became upset and declined to finish the story. He left the group and other group members presented as anxious and frustration. SW and patients discussed use of mindfulness to understand their emotions and reactions, their coping skills, and their options for moving forward. Group members provided feedback on the group and ideas for future session. This patient was actively engaged throughout the session. He discussed memories of his father having been brought up in the group and noted recent focus on mindful communication with others in his life.

There was no indication of S/I or H/I present. Next Core Mindfulness Skills group is scheduled for 22 August, 2017.

S/O Note Written by GWIN, KRISTIN MICHELLE @ 15 Sep 2017 1100 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

IOP Guest Speaker Group 0900-1000:

Facilitator: Brian Pampino, Kristin Gwin, LCSW-C, Tammy Buford, RN

PURPOSE: The purpose of this group is to have guest speakers bring various topics that would be relevant to group members and their treatment/recover. Group topics range from finance experts, VA experts, Chaplin, and Med Board experts.

TOPIC: Today, Mr. Pampino from Fleet and Family Services/Financial Department discussed the Eight Steps to Financial Fitness. He engaged the group to discuss budget planning, retirement planning, the cash flow formula, and spending. Group members engaged actively in discussing how to set themselves up for financial fitness and what needs to be considered to do so.

PARTICIPATION: SM was actively involved in listening to the presentation of the guest speaker and taking notes, and well as asked clarifying questions to better understand the material. SM had no evidence of homicidal/suicidal ideation. SM actively participated. Next group is scheduled for 09-22-17.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1244 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0740

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1245 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 15 Sep 2017 1303 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 1000-1050. SM presented in positive mood and was talkative and smiling throughout session. SM started off session weighing his options for future jobs. He admitted to having many options and considers this a positive. He spent a considerable amount of time discussing his issues with male/female relationships and comparing the 2 women he is currently seeing. SM admits that he needs work on verbal communication and how to be mindful of his word choices. We also discussed what he is hoping to gain from relationships and explored his needs in regards to relationships. SM admitted to having a hard time with male relationships and usually gravitates towards females. SM considered that this may have to do with his experiences being bullied as an adolescent. We discussed his psychiatric diagnosis and the treatment team's decision not to change it. He seemed to accept this without a problem. SM is still contending with his IBS symptoms and shared his frustration. He will work on word mindfulness this weekend. We will meet on Tuesday. No SI/HI plan or intent present.

S/O Note Written by SMITH, JESSICA ANN @ 15 Sep 2017 1317 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH, JESSICA ANN @ 15 Sep 2017 1318 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 18 Sep 2017 0932 EDT

Released w/o Limitations

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 18 Sep 2017 0933

CHANGE HISTORY

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 15 Sep 2017 1318 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 15 Sep 2017 1318 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 15 Sep 2017 1311 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 15 Sep 2017 1248 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 15 Sep 2017 1248 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 15 Sep 2017 1140 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

14 Sep 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29632074 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **14 Sep 2017 1327 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 14 Sep 2017 1330 EDT**Subjective**

Provider was contacted by Dr. Benton regarding collateral information of patient for assessment purposes. Provider presented observational data based on record review and recall of interactions with patient.

A/P Last Updated by PAUL, SHERIN @ 14 Sep 2017 1330 EDT**1. Generalized anxiety disorder****Disposition** Last Updated by PAUL, SHERIN @ 14 Sep 2017 1330 EDT**Follow up:** in the PSYCHIATRY BE clinic.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 14 Sep 2017 1330

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29630836 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **14 Sep 2017 1238 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 1238 EDT
CRP

S/O Note Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1253 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1145 Check in to afternoon program. SM denied SI/HI. Will attend groups this afternoon.

S/O Note Written by DONKIN, LAURA G @ 14 Sep 2017 1406 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Life Skills Group

1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "11 Warning Signs of Depression and Relapse." Group members shared their individual warning signs and explored how they should react. This SM actively participated in group discussion. No SI/HI plan or intent present. The next group will be on 22 September.

S/O Note Written by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMUNICATION SKILLS 1330-1420

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician

Purpose: Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.

Intervention: Group members were given a handout that discussed 3 different responses to criticism - passive, aggressive, and assertive. Group members learned the differences between the types and discussed which ones they engage in when encountering criticism. Also, group members discussed how the expressed feedback to other people. Lastly, group members discussed how the messenger and delivery style of the message impacts how they receive feedback and criticism.

Participation: SM participated in group discussion.

Assessment: No indication of distress. No indication of SI/HI

Plan: Next group scheduled for Thursday 21 September 2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1541 EDT

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1430 Check out of PCS for the day. SM denied SI/HI. 1200 TMS tomorrow - will report for groups in morning.

A/P Last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 2

-Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND, MIRIAM @ 15 Sep 2017 0754 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 15 Sep 2017 0754**CHANGE HISTORY****The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT:**

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1542 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT:

The A/P section was last updated by GHOLSON, GEORICA K @ 14 Sep 2017 1442 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 14 Sep 2017 1407 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 14 Sep 2017 1337 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 1254 EDT.

1. Generalized anxiety disorder

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29629914 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **14 Sep 2017 1141 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 1141 EDT
TMS

S/O Note Written by BAHROO, BHAGWAN A @ 14 Sep 2017 1227 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.
Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.
Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.
Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos
SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0
Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.
Adjustments were made to accommodate comfort.
This session number 3 was the first session at 120% MT.

S/O Note Written by BRAGGS, DEBORAH C @ 14 Sep 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #3 and #1 at therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.45 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 3 and # 1 with MT level at therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by BAHROO, BHAGWAN A @ 14 Sep 2017 1229 EDT

1. Generalized anxiety disorder

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
PROVIDER(S): BAHROO, BHAGWAN A; BRAGGS, DEBORAH C

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Disposition Last updated by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 14 Sep 2017 1319

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT:

The Disposition section was last updated by LANDE, RAYMOND G. @ 14 Sep 2017 1319 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO, BHAGWAN A @ 14 Sep 2017 1229 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

14 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29623620 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **14 Sep 2017 0756 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 14 Sep 2017 0756 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 14 Sep 2017 0801 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800 Check in to PCS Team A. SM denied SI/HI. No appts scheduled today.

S/O Note Written by GHOLSON, GEORICA K @ 14 Sep 2017 1013 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Interpersonal Effectiveness (0800-0850) Georica Gholson, PhD and Narce Pratt, LCSW-C

Purpose: Patients will examine their patterns of relating to others. Patients will begin to explore how to interrupt unhelpful patterns and foster healthy patterns of relating. Patients will be challenged to find a balance between passivity (as well as passive-aggressive behavior) and aggression. Patients will rehearse ways to effectively ask for what they want, keep relationships they want or need to keep and maintain their self-respect. Developing and maintaining a level of healthy interpersonal boundaries will also be addressed.

Today group began with introductions and recognition of one way they have helped or been helped by others this week. All patients participated. Patients were introduced to the idea of identifying the goal of their interactions- getting what they want/need, keeping the relationship, or maintaining self-respect. Group members considered ways of approaching difficult conversations and were introduced to the DEAR-MAN skills, emphasizing the importance of asking or asserting rather than hinting, and being aware of one's approach. Group members discussed the idea of how or when this is used as manipulation. Group members discussed approaches to the skill and the idea that sometimes people are not will or able to give them what they want or need. This patient was actively engaged in the discussion.

There was no indication of S/I or H/I present. Next interpersonal effectiveness group is scheduled for 21 September 2017.

S/O Note Written by DONKIN, LAURA G @ 14 Sep 2017 1036 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

S/O Note Written by HARDY,MARGARET L @ 14 Sep 2017 1057 EDT**History of present illness**

The Patient is a 32 year old male.

Creative Writing group (0900 - 1000) Facilitated by Margaret Hardy, LCSW-C, and Seema Reza, Creative Writer. This group is co-led by two providers to address the high acuity of the group members and to have a staff member available should a group member become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively.

PURPOSE: Introduce patients to writing as a means for self-expression, self-care, stress relief, and to increase engagement with treatment. The relationship between writing and healing is evidence-based. Research supports that writing combines the objective (what happened) with the subjective (how you felt about it). Writing helps Patients gain insight and process trauma, life events, and gain understanding of their feelings and behavior. Further, research supports that writing for 20 minutes on a consistent basis results in positive effects on white blood cell counts, reduces sick visits, and reduces blood pressures.

TOPIC: Ms Reza read - What Secrets We Keep (pg 10-11) by Shinji Moon from his book, The Anatomy of Being (2012). Group participates wrote for 7 minutes from prompt, For so many years I've held words beneath my tongue like ... The second poem by the same author was Kintsugi (pg 13). Prompt: We were never taught ... Final poem was Joy by Seema Reza from her book, When the World Breaks Open.

PARTICIPATION: Patient participated fully. Provider observed no evidence of SI/Hi during group.

FOLLOW-UP: Next Creative Writing Group is scheduled for Thursday, 21 SEP 2017 at 0900 hours. Next IOP group is Recreation Therapy at 1000 hours today.

S/O Note Written by PRATT,NARCEDALIA @ 14 Sep 2017 1114 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Interpersonal Effectiveness (0800-0850) Narcedalia Pratt, LCSW-C and Dr. Gholson, Ph.D.

Purpose: Patients will examine their patterns of relating to others. Patients will begin to explore how to interrupt unhelpful patterns and foster healthy patterns of relating. Patients will be challenged to find a balance between passivity (as well as passive-aggressive behavior) and aggression. Patients will rehearse ways to effectively ask for what they want, keep relationships they want or need to keep and maintain their self-respect. Developing and maintaining a level of healthy interpersonal boundaries will also be addressed.

Topic: Today group focused on DEAR-MAN skill for getting what one wants/needs in a relationship. This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

Participation: SM was actively engaged in the group discussion.

There was no indication of S/I or H/I present. Next interpersonal effectiveness group is scheduled for 21 September 2017.

S/O Note Written by LOWENSTEIN,HELEN T @ 14 Sep 2017 1233 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

(1000-1050) - Recreation Therapy- "This group was facilitated by Penny Miller, recreation therapist and Helen Lowenstein, social worker LCSW.

Purpose: To provide an opportunity for healthy communication, problem-solving, encourage teamwork and compromise.

TOPIC: Ice breaker/group activity. Hand out provided that asked patients to identify other group members to Find Someone Who. There were 20 questions asked such as have you lived in another country, have you lived in the barracks and so forth. Patients were asked to talk with others they normally don't talk with. This allowed patients to work together and experience team work, utilize communication skills, and movement.

Participation: PT was an active participant throughout the group. No evidence of S/I or H/I. Next session is scheduled for 9/21/17,1000.

S/O Note Written by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1251 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1100 Check out of morning program. SM denied Si/Hi. Will return for afternoon groups.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by POURZAND,MIRIAM @ 15 Sep 2017 0748 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Met with sm for BHPD treatment plan individual encounter placed.

A/P Last updated by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1253 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 2

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by POURZAND,MIRIAM @ 15 Sep 2017 0749 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 15 Sep 2017 0749**CHANGE HISTORY****The following A/P Note Was Overwritten by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1253 EDT:**

The A/P section was last updated by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1253 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 14 Sep 2017 1037 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1 ADDITIONAL PROVIDER(S): DEUTSCH,ANNE MARIE

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 14 Sep 2017 1037 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 14 Sep 2017 1037 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 14 Sep 2017 0921 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 13 Nov 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1 ADDITIONAL PROVIDER(S): DEUTSCH, ANNE MARIE

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 14 Sep 2017 0921 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 14 Sep 2017 0802 EDT.

1. Major depressive disorder, recurrent, moderate**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29621315 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **13 Sep 2017 1552 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT
Treatment Plan Update Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1552 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Daniel Anderson
13 SEPT 2017

Follow-Up Data Only

Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: N/A

Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No

past attempts as of 09/06/2016: 3

Most recent Suicidal Ideation: Within the past week

Suicidal Ideation Duration: Fleeting - a few seconds or minutes

Suicidal Ideation Frequency: Once a week

Protective Elements Stopping Suicidal Actions: Family, Fear of failing

Harm Others Risk over next week as of 9/13/2017 - None Active Plan: N/A

Patient with access to weapons: No

Recent Outcome Measures (last 30 days)

BASIS24 - Score: 2.63 - High levels of general distress reported (9/13/2017)

PHQ9 - Score: 21 - Severe depressive symptoms reported. Evaluation indicated. (9/13/2017)

GAD7 - Score: 20 - Severe anxiety symptoms reported. Evaluation indicated. (9/13/2017)

PCL-5 - Score: 61 - Significant PTSD symptoms reported (9/13/2017)

PCL-C: N/A

AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

CSI - Score: -2 - Pt reports no significant other - no score (9/13/2017)
 ISI - Score: 25 - Clinical insomnia (severe) (9/13/2017)
 BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)
 TREATMENT PLAN UPDATE Treatment team met Wednesday 30 AUG to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). SM has been referred to Recreation Therapy and has started TMS treatment for anxiety. His discharge date from PCS is 21 SEPT.

S/O Note Written by POURZAND,MIRIAM @ 14 Sep 2017 0949 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: BHDP completed see add note section.

Note Written by POURZAND,MIRIAM @ 14 Sep 2017 0949 EDT

Met with SM to complete BHDP from 0920-0950**NOTES FROM TODAY'S SESSION:**

Treatment modality currently used: Not Set

Response to treatment: [] None [x] Some [] Significant [] Marked

RISK ASSESSMENT:

Clinician-determined risk level at start of appointment - No risk level set

MEDICATIONS:

Current side effects: none

Current response: doesn't feel any changes

Allergies were reviewed as indicated. Allergic to cats and dogs

OBJECTIVE (O):**MENTAL STATUS EXAM:**

Appearance: well-kept

Behavior/Orientation: x4, appropriate

Abnormal Movements: trichotillomania-back of hair picking- 25% of waking hours

Rapport: appropriate

Speech: non pressured

Mood: grumpy per report, but presents pleasant

Affect: full ranging

Thought Process: clear, direct, oriented

Thought Content: non delusional

Judgment: good

Insight: good

Impulsivity: none impulse- hx of ETOH

Cognition: Average

Fund of Knowledge: well

OTHER OBJECTIVE FINDINGS/LAB RESULTS:**ASSESSMENT (A):****DIAGNOSIS:**

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

anxiety d/o

SAFETY RISK:

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ HighHarm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.☐ Patient released to Chain of Command with the following limitations: _____**LEARNING/NEEDS ASSESSMENT:**

Patient would like the following information at this appointment: none

PLAN (P):

Patient was educated about and stated understanding of the diagnosis and treatment options. Patient collaborated on and agreed to the following treatment plan:

High Interest Case? No

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____Labs: ☒ CBC ☒ LFTs ☒ TSH ☒ Chem 8 ☐ Lipids☒ Fasting Glucose ☒ HCG ☒ UDS ☒ Vit B12 ☐ _____Safety Plan:

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety

Goal: reduction

Objective: sx reduction by 20% next BHDP screening

Intervention: TMS

Measure: GAD score 20 9/13/17 indicating severe anxiety

Progress: to be determined sm recently started TMS anxiety treatment on 9/13/17

Problem #2: depression

Goal: reduction

Objective: sx reduction by 20% next BHDP screening

Intervention: medication increase Effexor 150 mg to 225 mg on 9/6/17

Measure: PHQ9 severe 21 depression score

Progress: sm reports increase severity due to circumstantial due to command stress

Therapy Type: CBT, DBTPlanned Frequency:

Patient's capacity to participate in and benefit from therapy is evidenced by:

☒ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication:

Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery. Patient reports taking medications as prescribed: Yes/No
Patient reports following changes in medication:

MED	SIG	Target Dose	Target Symptoms
Effexor XR 225 mg daily			for depression and anxiety treatment
Rozarem 8 mg qhs			for sleep -sm has not started medication yet
Naltrexone 50 mg daily			prevent ETOH cravings

Other Interventions (Social, Occupational, Case Management): recreation therapy referral entered 9/13/17

Prognosis:

[] Excellent [] Good [] Fair [x] Guarded [] Poor

Follow-up: PSYCHIATRY/WRNMMC KEMEZIS,PAT 26Sep2017@1000 GRP/90 PENDING

PSYCHIATRY BE/WRNMMC PAUL,SHERIN 27Sep2017@1000 FTR/60
PSYCHIATRY BE/WRNMMC TOBAR,EDEN 27Sep2017@1100 FTR/30
Sm scheduled to be discharged from PCS 9/21, will continue to present for TMS only

Referrals: recreation therapy, TMS

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile:**SM in process of MEB**

Is Service Member able to carry and fire weapon, from a Behavioral Health perspective (safety)? **No**
Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
Is Service Member able to deploy? **No**
Can Service Member perform MOS duties? **No**

A/P Last updated by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1 ADDITIONAL
PROVIDER(S): POURZAND,MIRIAM
-Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH,ANNE MARIE @ 14 Sep 2017 1304 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 14 Sep 2017 1304

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 14 Sep 2017 0951 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 13 Sep 2017 1553 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29615608 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **13 Sep 2017 1159 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1334 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 1159 EDT LST

S/O Note Written by SMITH, JESSICA ANN @ 13 Sep 2017 1327 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at: 1230

Program Track:

(x) Comprehensive Recovery Program (CRP)

() Interpersonal Recovery Program (IRP)

() Trauma Recovery Program (TRP)

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by EARLEY, KERRIE GLYN @ 14 Sep 2017 0635 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Service Dog Training Group 1230-1405 -Facilitated by Kerrie Earley, LCSW; SPC Santiago, behavioral health tech Co-Led by Jen Blessing service dog trainer

Purpose: This group's intent is to provide a therapeutic opportunity for active hands on involvement in process training dogs in the service dog training program. The group reviews the concept of mindfulness and provides an experiential opportunity to incorporate skills into daily life. In attempt to bridge the gap between information and application, this group provides a practical exercise to apply coping skills in action within a safe supportive environment.

Group members review concepts of mindfulness practice and considered how those skills may be useful with service dog training as well as in other areas of their lives. Patients were asked to be mindful about their own moods, reactions, and behaviors in addition to the dogs. Patients were guided through training exercises, and were given time to pet the dogs and ask questions. Participation: This patient was very motivated and engaged. He reported a strong connection with dogs and had working knowledge of training. He noted the possibility that it is something he wants to pursue further.

Next opportunity for art, recreational, and off-unit activities will occur next Wednesday. Service Dog Training group is held twice monthly. No suicidal, homicidal, plan or intent present.

S/O Note Written by SMITH, JESSICA ANN @ 14 Sep 2017 0843 EDT

History of present illness

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at: 1420

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Group Interview x 1

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 14 Sep 2017 1327 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 14 Sep 2017 1327

CHANGE HISTORY

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 14 Sep 2017 0844 EDT - see above. Previous Version of A/P section was entered/updated by EARLEY,KERRIE G @ 14 Sep 2017 0636 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical RecordAnderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by EARLEY, KERRIE G @ 14 Sep 2017 0636 EDT:

The A/P section was last updated by EARLEY, KERRIE G @ 14 Sep 2017 0636 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 13 Sep 2017 1334 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safer/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29615449 Primary Dx: Alcohol dependence, uncomplicated

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Sep 2017 1100 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

jbf

Note Written by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1227 EDT**Focus Of Session: Recent Cravings**

S) SM reported that he has been having less frequent IBS episodes but reported that when they do happen they are more intense. SM stated that he has been doing the gratitude list as a family text and while sometimes it's difficult to find things to be grateful for it is forcing dialogue with his family. SM reported he's been less successful with his "to do list" goals, but agreed to step back from trying to accomplish one goal a day and try to accomplish 2-3 goals per week instead. SM stated he went to one meetings in the last 3 weeks and found it "ok". SM agreed to continue going to one meeting per week. SM reported he is not sure if PCS is helpful and is not learning many new skills but is finding some self discovery through group discussion. SM reported he has two weeks of groups left and then he will continue getting TMS through PCS for another 2 weeks. SM stated he's been having more cravings and shared that his BH provider may switch him from Naltrexone to Campral. SM stated he's been getting through the cravings by eating and sleeping. He stated his anxiety is also increasing and was able to identify some of the reasons this may be happening. SM reported he had a preliminary sleep study which resulted in a consult to the sleep clinic. SM reported he is hopeful that if his sleep improves his anxiety, cravings and concentration issues may also improve. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that are being addressed through PCS and BH. SM would benefit from engaging in community recovery. Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week. SM will work on treatment planning goals as homework.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1153 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 13 Sep 2017 1159 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 13 Sep 2017 1228

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29608213 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Sep 2017 0752 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 13 Sep 2017 1345 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 0752 EDT
TMS

S/O Note Written by BRAGGS, DEBORAH C @ 13 Sep 2017 1236 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed.

Procedure: MT 120%. TMS Treatment for anxiety session #2 at none therapeutic level; administered using settings of 1500 pulses given at 1 pulses per second, with 26 second stimulation times, in 4 second intervals for a total of stimulation time of 29.50 minutes. A procedural time out was done during which settings and patient was re-identified.

PROGRESS IN MEETING GOALS:

This is session # 2 with MT level at non-therapeutic treatment level for entire session.

Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

S/O Note Written by BAHROO, BHAGWAN A @ 13 Sep 2017 1341 EDT

Reason for Visit

Visit for: Transcranial magnetic stimulation for Anxiety (12:15-13:00).

Subjective

A procedural time out was done during which settings and patient was re-identified.

Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.

Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.

Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos

SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0

Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.

Adjustments were made to accommodate comfort.

This session number 2 started at 95% and ended with 120% MT.

Objective

Next session was scheduled.

A/P Last Updated by BAHROO, BHAGWAN A @ 13 Sep 2017 1344 EDT

1. Generalized anxiety disorder

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Procedure(s): -Subsequent High Focal Magnetic Pulses For Cortical Neuron Stimulation x 2 ADDITIONAL
 PROVIDER(S): BAHROO,BHAGWAN A; BRAGGS,DEBORAH C

Disposition Last updated by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C,Psychiatry Continuity Service, WRAMC) @ 13 Sep 2017 1346

CHANGE HISTORY

The following Disposition Note Was Overwritten by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT:

The Disposition section was last updated by LANDE,RAYMOND G. @ 13 Sep 2017 1345 EDT - see above. Previous Version of Disposition section was entered/updated by BAHROO,BHAGWAN A @ 13 Sep 2017 1345 EDT.

Released w/o Limitations

Follow up: as needed in 1 day(s) with PCM and/or in the PSYCH DAY HOSP BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

13 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29608135 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Sep 2017 0750 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1006 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 13 Sep 2017 0750 EDT
IOP

S/O Note Written by HART, DANIEL C @ 13 Sep 2017 1111 EDT

History of present illness

The Patient is a 32 year old male.

Core Beliefs

IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Dan Hart, M.D., J.T. Cederberg, D.O., and Sam Woodlee, MS4

Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored understanding and identifying core beliefs. Patients also discussed how core beliefs are related to their automatic thoughts and emotional experiences. Intervention: Discussion of maladaptive and adaptive core beliefs and how to support/challenge them. Participation: Patient initially stated that he was "indifferent" at the outset of the group but later was attentive throughout psycho education and participated in group discussion - he volunteered to share his core belief and the rest of his worksheet. No evidence of SI/HI. Next group session is ABCDE Model.

S/O Note Written by SMITH, JESSICA ANN @ 13 Sep 2017 1317 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-In at :0750

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH, JESSICA ANN @ 13 Sep 2017 1321 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100
5 min Check-Out at :1015

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 13 Sep 2017 1325 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by GHOLSON,GEORICA K @ 13 Sep 2017 1346 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Dr. Gholson, Ph.D. Co-facilitators: Dan Hart, M.D., J.T. Cederberg, D.O., and Sam Woodlee, MS4

Purpose: To provide psycho education on cognitive behavioral therapy and application. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Today patients explored understanding and identifying core beliefs. Patients also discussed how core beliefs are related to their automatic thoughts and emotional experiences. Intervention: Discussion of maladaptive and adaptive core beliefs and how to support/challenge them. Participation: Patient was attentive throughout psycho education and participated in group discussion. No evidence of SI/HI. Next group session is 20 September 2017.

S/O Note Written by POURZAND,MIRIAM @ 13 Sep 2017 1418 EDT**History of present illness**

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

0945-1010 met with SM for follow up. Sm reports anxiety and depression remains aware Effexor recently increased from 150 to 225 mg daily. Also aware recently started TMS so TMS and effexor should be beneficial in sxs reduction but will take some time. Sm reports sleep problems taking melatonin in the past and somewhat effective. Rozorem 8 mg qhs ordered reviewed administration and potential side effects. Sm aware to take medication on an empty stomach. Also discussed discharge planning referral entered for rec therapy as adjunct treatment. Also gave sm list of discharge appts as sm has end date of 9/21/17 will present only for TMS.

FOLLOW UP PLANS

end of the week

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal. Full range, stable, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

S/O Note Written by DEUTSCH, ANNE MARIE @ 13 Sep 2017 1626 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800-0850: Positive Psychology group, co-facilitated by Dr. Deutsch, psychologist and SPC Santiago, psychiatric technician. This group is designed to help members learn ways to increase well-being, meaning, and joy in their lives using research-based methods of positive psychology. The model used is that developed by Martin Seligman, using the PERMA acronym: positive emotion, engagement, relationships, meaning and accomplishment. Today's group was a discussion of positive emotion. Members discussed "what constitutes a good life?", then identified positive emotions which come from each of our senses. This SM. There was no evidence of SI/HI. Released without limitations to attend 0900 group. Next Positive Psychology group will meet in one week.

A/P Last updated by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):	-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1
Consult(s):	-Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE Provisional Diagnosis: Generalized anxiety disorder

Disposition Written by POURZAND, MIRIAM @ 14 Sep 2017 1320 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 14 Sep 2017 1321**CHANGE HISTORY*****The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT:***

The A/P section was last updated by POURZAND, MIRIAM @ 13 Sep 2017 1423 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 13 Sep 2017 1325 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

Consult(s):

-Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE

Provisional Diagnosis: Generalized anxiety disorder

The following A/P Note Was Overwritten by SMITH, JESSICA ANN @ 13 Sep 2017 1322 EDT:

The A/P section was last updated by SMITH, JESSICA ANN @ 13 Sep 2017 1322 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 13 Sep 2017 1043 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Consult(s):

-Referred To: OCCUPATIONAL THERAPY MTF BE (Routine) Specialty: THERAPY, OCCUPATIONAL Clinic: OCCUP THERAP BE

Provisional Diagnosis: Generalized anxiety disorder

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29599553 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **12 Sep 2017 1153 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 1153 EDT TRP

S/O Note Written by VANFOSSEN, MALLORY B @ 12 Sep 2017 1336 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1150.
Pt denies SI/HI.
Pt reports the following appts this afternoon: 1200 TMS. No PM programming.

S/O Note Written by VANFOSSEN, MALLORY B @ 12 Sep 2017 1337 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1300.
Pt denies SI/HI.
Pt reports following appts on tomorrow, 13 September: 0900 individual therapy, 1200 TMS.
Pt will return to program tomorrow at regularly scheduled time.

A/P Last Updated by CLOPPER, TAMMY J @ 12 Sep 2017 1306 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Disposition Written by POURZAND, MIRIAM @ 13 Sep 2017 1357 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 13 Sep 2017 1357

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29599549 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **12 Sep 2017 1152 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 1152 EDT
TMS

S/O Note Written by GHURANI, SAWSAN @ 12 Sep 2017 1324 EDT

History of present illness

The Patient is a 32 year old male.
A procedural time out was done during which settings and patient was re-identified.
60 minutes.
Purpose of visit was for the initial session of Transcranial Magnetic Stimulation to determine level and location.
Thought content was without evidence of suicidal or homicidal ideation and patient behavior during the session was appropriate.
Patient arrived for TMS anxious. Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos
SM was a bit less anxious as procedure unfolded. At conclusion of the procedure the settings were determined to be: SOA = 30, AP Bar = 10.7, Coil Angle = 10.0, SMT = 0.94; The headrest settings were: up/down 7.5; front/back 1.0
Treatment administered using standardized settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 16 second intervals for a total stimulation time of 22.04 mins.
Adjustments were made to accommodate comfort.
This session number 1 ended with 95% MT.

S/O Note Written by BRAGGS, DEBORAH C @ 12 Sep 2017 1349 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Pre procedure: Thought content was without evidence of suicidal or homicidal ideation and SM behavior during the session was appropriate; SM arrived for TMS without evidence of distress.
Confirmed that there was no metal above the waistline, no history of seizure disorder, no physiologic sensing devices, no metallic facial or neck tattoos. SM placed ear plugs in his ears. SM was placed into the chair and placed into the Head Support System with guidance tape adhered to the forehead. Laser light used for midline placement and lateral canthus alignment completed. Up/Down 7.5, Side/Side 1, LLC 1.0, MT .94, SOA 30, AP 10.7, Coil +10.
Procedure: MT 80% up to 95%. TMS Treatment for depression session #1 at non therapeutic level; administered using settings of 3000 pulses given at 10 pulses per second, with 4 second stimulation times, in 12 second intervals for a total of stimulation time of 22.04 minutes. A procedural time out was done during which settings and patient was re-identified.
PROGRESS IN MEETING GOALS:
This is session # 1 with MT level at non-therapeutic treatment level for entire session.
Post Procedure: SM monitored briefly. SM had no reports of distress associated with TMS. PLAN: Data is reviewed with treatment team and data did not suggest any changes to treatment plan at this time. Treatment plan will continue as is pending further review. Next session scheduled for tomorrow.

A/P Last Updated by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Delivery Of High Focal Magnetic Pulses For Cortical Neuron Stimulation x 1

Disposition Last Updated by LANDE, RAYMOND G. @ 12 Sep 2017 1339 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 13 Sep 2017 0659

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

12 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29592059 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **12 Sep 2017 0755 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 13 Sep 2017 1350 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 12 Sep 2017 0755 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by DONKIN, LAURA G @ 12 Sep 2017 1117 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0900-1000. SM presented in positive mood. SM started off discussing his future career, as he has been pondering this. He feels that his current job with NSA in IT has been very stressful and wonders whether the financial benefit is worth the anxiety. SM said that he loves to cook and wonders if that can be turned into a career. This SW pointed out that a career in computers does not necessarily mean that it will be stressful and that SM is very talented in this field. SM replied that this is true and will give this some more thought. SM said that he will be starting VA medical appointments in about a week for his medical board. We explored the current state of his anxiety and depression. SM is to start TMS treatments for anxiety today at noon. SM said that he has learned some new things about himself while in groups and gave some examples. He mentioned that he talked with estranged sister last Friday and told her that he would like to meet with her and talk about his sexual molestation of her when they were adolescents. SM reported that sister said that she is open to discussion and moving forward. SM is to think about what he would like to focus on in therapy for his final week at PCS. We will meet again on Friday. No SI/HI plan or intent present.

S/O Note Written by LOWENSTEIN, HELEN T @ 12 Sep 2017 1210 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Distress Tolerance Group, (1000-1050). Facilitated by Ms. Helen Lowenstein,

LCSW and SPC Santiago. Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis. Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.

Topic: Self soothing skills ways to incorporate old and new coping patterns for healthier outcomes. First hand out provided

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

was Self Soothing Comforting yourself through the five senses and it listed the five as Touch, Hear, See, Taste, & Smell. The 2nd hand out provided was the Road to a Life Worth Living. One side of the pyramid was the problems, and things to decrease, the other side DBT skills and increase. These hand outs sparked lively discussions on ways to incorporate and adopt healthy coping skills in distressing situations.

PARTICIPATION: Pt was an quiet throughout most of the group, however, shared he uses coffee as his go to coping skill because of the taste and smell and food at times especially love of pizza helps him when in distress to calm down. No evidence of SI/HI. Next group to meet 09/19/17 at 1000.

S/O Note Written by HARDY,MARGARET L @ 12 Sep 2017 1216 EDT

Therapy

Intervention This Appointment - Group Therapy.

Intervention This Appointment - Dialectical Behavior therapy (DBT)- emotion regulation.

S/O Note Written by VANFOSSEN,MALLORY B @ 12 Sep 2017 1328 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0800.

Pt denies SI/HI.

Pt reports following appts this morning: 0900 individual therapy, 1200 TMS, No PM program today.

S/O Note Written by VANFOSSEN,MALLORY B @ 12 Sep 2017 1329 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1055

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by DONKIN,LAURA G @ 12 Sep 2017 1127 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by POURZAND,MIRIAM @ 13 Sep 2017 1351 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 13 Sep 2017 1351

CHANGE HISTORY

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 12 Sep 2017 1127 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 12 Sep 2017 1127 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 12 Sep 2017 0935 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 12 Sep 2017 0757 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29582912 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **11 Sep 2017 1133 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM****AutoCites** Refreshed by POURZAND, MIRIAM @ 12 Sep 2017 1114 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 11 Sep 2017 1133 EDT
CRP

S/O Note Written by GHOLSON, GEORICA K @ 11 Sep 2017 1341 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: EXPLORATION OF STIGMA @1230-1320

Facilitators: Georica Gholson, PhD, psychologist and Tammy Buford, psychiatric clinical nurse.

PURPOSE: The purpose of this group is to help patients gain an understanding about mental health stigma. Additionally, the group discusses mental health stigma within the military, their family and friends and in other settings. Also, the group learns about myths and facts related to mental health disorders.

TOPIC: Group discussion centered on internalized mental health stigma. Group members took a quiz to determine the degree of the own internalized mental health stigma. Group discussed thoughts and beliefs they held about their diagnosis as well as ideas that they disagreed with.

PARTICIPATION: SM arrived late to group due to a previous appointment. However, he was actively engaged and offered insightful commentary and suggestions to other group members. Also, SM shared a video on depression with the group that he said helped him explain his mental illness to those around him. No evidence of SI/II. Next group session is 25 September 2017.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1518 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at: 1135

Program Track:

(x) Comprehensive Recovery Program (CRP)

() Interpersonal Recovery Program (IRP)

() Trauma Recovery Program (TRP)

() Leisure Skills Training (LST)

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1520 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by POURZAND,MIRIAM @ 12 Sep 2017 1114 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

Disposition Written by POURZAND,MIRIAM @ 12 Sep 2017 1114 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 12 Sep 2017 1117**CHANGE HISTORY****The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 12 Sep 2017 1114 EDT:**

The A/P section was last updated by POURZAND,MIRIAM @ 12 Sep 2017 1114 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 11 Sep 2017 1521 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Group Interview x 1
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 11 Sep 2017 1521 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 11 Sep 2017 1521 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON,GEORICA K @ 11 Sep 2017 1343 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Group Interview x 1

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

11 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29577207 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Sep 2017 0842 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 12 Sep 2017 1107 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 11 Sep 2017 0842 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 11 Sep 2017 1032 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 11 Sep 2017 1033 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMON CONCERNS GROUP - "0900-0950" Facilitators: This group was co-led by Ms. Lowenstein, LCSW and Ms. Delacie Gardiner.

PURPOSE: The purpose of this group is to allow group members to identify and process common emotional states and how to cope with states using various CPT/DBT techniques. Group members will discuss topics such as anxiety, depression, insomnia, grief, anger, etc, and connect with each other on an emotional level with other group members. This group consists of all three IOP tracks: IRP, CRP, TRP.

TOPIC: Conflict Resolution Tips. Patients were provided a hand out with 12 conflict resolution tips. Each tip was identified and explained in the hand out. Patients were asked to discuss the steps and how they can adopt healthier skills with conflict. This opened up a lively discussion on different ways to handle conflict resolution in a more constructive way.

PARTICIPATION: This group is co-led by two providers to address the high acuity of the group members and to have a staff member available should a group member become triggered in the group. This also allows for the other staff member to monitor behaviors and participation attentively. SM was quiet throughout the group. SM appeared to be listening as evidenced by head nodding, and direct eye contact. No evidence of S/I or H/I. Next group scheduled for 09/18/17 at 0900.

S/O Note Written by CLOPPER, TAMMY J @ 11 Sep 2017 1057 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group: "Taking Good Care of Yourself" 0800-0850 Facilitators: Dr. Gragnani and Tammy Buford, RN.

PURPOSE: The purpose of this group is based on five central ideas (1) safety as the priority of this first-stage-treatment (2) integrated treatment of PTSD and substance abuse (3) a focus on ideals (4) four content areas: cognitive, behavioral, interpersonal, and case management and (5) attention to the therapist processes.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

TOPIC: This group focused on "Taking Good Care of Yourself" in which patients were asked to evaluate whether they are taking good care of themselves. Patients filled out the questionnaire and discussed their answers.

PARTICIPATION: SM attended group, was attentive to facilitators and participated in group discussion. SM reports feeling grumpy d/t being late this morning from 3 car accidents on the way to programming. States his weekend was ok, stating he went to a friend's house and watched a movie and had dinner. States on Sunday he had to go to the VA for an appointment then went on a date. States he also talked to his family. No evidence of SI/HI. Next group 18Sept2017.

S/O Note Written by DEUTSCH,ANNE MARIE @ 11 Sep 2017 1130 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1000-1100: Sleep Improvement Group in IOP. Group led by Dr. Deutsch, psychologist. This was the first session of the 4-week sleep improvement series, which meets to address insomnia and nightmares from a CBT-I perspective. Members were introduced to the topic of sleep as a whole, and were given a National Sleep Foundation quiz on their knowledge about sleep. Patients were given handouts on sleep architecture and sleep hygiene. A lively discussion ensued re: the relationship between dreams and anxiety. This SM was attentive and well-engaged throughout. No evidence of SI/HI. Next sleep improvement group will meet in one week.

S/O Note Written by DONKIN,LAURA G @ 11 Sep 2017 1147 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0805

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN,LAURA G @ 11 Sep 2017 1147 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at : 1055

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

A/P Last updated by DONKIN,LAURA G @ 11 Sep 2017 1149 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by POURZAND, MIRIAM @ 12 Sep 2017 1112 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 12 Sep 2017 1112

CHANGE HISTORY

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 11 Sep 2017 1149 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 11 Sep 2017 1149 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

--> Unassociated Orders, Procedures and Injuries/Accidents <--

INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 11 Sep 2017 1104 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 11 Sep 2017 1033 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by GRAGNANI, CYNTHIA T

Encounter ID: BETH-29568630 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Sep 2017 1243 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **GRAGNANI, CYNTHIA
 THERESA**

Reason for Appointment: Written by CLOPPER, TAMMY J @ 08 Sep 2017 1243 EDT
 CES

Appointment Comments: Written by CLOPPER, TAMMY J @ 08 Sep 2017 1243 EDT
 TB

S/O Note Written by CLOPPER, TAMMY J @ 08 Sep 2017 1244 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 1000-1030 Registered Nurse met with the patient today for a follow-up Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, and insomnia. The patient was given directions about completing the Alpha-stim session. Before the initiation of the protocol the patient reported that he slept 7 hours interrupted sleep last. The intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The patient was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The patient was scheduled for a follow-up appointment Monday.

A/P Last Updated by CLOPPER, TAMMY J @ 08 Sep 2017 1245 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
 PROVIDER(S): CLOPPER, TAMMY J

Disposition Written by GRAGNANI, CYNTHIA T @ 08 Sep 2017 1455 EDT

Released w/o Limitations

Follow up: with PCM.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GRAGNANI, CYNTHIA T (Physician) @ 08 Sep 2017 1455

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29568374 Primary Dx:

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **08 Sep 2017 1229 EDT**
Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
Provider: **POURZAND, MIRIAM**

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 1229 EDT
TRP

Appointment Cancelled by Facility

Encounter Cancelled by POURZAND, MIRIAM @ 08 Sep 2017 1413 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29567981 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Sep 2017 1202 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 11 Sep 2017 0817 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 1202 EDT
CRP

S/O Note Written by CLOPPER, TAMMY J @ 08 Sep 2017 1248 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check IN PM - Intensive Outpatient Program (IOP) Team A

Check- In Time: 1202

Afternoon Track: CRP

Appointments Reported this afternoon: None

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by CLOPPER, TAMMY J @ 08 Sep 2017 1412 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Check OUT PM - Intensive Outpatient Program (IOP) Team A

CHECKOUT TIME: 1403

Afternoon Track: CRP

Appointments Reported for Monday: None

Pain level Reported (0-10): Denies

Psychiatric Exam: SM denied Suicidal Ideation/Homicidal ideations.

S/O Note Written by MILLER, PENNY E @ 08 Sep 2017 1447 EDT

Reason for Visit

Visit for: (1230-1400) Comprehensive Recovery Program- Recreation Therapy- Facilitators: This writer Penny Miller, recreation therapist, Narcedalia Pratt, social worker and Jessica Shipman, WRNMMC Hospital Recreational Arts Coordinator.

Purpose: This session provided the patients with the opportunity to be creative, self-reflect and apply safe coping skills.

Activity: Patients were introduced to the activity of "Japanese Book Binding". Patients were provided with step-by step instruction in order to complete the process. Steps for book making consisted of cutting, folding, and prepping pages, clamping materials and piercing holes with an awl, and weaving binding thread through to secure pages. Patients were provided with tools, materials, and instructions, and were then given time to independently work. When finished, pts were given the opportunity to share their book with the group and discuss their experience, as well as coping skills used during the process. Patients were encouraged to think about how they can transfer the skills used during the session into their daily lives.

Participation: This patient was actively involved in the book making process. Patient used creative abilities to express thoughts

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

and emotions in a new way. Patient was focused and concentrated and completed the process. Next Comprehensive Recovery Program, Recreation Therapy session is scheduled for Friday September 22, 2017.

S/O Note Written by PRATT,NARCEDALIA @ 08 Sep 2017 1459 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program- Recreation Therapy (1230-1400) - Staff present: Penny Miller, recreation therapist, Narcedalia Pratt, social worker and Jessica Shipman, WRNMMC Hospital Recreational Arts Coordinator.

Purpose: This session provided the SM with the opportunity to practice creativity and utilize a new outlet for expression.

Activity: "Japanese Book Binding". This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

Participation: SM participated in the book making activity. SM used creative abilities to express thoughts and emotions in a new way.

There was no indication of SI/HI present. The next group session will be held on Friday September 22, 2017.

A/P Last updated by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 11 Sep 2017 0817 EDT

Released w/o Limitations

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 11 Sep 2017 0817

CHANGE HISTORY

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 08 Sep 2017 1501 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 08 Sep 2017 1248 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 13 Nov 2017

movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29562511 Primary Dx: Insomnia, unspecified

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2017 0807 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE, RAYMOND G.**

AutoCites Refreshed by LANDE, RAYMOND G. @ 08 Sep 2017 0945 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 0807 EDT
SLEEP ASSESSMENT

S/O Note Written by LANDE, RAYMOND G. @ 08 Sep 2017 0946 EDT

Reason for Visit

Visit for: Attending Note: SM referred for enhanced sleep assessment.
45 minutes.

History of present illness

The Patient is a 32 year old male.

He reported: Sleep This was a valid study. Total Sleep time = 6 hours and 16 minutes. The pApnea/Hypopnea index = 8.3, Mean oxygen saturation = 94, Mean heart rate = 67, Rapid eye movement (REM) % = 17.93, Deep Sleep % = 4.92, Light Sleep % = 77.16 Wake % = 18.33, Sleep latency (minutes) 23, REM latency (minutes) 174, Number of Awakenings = 11, BMI=23.5, The SM had two REM episodes. The SM appeared to awaken from light sleep.

Objective

Plan: SM has screening evidence for mild breathing problems while asleep. SM has decreased deep sleep and REM sleep latency. Consider referral to sleep clinic.

A/P Written by LANDE, RAYMOND G. @ 08 Sep 2017 0948 EDT

1. Insomnia, unspecified

Procedure(s): -Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time x 1

Disposition Written by LANDE, RAYMOND G. @ 08 Sep 2017 0949 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 08 Sep 2017 0949

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29562379 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2017 0800 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 11 Sep 2017 0806 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 08 Sep 2017 0800 EDT
IOP

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1113 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0800

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1114 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10)

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by DONKIN, LAURA G @ 08 Sep 2017 1246 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0900-0945. SM presented in positive mood and was talkative throughout session. SM had just returned from some psychological testing.

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Additional testing for Autism had been requested by this SW. We discussed SM behaviors and whether or not he felt that these behaviors meet the criteria for Autism. SM feels that knowing his diagnosis will be helpful to understand his limitations and to make future plans for his career. In general SM feels that his anxiety has gone down in the past few days. He is not sure if this is due to medications or the lessening of stress, as he is not working. He said that his providers have differing viewpoints as to his future in the military. Dr. Paul is advocating for SM to be separated from military but Dr. Tobar would like SM to continue to get more mental health treatment. Dr. Pourzand entered and joined discussion on treatment for about 10 minutes. We also discussed SM's Irritable Bowel Syndrome. SM reported that he has scheduled weekend plans and is pleased that he will not be isolating. We will meet again on Tuesday. No SI/HI plan or intent present.

S/O Note Written by SMITH,JESSICA ANN @ 08 Sep 2017 1319 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Innovations Group 20 min group-(SM dispersed into individual innovations) facilitated by: Ms. Buford, Ms. Braggs, Dr. Pourzand, Mrs. Smith. During this group the SM were given the opportunity to learn about the various types of innovations offered at PCS to include light therapy, Alpha-Stim CES/MET, Brain Computer Interface, MindFlex, MUSE, and temple massager. SM participated in group. SM engaged in individual innovative activity (see individual encounter in AHLTA) . No indication of distress. No indication of SI/HI. Next group Friday.

S/O Note Written by SMITH,JESSICA ANN @ 08 Sep 2017 1517 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by SMITH,JESSICA ANN @ 08 Sep 2017 1518 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2
-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
ADDITIONAL PROVIDER(S):
SMITH,JESSICA ANN

Disposition Written by POURZAND.MIRIAM @ 11 Sep 2017 0806 EDT

Released w/o Limitations

Follow up: 3 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 11 Sep 2017 0807

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

CHANGE HISTORY**The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 08 Sep 2017 1518 EDT:**

The A/P section was last updated by SMITH,JESSICA ANN @ 08 Sep 2017 1518 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 08 Sep 2017 1256 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2

-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 08 Sep 2017 1116 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 08 Sep 2017 1116 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER,TAMMY J @ 08 Sep 2017 0822 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

08 Sep 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-29562639 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **ANDERSON, DANIEL D**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **08 Sep 2017 0800 EDT**
Clinic: **PSYCHOLOGY ASSESSMENT BE**Appt Type: **PROC**
Provider: **BENTON, JIKESHA R****AutoCites** Refreshed by BENTON, JIKESHA R @ 08 Sep 2017 1440 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING	3 of 3	06 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	#0 RF3 TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment:

F/U Testing

Appointment Comments:

CAC

S/O Note Written by BRYANT,JASMINE RESHAE @ 08 Sep 2017 0846 EDT**Objective**

Assessment: 2 hours. SM was escorted by writer from PDS lobby to RM 4116 for continued DX testing. Testing was completed 8 DEC 2016. SM was sociable, paranoid, and cooperative during testing AEB asking if he could "get into trouble over testing answers?" SM reported "abusing prescribed medications" in order to "feel high" and stated he was worried about "being honest." SM was redirected and continued with testing. SM stated mood was "anxious, energetic, and content" and his affect was bright and congruent with mood. SM reported 2-3 weeks of increased "anxiety" due to "everyday" triggers. SM reported a "normal" appetite with 1-2 small meal consumption throughout the day. SM reports having chronic IBS and is currently MEDBRD out of the military due to its "discomfort." SM reported a significant weight loss of 12lbs within a 60 day period. SM reports he is reframing from alcohol and it could be his "main contributor" to his recent weight loss. SM reported a "poor" sleep pattern with difficulty staying asleep with a possible sleep disorder. SM reports 6-7 hours of restless sleep per night with a medication aid to "slight" effect and relief. SM reported experiencing sleep paralysis on a "frequent" basis and vivid nightmares about "real life situations." SM denied to clarify. SM is currently awaiting a sleep study with the Sleep Clinic here at Walter Reed. SM reports a 2/10 intestinal pain. SM also has a H/O of headaches/migraines but, did not experience any while testing. SM currently denies any SI/HI/AVH. SM escorted himself back to IOP and was advised to speak with social worker before resuming scheduled activities. Writer informed front desk of SM arrival.

Tests

PAI, AQ completed today

Testing completed 8 DEC 16 MMPI-II, MCMI, RISB

Plan

Limits of confidentiality was explained and understood by SM. Original documentation can be found in BLD 10 7C RM 7131. DX Interview to be scheduled and completed by Dr. Benton.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT**1. Major depressive disorder, recurrent, moderate**

Procedure(s): -Psychologic Testing And Report Administered By Technician x 2

Disposition Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 08 Sep 2017 1442

Note Written by BENTON, JIKESHA R @ 14 Sep 2017 1516 EDT**(Added after encounter was signed.)****Psychological Evaluation Addendum****WALTER REED NATIONAL MILITARY MEDICAL CENTER***8901 Rockville Pike, Bethesda, Maryland 20889-5600***DEPARTMENT OF BEHAVIORAL HEALTH CONSULTATION AND EDUCATIONAL SERVICES****PSYCHODIAGNOSTIC ASSESSMENT SERVICE****8901 Wisconsin Ave****Bethesda, MD 20889****PSYCHOLOGICAL EVALUATION ADDENDUM****NAME:** Daniel Anderson (nee Merwin)**RANK:** PO2**SSN:** 20/8503**DATE:** 01AUG17**IDENTIFYING AND REFERRAL INFORMATION:** SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

It should be noted SM received a psychological evaluation conducted by 2LT Hannah Martinez, Doctoral Practicum Student, with PsychoDiagnostic Assessment Services on 02FEB17. This writer served as a covering supervisor for the psychological evaluation. SM was referred for the psychological evaluation by Dr. Sherin Paul, Clinical Psychologist, with Adult Outpatient Behavioral Health for diagnostic clarification. The consult indicated SM has a history of undiagnosed Borderline Personality Disorder and Reactive Attachment Disorder. SM's family history is also significant for Bipolar Disorder.

On 08SEP17, SPC Jasmine Bryant administered the Personality Assessment Inventory (PAI) and Autism Spectrum Quotient (AQ). 2LT Hannah Martinez administered the Minnesota Multiphasic Personality Inventory-2nd edition (MMPI-2), Million Clinical Multiaxial Inventory-Third Edition (MCMI-III), and Rotter Incomplete Sentence Blanks (RISB) on 02FEB17. This writer conducted a collateral interview with Ms. Despina Hangemanole, Social Worker, with Addiction Treatment Services on 13SEP17. Dr. Benton conducted a collateral phone interview with Dr. Sherin Paul, Clinical Psychologist, with Adult Outpatient Behavioral Health on 14SEP17.

Please refer to AHLTA records and the original psychological evaluation for a comprehensive background history.

PSYCHOLOGICAL TEST RESULTS:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

MMPI-2: The validity indicators suggested that SM endorsed test items in a manner to cry for help. SM is likely to present with extreme somatic problems or chronic pain and to complain of being physically ill although there may not be an organic basis to his problems. He is anxious, tense, nervous, restless, irritable, dysphoric, brooding, and unhappy. He has a loss of initiative. He reported depressed mood, social withdrawal, and reclusiveness. He is self-conscious in talking with others. Doubts about his abilities are common, as is vacillation and indecision about even minor matters. SM is hypersensitive to criticism.

MCMI-III: The validity indicators suggested that SM was being open and honest. SM does not have any close friends, so he tends to remain detached and isolated. There is evidence that SM strongly wishes to be liked and accepted by others on his terms. He is often guarded and experience social situations negatively. SM is apprehensive and nervous in social situation. SM usually avoids relating to others, which forces him to give up the support and affect that the relationship might have brought. Life is experienced as a conflict between taking a risk and accepting the discomfort of forming a relationship or retreating to the unfulfilling safety of isolation.

PAI: The results of the PAI were considered invalid. SM consistently endorsed items that portrayed him in an especially negative or pathological manner. The test results involved considerable distortion and does not reflect an inaccurate reflection of SM's psychological functioning.

AIQ: The Autism Spectrum Quotient is a questionnaire used to determine the extent to which an adult of normal intelligence has the traits associated with Autism spectrum conditions. A content analysis of the AIQ indicated SM elevated on the measure due to his endorsement of social avoidance; he did not endorse the developmental criteria of Autism and Asperger's Disorder.

FINDINGS AND CONCLUSIONS: SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

Given all available information to include psychometric instruments, chart review, diagnostic interview, and collateral interviews, SM does not have Autism or Asperger's Disorder. SM does have relational apathy or a lack of emotional reciprocity but this is not enough to substantiate the disorder. SM has the ability to cultivate age appropriate friends and relationships. Furthermore, there is no impairment in the use of nonverbal behaviors. There is no impairment in communication particularly selective mutism that is commonly found with these disorders. There is no evidence of inflexible adherence to routines or rituals. He has not demonstrated persistent preoccupation with parts of objects. This writer did not observe repetitive motor mannerisms. SM's social detachment and emotional numbness could represent a schizoid adjustment, a neurotic reaction, abuse history, or simply a lifestyle preference yet it is not Autism.

There is evidence from testing of Schizoid Personality traits characterized as lack of interest in social relationships, a tendency towards a solitary or sheltered lifestyle, secretiveness, emotional coldness, detachment, and apathy. There is research to support that Schizoid Personality traits are developed due to an insecure attachment in childhood. This is consistent with his prior history of Reactive Attachment Disorder. However, SM grew up in an environment with physical, sexual, and emotional abuse. He was in a household with a father that had an authoritarian parenting style, which contributed to him being overly controlled, unable to express emotions, and living in fear. SM's emotional development is stunted due to the childhood environment he was reared. SM is emotionally immature; emotionally immature people can be extremely challenging to deal with, because their ability to interpret and react to the variety of life's challenges is often impaired. When emotionally immature people do not get their way, they often respond to their circumstances in ways that are irrational. They need to control and this lack of control motivates them to act out. They pout, whine, cry, manipulate, or violate the object of their obsession, all the whilst believing they are entitled to behave this way.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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SM has mood swings, anger outbursts, hyper sexuality, and suicidal ideations/gestures that can be function of his emotional immaturity. Although these behaviors can be symptoms of Borderline Personality Disorder, psychological test results do not support SM having a personality disorder. The hallmark feature of Borderline Personality Disorder is the fear abandonment. SM does not have a fear of abandonment. SM is introverted, socially withdrawn, and prefers his own company. Typically, SM cuts people off when they become too close to him. This seems to be more of a function of his schizoid personality traits and attachment style. When his personal space is violated, he feels suffocated and desires independence. It should be noted that like individuals with schizoid personality traits, SM is capable of developing relationships when they are based on his terms. His terms do not include emotional intimacy. For example, he desires to connect with his family of origin but with self-imposed boundaries. Additionally, SM indicated he has a relationship with his neighbors in which he can come and go friendly into their home without demands or expectations. This is how he desires all of his interpersonal and romantic relationships. SM is happiest when people place few emotional and intimate demands on him. It is not people that SM wants to avoid, it is the emotions but since there are no emotionless people it is easier to socially withdraw.

RISK ASSESSMENT: SM has a history of suicidal ideation occurring approximately once a month since adulthood. His protective factors include his job, his hobby of creating video games, and wanting to find purpose in his life. SM has low social support, but this does not seem to be a significant stressor. SM does not have a history of attempts and denies access to lethal means. He denied current ideation, plan, or intent. SM is currently assessed at a mild risk for suicide, and should continue to be monitored by his healthcare providers.

DSM-5 Diagnoses:

Given the level of information obtained for this assessment, the following DSM-5 diagnoses are warranted:

Other Specified Trauma and Stressor Disorder
Schizoid Personality Traits
Reactive Attachment Disorder – By History

If there is a need for further discuss of this case, please feel free to contact the undersigned at 301.400.0591.

Jikesha Benton, Psy.D.
Clinical Psychologist

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29555227 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Sep 2017 1213 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 08 Sep 2017 1240 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 1213 EDT
CRP

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1238 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1215 Check in to PCS afternoon program. SM denied SI/HI. Will attend afternoon groups.

S/O Note Written by DONKIN, LAURA G @ 07 Sep 2017 1414 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1230-1330. Intensive Sleep Improvement Group for CRP. Facilitator: Laura Donkin, LCSW-C. This bi-monthly group is meant to be an adjunct to the morning Sleep Improvement Group. In this group, members will explore their sleep issues in a more personal and intensive way. We review topics such as: napping, nightmares and sleep hygiene. Today we focused on the physiological and mental benefits of sleep. We discussed sleep hygiene and went around the room asking each group member what they're doing right and how they can improve. Group members discussed benefits of power napping. The group unanimously agreed to practice power napping for last 10 minutes of the group. SM actively contributed to group discussion. We will meet again on 21 September, 2017. No SI/HI plan or intent present.

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1447 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1430 Check out of PCS afternoon program. SM denied SI/HI. Tomorrow, 0800 psychological testing.

S/O Note Written by GHOLSON, GEORICA K @ 07 Sep 2017 1449 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: COMMUNICATION SKILLS

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician from 1330-1420.

Purpose of communication skills group is to explore and discuss components of communication among co-workers, peers, family, and friends, and to use effective communication strategies to enhance and improve relationships.

Intervention: Discuss and identify aspects of "fighting fair/unfair." Discuss elements of what constitutes a conflict and which behaviors can escalate a conflict. Additionally, group discussed how "unfair fighting" can become abuse and which behaviors are

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

considered verbal and emotional abuse. SM participated in group. He discussed how his father's conflict style influenced how he manages arguments. Additionally, he explained that he is passive in arguments and will stockpile. He was able to recognize how stockpiling can damage relationships and expressed how he struggles with confronting others about offenses in the moment

No indication of SI/HI.

Next group scheduled for 21 September 2017.

A/P Last updated by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 2

-Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 08 Sep 2017 1242 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 08 Sep 2017 1242

CHANGE HISTORY

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 07 Sep 2017 1448 EDT - see above.Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 2

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT:

The A/P section was last updated by DEUTSCH,ANNE MARIE @ 07 Sep 2017 1448 EDT - see above.Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 07 Sep 2017 1415 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

-Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 07 Sep 2017 1415 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 07 Sep 2017 1415 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT:

The A/P section was last updated by CLOPPER, TAMMY J @ 07 Sep 2017 1245 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 07 Sep 2017 1240 EDT.

1. Generalized anxiety disorder**Procedure(s):**

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by LANDE, RAYMOND G.

Encounter ID: BETH-29546622 Primary Dx: Insomnia, unspecified

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Sep 2017 0649 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **LANDE,RAYMOND G.**

AutoCites Refreshed by LANDE,RAYMOND G. @ 07 Sep 2017 0706 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 0649 EDT
SLEEP ASSESSMENT

S/O Note Written by LANDE, RAYMOND G. @ 07 Sep 2017 0720 EDT

Reason for Visit

Visit for: Attending Note: SM referred for enhanced sleep assessment. 45 minutes.

History of present illness

The Patient is a 32 year old male.

He reported: Sleep SM described sleep as follows. SM goes to bed at 2200 and awakens at 0600. During the night's sleep it takes SM 15 minutes to fall asleep after which SM awakens 2-3 times "noise, bathroom, dreams". SM feels "unrested" upon awakening. SM does not snore, does not talk in sleep and has no morning headaches. SM last use of alcohol two weeks ago. SM uses no nicotine.

Epworth = 18 PreSleep = 13/17 PIRS = 37.

Objective

Plan: SM instructed in proper use of device. Device passed test. SM instructed to return device tomorrow.

A/P Written by LANDE, RAYMOND G. @ 07 Sep 2017 0723 EDT

1. Insomnia, unspecified

Procedure(s): -Sleep Study Unattended Record: Heart Rate, O2 Sat, Resp Analysis, Sleep Time x 1

Disposition Written by LANDE, RAYMOND G. @ 07 Sep 2017 0723 EDT

Released w/o Limitations

Follow up: in the PSYCH DAY HOSP BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LANDE, RAYMOND G. (C, Psychiatry Continuity Service, WRAMC) @ 07 Sep 2017 0724

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

07 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29546619 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **07 Sep 2017 0648 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 08 Sep 2017 0852 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SUBL, SUBLINGUAL		UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 07 Sep 2017 0648 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 07 Sep 2017 0745 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0725 Check in to PCS Team A. morning program. SM denied SI/HI. Has 0830 orthodonture appt, which may be short or may be most of the day. He will call and let us know if it lasts more than an hour.

S/O Note Written by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Accountability- sm excused for psych testing.

A/P Last updated by POURZAND, MIRIAM @ 08 Sep 2017 0900 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Individual Approximately 30 Minutes x 1

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Disposition Written by POURZAND, MIRIAM @ 08 Sep 2017 0900 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 08 Sep 2017 0901**CHANGE HISTORY**

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 08 Sep 2017 0859 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 08 Sep 2017 0859 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following S/O Note Was Deleted by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT:

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

The following S/O Note Was Deleted by POURZAND, MIRIAM @ 08 Sep 2017 0857 EDT:

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: SM called at 0930 to say he will be at orthodontics longer than expected. He will come to afternoon groups when he is released.

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 07 Sep 2017 1129 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 07 Sep 2017 1032 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29542585 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **06 Sep 2017 1355 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1356 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)
- not maternal uncle's history of referred here (Maternal Uncle)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY	0 of 1	06 Sep 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE ONE CAPSULE BY 0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	MOUTH EVERY DAY #0 RF1 TAKE 2 BY MOUTH EVERY 2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	DAY #0 RF3 RINSE BY MOUTH ONE NR	09 Aug 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TIME PER DAY FOR 14 DAYS. #0 RF0	
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	TAKE ONE PACKET BY 1 of 1 MOUTH EVERY DAY #0 RF1	06 Jun 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	18 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
			NR 05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1355 EDT
Treatment Plan Update/BHDP Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1356 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Daniel Merwin 29 AUG

Follow-Up Data Only

Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 3 Currently treated: Yes

Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No

past attempts as of 09/06/2016: 3

Most recent Suicidal Ideation: 2-4 weeks ago

Suicidal Ideation Duration: Fleeting - a few seconds or minutes

Suicidal Ideation Frequency: Once a week

Protective Elements Stopping Suicidal Actions: Family, Fear of failing

Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A

Patient with access to weapons: No ~Recent Outcome Measures (last 30 days)

BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)

PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)

GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)

PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)

PCL-C: N/A

AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

CSI: N/A

ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). No changes in treatment plan.

A/P Last Updated by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1400 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 06 Sep 2017 1401 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 06 Sep 2017 1401

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29537684 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Sep 2017 1035 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 06 Sep 2017 1223 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3	3 of 3	06 Sep 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Refill	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	0 of 1	06 Sep 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	2 of 3	06 Sep 2017
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH	2 of 2	18 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 06 Sep 2017 1035 EDT
LST

S/O Note Written by GHOLSON, GEORICA K @ 06 Sep 2017 1515 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)"Golf Clinic" Staff: Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.
Co-facilitator was present to provide support. Co-facilitator ensured the activity and group members were safe, actively participated, and observed and remediated any disruptive behaviors.
Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The objective was to provide an opportunity for patients to recreate and to learn golfing fundamentals in a safe supportive environment. The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water) , golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Today patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post activity a group discussion about the experience they created and coping skills used .
Participation: Pt actively participated throughout the session. Pt ate lunch with the group and was receptive to golf instruction. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted. Next LST Therapeutic Field Exercise (TFX) is scheduled for Wednesday October 4, 2017.

S/O Note Written by SMITH, JESSICA ANN @ 06 Sep 2017 1532 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Reason for Visit
Check in for Afternoon Programming 1230-1430
5 min Check in at: 1115
Program Track:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

- (x) Comprehensive Recovery Program (CRP)
 () Interpersonal Recovery Program (IRP)
 () Trauma Recovery Program (TRP)
 0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 06 Sep 2017 1542 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at: 1400

Plan for Next Day of Programming

x() Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by MILLER,PENNY E @ 06 Sep 2017 1759 EDT**Reason for Visit**

Visit for: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)"Golf Clinic" Staff: this writer Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.

Objective: To provide an opportunity to recreate and learn golfing fundamentals in a safe supportive environment.

Activity: Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water) , golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post participation this writer Penny Miller, recreation therapist facilitated a group discussion about the experience created and coping skills applied during the process.

Participation: Pt actively participated throughout the session. Pt ate lunch with the group, socialized with peers and demonstrated willingness to be actively involved. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted.

The next LST Therapeutic Field Exercise (TFX) planned by this writer Penny Miller, recreation therapist is scheduled for Wednesday October 4, 2017.

A/P Last updated by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Procedure(s): -Psychiatric Therapy Group Interview x 1
 -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 07 Sep 2017 1247 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 07 Sep 2017 1247**CHANGE HISTORY**The following S/O Note Was Deleted by MILLER,PENNY E @ 06 Sep 2017 1801 EDT:**Reason for Visit**

Visit for: (1230-1430) Life Skills Training- Therapeutic Field Exercise (TFX)"Golf Clinic" Staff: this writer Penny Miller, recreation therapist, PO3 Bryant Seeley, corpsman and Dr. Georica Gholson, psychologist.

Objective: To provide an opportunity to recreate and learn golfing fundamentals in a safe supportive environment.

Activity: Today's TFX consisted of transporting the group to Olney Golf Park, Olney MD for a golf instruction sponsored by Salute Military Golf Association (SMGA). The goals for today's golf clinic were: 1) recreation participation 2) socialization and 3) physical activity. Today was the golf clinic consisted of the provision of lunch (sandwich, cookie, chips and water) , golf equipment and golf instruction from professional PGA golfers and SMGA volunteers. Patients spent time on the driving range where they learned how to grip the club, and swing for short and long distances. At the end of the session a team building competition was provided, enabling patients to work together to reach a common goal. Post participation this writer Penny Miller, recreation therapist facilitated a group discussion about the experience created and coping skills applied during the process.

Participation: Pt actively participated throughout the session. Pt ate lunch with the group, socialized with peers and demonstrated willingness to be actively involved. 13 patients attended this TFX No suicidal ideation, homicidal ideation, plan or intent noted.

The next LST Therapeutic Field Exercise (TFX) planned by this writer Penny Miller, recreation therapist is scheduled for Wednesday October 4, 2017.

The following A/P Note Was Overwritten by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT:

The A/P section was last updated by SMITH,JESSICA ANN @ 06 Sep 2017 1543 EDT - see above.Previous Version of A/P section was entered/updated by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

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Treatment Plan:

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Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 06 Sep 2017 1515 EDT - see above.Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 06 Sep 2017 1224 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Sep 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29535723 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
Patient Status: **Outpatient**Date: **06 Sep 2017 0930 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **TOBAR, EDEN T****AutoCites** Refreshed by TOBAR,EDEN @ 06 Sep 2017 0949 EDT**Allergies**

•No Known Allergies

Vitals

No Vitals Found.

Appointment Comments:

ett/phq9/gad7

Note Written by TOBAR,EDEN @ 06 Sep 2017 1135 EDT**Followup Note**Patient: Daniel Merwin Gender: M
DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #12

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**Branch: Navy Rank: MOS: CTN TIS: 11 yrs
UIC: Commander: NIOC Maryland Unit Phone: 3016770217
Deployment Related? No # Deployments: 1 Months Deployed: 36
WTU: No MEB: No AdmSep: No
Special Clearance: Yes Current PULHES: UNK**CC/Background:** The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes Work Colleague Problems: No
Anger Problems: Yes Spouse/Sig Other Problems: No
Legal Problems: No Financial Problems: Yes
Overall level of difficulty in work, home, social functioning: Very difficult**Behavioral Health Vitals (patient reported):**

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A

Medical Record

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SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. We last met four weeks ago, at which time pt was waiting to find out if his command would allow him to attend IOP. Since that time he was accepted into the program and started it last week. He has been feeling more depressed and anxious and says his phq9 and gad7 scores are higher today because he is answering the questions more honestly now. He has felt increasingly upset with his command as he finds them very unsupportive. He cites as examples that they tried to separate him for his ATS enrollment, calling it a treatment failure even though he self-referred. His ATS counselor contacted his command to intervene. He also states there was an 'all-hands' meeting about him in which the reasons his clearance were revoked and other topics were discussed per pt in front of 150 service members without his knowledge, supposedly to minimize gossip about him. WE discussed these episodes as triggers for his increased depression and anxiety symptoms. HE states his MEB referral for IBS was accepted, which he is pleased about. He is not sure if Effexor xr is helpful. He still has cravings to drink despite taking naltrexone and feels tired all the time. He has a sleep study coming up. He has cut out all caffeine and has been having headaches, about which I encouraged him to speak to his PCM. HE states he has a number of medical conditions he wants documented in his chart for his medical board. He admits he had a thought over the weekend of jumping off a building while sitting on the toilet but denies intent to act.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

Anderson, Daniel Dennis

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PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.
Thoughts that you would be better off dead, or of hurting yourself in some way
Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen

Rating scales:

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

06SEP17 phq9= 19 (#9=1); gad7= 19

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)

☒ Male ☐ History of family/friend suicide

☐ Chronic medical conditions ☒ Impulsivity

☒ History of abuse ☐ Chronic pain

PROTECTIVE FACTORS (Strengths):

☐ Married, children ☒ Active treatment engagement

☐ Good coping/problem solving skills ☒ Hopefulness present

☐ Faith/religion commitment ☐ Positive future orientation

Allergies:nkda

Medical Record

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DoD ID: 1286180538

Created: 13 Nov 2017

Medications:

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING 3 Ordered 06 Sep 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 0 Refill
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY DAY 0 Active 06 Sep 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 2 Active
Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. 0 Active 09 Aug 2017@0001

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
Active 06 Jun 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS 2 Active 18 May 2017@0001

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN 3 Active
10 May 2017@0001

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

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Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in casual clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:fair

Speech:talkative

Mood:dysphoric

Affect:full

Thought Process: circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase SERUM	49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin SERUM	4.9 g/dL	(3.5-5.2)		
Alkaline Phosphatase	SERUM	58	U/L	(40-129)
Alanine Aminotransferase	SERUM	34	U/L	(0-41)
Aspartate Aminotransferase	SERUM	24	U/L	(0-40)
Bilirubin SERUM	0.3 mg/dL	(0.15-1.2)		
Bilirubin Direct	SERUM	<0.2 mg/dL	(0.0-0.3)	
Protein SERUM	7.6 g/dL	(6.6-8.7)		

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8 mg/dL	(6-20)	
Carbon Dioxide	SERUM	28 mmol/L	(22-29)	
Chloride	SERUM	98 mmol/L	(98-107)	

Medical Record

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1985 SSN: ***-**-****

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Created: 13 Nov 2017

Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF	NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)

Medical Record

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1985 SSN: ***-**-****

DoD ID: 1286180538

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Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	
Barbiturates	URINE	NEGATIVE <i>	(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)	
Cocaine	URINE	NEGATIVE <i>	(Negative)	
Opiates	URINE	NEGATIVE <i>	(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)	
Cannabinoids	URINE	NEGATIVE <i>	(Negative)	
Methadone	URINE	NEGATIVE <i>	(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Intervention: increase Effexor to 225 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will abstain from drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Consider adding acamprosate in future as pt reports continued cravings, though he has not relapsed. Normal b12 panel drawn after July 2017 visit.

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of medication plan with patient who stated understanding and agreement with plan.

Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR, EDEN @ 06 Sep 2017 1137 EDT

1. Generalized anxiety disorder

Medication(s):

-VENLAFAXINE XR--PO 75MG CPSR 24H - TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #30 RF3 Ordered By: TOBAR, EDEN
Ordering Provider: TOBAR, EDEN T

2. Major depressive disorder, single episode, unspecified

Disposition Written by TOBAR, EDEN @ 06 Sep 2017 1137 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 06 Sep 2017 1138

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29531948 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **06 Sep 2017 0739 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 06 Sep 2017 0825 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 06 Sep 2017 0739 EDT
 IOP

S/O Note Written by DONKIN, LAURA G @ 06 Sep 2017 0935 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Positive Psychology Group 0800-0900 facilitated by Laura Donkin, LCSW-C and Ms. Gardiner. The purpose of this group is to assist patients in viewing themselves and their situations based on their strengths, rather than weaknesses or symptoms, with the aim of helping them flourish and live a fulfilling life. Today's group was focused on reviewing the factors identified by Dr. Martin Seligman, which are present in people who describe themselves as happy. Today's discussion was centered on Accomplishment and how this factor can enhance one's feelings of happiness. SM actively participated in group discussion. The next group will be held @ 0800 on Wednesday, 13 September. No SI/HI plan or intent present.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by SMITH,JESSICA ANN @ 06 Sep 2017 1358 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0745

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 06 Sep 2017 1403 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :0900

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

S/O Note Written by SMITH,JESSICA ANN @ 06 Sep 2017 1413 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by POURZAND,MIRIAM @ 07 Sep 2017 1124 EDT**History of present illness**

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

SUBJECTIVE /NOTE

1000-1020 met with sm for follow up he reports he went to Dr. Tobar for scheduled follow up since appointment was already made. Sm reports notified Dr. Tobar anxiety and depression measures have increased therefore Effexor increased from 150 mg daily to 225 mg daily. Sm reports no side effects. Also discussed TMS and starting treatment for anxiety next week.

FOLLOW UP PLANS

end of the week

.....

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

MEDICATION RECONCILIATION AND COMPLIANCE

[x] ...Medication reconciliation completed. Risks, benefits, major/common side effects, and alternatives reviewed with patient who stated an understanding and agreement with plan.

[x] Yes.....[] No.....Compliant with medications.....Comments:

Current medication

CURRENT MEDICATIONS and OTCs/Supplements/Herbals

MEDICATION TRACKING

Date Effexor 225 mg daily

Comments- for mood

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired - recent and remote memories are intact. ° Judgement was not impaired.

Speech: ° Normal - Regular rate, rhythm, tone, volume; non-pressured.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic.

Affect: ° Normal . Full range. stabile, appropriate to situation, normal intensity, congruent with mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Last updated by POURZAND,MIRIAM @ 07 Sep 2017 1128 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

-Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND,MIRIAM @ 07 Sep 2017 1129 EDT**Released w/o Limitations**

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 07 Sep 2017 1129

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 07 Sep 2017 1128 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 07 Sep 2017 1128 EDT - see above. Previous Version of A/P section was entered/updated by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH, JESSICA ANN

The following A/P Note Was Overwritten by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT:

The A/P section was last updated by SMITH, JESSICA ANN @ 06 Sep 2017 1404 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND, MIRIAM @ 06 Sep 2017 0826 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29523988 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **05 Sep 2017 1223 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 05 Sep 2017 1324 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Sep 2017 1223 EDT
IRP

S/O Note Written by DONKIN, LAURA G @ 05 Sep 2017 1405 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Anger Management Group 1230-1330. 5 September, 2017. Facilitator: Laura Donkin, LCSW-C, and Ms. Gardiner
Purpose: The purpose of this group is to help people understand the effect that anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the triggers and precipitants that lead to anger and frustration.
Topic(s): "Anger Thermometer" Group began with a discussion of personal experiences with anger. A worksheet with a thermometer was used for members to rate their experiences with feelings of anger, and to measure their reactions on a scale from 1 to 10. We then reviewed positive coping skills for stress relief and anger management. Patient participated in group activity and discussion. No indications of suicidal/homicidal ideation, intent, or plan present. Next group will be held on 11 September, 2017.

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1439 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 05 Sep 2017 1443 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Crisis Management Group (1330-1420) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW
PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.
TOPIC: Today's group began with introductions and what they did over the holiday weekend. All patients participated. Patients were then

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

introduced to today's topic/handout, "Definition of a Crisis" to provide increased awareness about what a crisis is, symptoms of distress and stages of a crisis reaction. Patients also discussed things that helped and hinder during crisis. Each group member was provided with a worksheet outlining the aforementioned.

PARTICIPATION: Patient actively participated in the small and large group discussion. There was no indication of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/12/17.

S/O Note Written by VANFOSSEN,MALLORY B @ 05 Sep 2017 1504 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information:
TEAM A AFTERNOON CHECK IN:
Pt checked in to afternoon programming at 1210.
Pt denies SI/HI.
Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSEN,MALLORY B @ 05 Sep 2017 1504 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: TEAM A AFTERNOON CHECK OUT:
Pt checked out from afternoon program at 1430.
Pt denies SI/HI.
Pt reports following appts on tomorrow, Wednesday 6 September: 0930 outpatient behavioral health.
Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by PRATT,NARCEDALIA @ 05 Sep 2017 1507 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Crisis Management Group (1330-1420) - Staff Present: Narcedalia Pratt, LCSW-C and Penny Miller, CTRS, LCSW-C.
PURPOSE: The purpose of this group is for patients to discuss a crisis or situation they have experienced and have an opportunity to discuss their experience in a safe supportive environment. This group focuses on strategies patients can implement in their lives to develop, utilize and maintain social supports.
TOPIC: Today's group began with introductions and what they did over the holiday weekend. All patients participated. Patients were then introduced to today's topic/handout, "Definition of a Crisis" to provide increased awareness about what a crisis is, symptoms of distress and stages of a crisis reaction. Patients also discussed things that helped and hinder during crisis. Each group member was provided with a worksheet outlining the aforementioned. This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.
PARTICIPATION: Patient actively participated in the small and large group discussion. There was no indication of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/12/17.

A/P Last updated by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

Disposition Written by POURZAND,MIRIAM @ 06 Sep 2017 1254 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 06 Sep 2017 1254

CHANGE HISTORY

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 05 Sep 2017 1508 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 05 Sep 2017 1407 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 05 Sep 2017 1325 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Sep 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29516510 Primary Dx: Generalized anxiety disorder

Patient: **ANDERSON, DANIEL D**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **05 Sep 2017 0808 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 05 Sep 2017 0824 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 05 Sep 2017 0808 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 0859 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Emotion Regulation (0800-0900) Facilitated by Anne-Marie Deutsch, Ph.D
Purpose: To introduce patients to Emotion Regulation strategies as ways to: understand the emotions they experience (correctly identify and label emotions); work to reduce emotional vulnerability by increasing pleasant emotions; work to decrease emotional suffering by letting go of painful emotions; and change painful/unpleasant emotions by acting in the opposite manner.
The content for this session focused on a structure to use in managing emotions, specifically a handout entitled "Recovery Action Plan". Group members answered questions such as "What do I notice when I am not doing well?" and others related to maintaining good emotional balance. SM was late to group -- he was quiet throughout the session and there were no concerns regarding SI/HI, intent or plan. The next emotional regulation group will be in one week. SM released without limitations to attend 0900 group.

S/O Note Written by DEUTSCH, ANNE MARIE @ 05 Sep 2017 1047 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 05 Sep 2017 1058 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Distress Tolerance Group, (1000-1050). Facilitated by Ms. Helen Lowenstein, LCSW.
Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis.
Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.
Topic: Distress Tolerance Cheat Sheet Hand out was discussed and discussed self soothing techniques for coping skills in distressing situations and the importance of practicing coping skills when not in distress to incorporate them into ones life. Patients were then asked to come up with a list of coping skills either they tried in the past that were positive and worked or ones they would like to try in the future. Each patient was provided turns to act or draw a coping skill and tell when it is good to use and why. The rest of the group was able to guess what the coping skill was. This sparked discussion on adopting healthy new coping skills and

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

behavior.

PARTICIPATION: PT was an active participant throughout the group. PT drew his coping skill and explained why it is important. No evidence of SI/HI. Next group to meet 09/12/17 at 1000.

S/O Note Written by DONKIN,LAURA G @ 05 Sep 2017 1114 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual note. SW met with SM for individual 1:1 session from 0900-0955. SM described Labor Day holiday as generally difficult and said that he is not drinking but "it was really hard." SM admitted to spending a lot of the time in bed. SM said that he has been reading excerpts from his mother's journal over the period of his childhood to help him refresh his memory of abuse from father and to clarify his emotions towards his father. SM read this SW from the journal and we used these passages as talking points. As SM was sharing incidents of childhood with this SW, he segued into discussion about sister who was diagnosed as bipolar and acted out in childhood and adolescence. SM admitted to sexually molesting sister when he was age 15 and she was 15. He said that father found out and called it "rape" and used it against him. He was punished for 1 year. SM did not share his feelings about this incident, but says that he and this sister do not communicate. SM also said that due to abuse from father, he was in Foster Care for a few weeks and that both sisters had attempted suicide. SM stated that he has had almost no contact with father over more than 10 years. This SW explored what SM his hoping for from father. SM would like some sort of apology for abuse, but at the same time knows that he will never get this. We also discussed his ambivalence towards father, as he is still hoping for recognition even though he says that he hates father. SM will think more about maintaining this emotional connection to father and why he finds it so difficult to let go of his need for love from him. SM admitted to fleeting suicidal ideation over the weekend but said that it was over in a few minutes. SM currently denies SI/HI plan or intent. We will meet again on Friday.

S/O Note Written by POURZAND,MIRIAM @ 05 Sep 2017 1326 EDT**History of present illness**

The Patient is a 32 year old male.

SUICIDE RISK ASSESSMENT

Suicide Risk Factors Review:

Suicide Plan: N

Suicide Preparation: N

Suicide Rehearsal: N

History of Suicidality: Y, passive intermittent

Single Attempts: Y, during childhood

Multiple Attempts: N

Current Intent: N

Impulsivity: Y

Substance abuse: Y

Significant Loss: N

Interpersonal Isolation: N

Relationship problems: Y

Burden to others: N

Health problems: N

Physical pain: N

Legal problems: N

Shame: N

Patient's Overall Suicide Risk: low.

S/O Note Written by VANFOSSEN,MALLORY B @ 05 Sep 2017 1503 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK IN:

Pt checked in to morning programming at 0805.

Pt denies SI/HI.

Pt reports following appts this morning: none.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by VANFOSSEN,MALLORY B @ 05 Sep 2017 1503 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

TEAM A MORNING CHECK OUT:

Pt checked out from morning programming at 1050.

Pt denies SI/HI.

Pt will return after lunch.

A/P Last updated by DONKIN,LAURA G @ 05 Sep 2017 1131 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by POURZAND,MIRIAM @ 06 Sep 2017 1249 EDT**Released w/o Limitations**

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 06 Sep 2017 1249**CHANGE HISTORY**

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 05 Sep 2017 1131 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 05 Sep 2017 1131 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 05 Sep 2017 1048 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

The following A/P Note Was Overwritten by DEUTSCH,ANNE MARIE @ 05 Sep 2017 1048 EDT:

The A/P section was last updated by DEUTSCH,ANNE MARIE @ 05 Sep 2017 1048 EDT - see above. Previous Version of A/P section was entered/updated by POURZAND,MIRIAM @ 05 Sep 2017 0825 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29498947 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **31 Aug 2017 1234 EDT**
Clinic: **PSYCH DAY HOSP BE**Appt Type: **FTR**
Provider: **POURZAND, MIRIAM****AutoCites** Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1421 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

			EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3		10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3		28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1		28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR		14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR		05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 31 Aug 2017 1234 EDT
IRP

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 1401 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Life Skills Group

1230-1330. Facilitator: Laura Donkin, LCSW-C. This CRP group addresses behaviors which promote a healthy and independent life style. Topics include: strategies for time management, building a support network, resilience, and relapse prevention. Today's topic was, "Treatment Expectations Survey." Patients filled out survey for their treatment expectations and the most important expectations were discussed by patients. SM actively participated in group discussion. The next group will be held on 7 September..

No SI/II plan or intent present.

S/O Note Written by GHOLSON, GEORICA K @ 31 Aug 2017 1435 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: FORGIVENESS

RELATIONSHIP SKILLS 1330-1420

FACILITATORS: Dr. Georica Gholson, psychologist and Mrs. Delacie Gardiner, psychiatric technician

Purpose: Explore and discuss components of healthy relationships, including peers, family, and friends. The group aims to guide patients into identifying maladaptive and adaptive relationship behaviors. Furthermore, the group aims to help patients apply concepts to their daily lives to strengthen their relationships, cultivate new relationships, and to improve discernment about relationships that may be beneficial or harmful to their recovery process.

Group task: Group members defined and discussed the concept of forgiveness. Group members described situations in which they forgave others. Additionally, they discussed barriers and challenges to forgiveness. Participation: SM participated in group discussion

Assessment: No indication of distress. No indication of SI/II

Plan: Next group scheduled for Thursday 7 September 2017.

A/P Last updated by POURZAND, MIRIAM @ 01 Sep 2017 1422 EDT

1. Major depressive disorder, recurrent, moderate: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. SM reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. SM presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 1

Disposition Written by POURZAND,MIRIAM @ 01 Sep 2017 1423 EDT

Released w/o Limitations

Follow up: 5 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1424

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 01 Sep 2017 1422 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 01 Sep 2017 1422 EDT - see above. Previous Version of A/P section was entered/updated by GHOLSON,GEORICA K @ 31 Aug 2017 1435 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Group Interview x 1

The following A/P Note Was Overwritten by GHOLSON,GEORICA K @ 31 Aug 2017 1427 EDT:

The A/P section was last updated by GHOLSON,GEORICA K @ 31 Aug 2017 1427 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 31 Aug 2017 1403 EDT.

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Group Interview x 1

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29491837 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **31 Aug 2017 0805 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1400 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active	NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active	NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 31 Aug 2017 0805 EDT
CES

Appointment Comments: Written by CLOPPER, TAMMY J @ 31 Aug 2017 0805 EDT
TB

S/O Note Written by CLOPPER, TAMMY J @ 31 Aug 2017 1126 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 0800-0830 Registered Nurse met with the patient today for a follow-up Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, and insomnia. The patient was given directions about completing the Alpha-stim session. Before the initiation of the protocol the patient reported that he slept 6 hours interrupted sleep last with nightmares. Reports taking a 3 hour nap in the evening as well. The intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The patient was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The patient was scheduled for a follow-up appointment tomorrow.

A/P Last Updated by CLOPPER, TAMMY J @ 31 Aug 2017 1133 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
PROVIDER(S): CLOPPER, TAMMY J

Disposition Written by POURZAND, MIRIAM @ 01 Sep 2017 1400 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1400

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29491169 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **31 Aug 2017 0741 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 01 Sep 2017 1352 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		FOR ABDOMINAL PAIN #0	
		RF3	
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3 10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3 28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1 28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 31 Aug 2017 0741 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0838 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: 0740 Check in to PCS Team A. SM denied SI/HI. 0800 appt with Ms. Donkin.

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 0935 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:
INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 31 Aug 2017 1343 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: (1000-1050) - Recreation Therapy- "This group was facilitated by Penny Miller, recreation therapist and Helen Lowenstein, social worker LCSW.
Purpose: To provide an opportunity for healthy communication, problem-solving, encourage teamwork and compromise. Patients were divided into 4 teams two teams played Uno and provided coping skills they utilized in the past that were healthy ones when needed when it was their turn or ones they want to try in the future. This was a way patients could recreate yet utilize skills to help in distressing situations. The other two two teams played games and shared coping skills.
TOPIC: Leisure planning and recreation. The ice breaker was an activity to get the patients to recreate and learn to work together. The game musical chairs was played and the group worked together in removing chairs from tables and supporting each other if they didn't make it to the next round. Then a hand out was provided discussing leisure planning and they were asked to get a partner and share their healthy plans for this weekend. Two additional hand outs were providing for coping skills list to prepare them in case stressful situations arise over the weekend.
Participation: PT was an active participant throughout the group. No evidence of S/I or H/I. Next session is scheduled for 9/07/17, 1000.

S/O Note Written by DONKIN, LAURA G @ 31 Aug 2017 1412 EDT

History of present illness

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017
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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

The Patient is a 32 year old male.

He reported: Encounter Background Information: Individual Note. SW met with SM for individual 1:1 session from 0810-0900. SM presented in positive mood and was talkative throughout session. This was SM's first individual session and we explored some areas that we will focus on for treatment. SM described himself as very OCD and described some of his behaviors. SM would like to learn to be more flexible in his behaviors and in thought processes. He has difficulty deciding if he is an introvert or extrovert and said that he vacillates in between the two. SM said that he has always had difficulty forming lasting friendships which also disturbs him. We spent much of session discussing his relationship with his father, who was generally physically and emotionally abusive during most of childhood. SM did not recognize that he was being abused until later in high school and realized how manipulative father is. He worries that he has many of the same negative qualities as father. He admits to having fleeting thoughts of suicidal ideation for 30 seconds a few days ago, but currently denies this. SM would also like to form intimate relationships which are not co-dependent, as most have been in past. He is currently working on being more strict with himself on sleep hygiene. No SI/HI plan or intent present. We will meet again on 5 September.

S/O Note Written by POURZAND, MIRIAM @ 01 Sep 2017 1353 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 1000-1020- met with sm for follow up reports adapting well to program. Discussed alternative treatment, sm reports using alpha-stim device. No other changes to treatment plan. No SI/HI. Plan follow up next week.

A/P Last updated by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Therapy Individual Approximately 30 Minutes x 1
 -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1
 -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by POURZAND, MIRIAM @ 01 Sep 2017 1355 EDT

Released w/o Limitations

Follow up: 5 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 01 Sep 2017 1355

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 01 Sep 2017 1354 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN, LAURA G @ 31 Aug 2017 1422 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

The following A/P Note Was Overwritten by DONKIN, LAURA G @ 31 Aug 2017 0936 EDT:

The A/P section was last updated by DONKIN, LAURA G @ 31 Aug 2017 0936 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s):

-Psychiatric Therapy Individual Approximately 30 Minutes x 1

The following A/P Note Was Overwritten by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT:

The A/P section was last updated by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0839 EDT - see above. Previous Version of A/P section was entered/updated by CLOPPER, TAMMY J @ 31 Aug 2017 0812 EDT.

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Page 405
AR 1871

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

31 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29490746 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **31 Aug 2017 0718 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 31 Aug 2017 0719 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG,	Active	TAKE 2 BY MOUTH EVERY	3 of 3	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

CAPSULE, ORAL		DAY #0 RF3	
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1 06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2	18 May 2017
		FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	
HYOSCYAMINE SULFATE, 0.125 MG, TAB	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3 10 May 2017
SUBL, SUBLINGUAL			
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3 10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3 28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1 28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment:Written by DEUTSCH,ANNE MARIE @ 31 Aug 2017 0718 EDT
Treatment Plan Update Team A/BHDP

S/O Note Written by DEUTSCH,ANNE MARIE @ 31 Aug 2017 0719 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Daniel Anderson

Follow-Up Data Only

Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 3 Currently treated: Yes

Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No

past attempts as of 09/06/2016: 3

Most recent Suicidal Ideation: 2-4 weeks ago

Suicidal Ideation Duration: Fleeting - a few seconds or minutes

Suicidal Ideation Frequency: Once a week

Protective Elements Stopping Suicidal Actions: Family, Fear of failing

Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A

Patient with access to weapons: No

Recent Outcome Measures (last 30 days)

BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)

PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)

GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)

PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)

PCL-C: N/A

AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

CSI: N/A

ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, Ms. Buford and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

medication list). This SM was admitted t his week. Treatment was reviewed and there were no changes to present plan.

A/P Written by DEUTSCH,ANNE MARIE @ 31 Aug 2017 0720 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH,ANNE MARIE @ 31 Aug 2017 0720 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 31 Aug 2017 0721

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29489550 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Aug 2017 1605 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1605 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1605 EDT
Treatment Plan Update Team A

S/O Note Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1607 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Merwin 29 AUG
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 3 Currently treated: Yes

Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No

past attempts as of 09/06/2016: 3

Most recent Suicidal Ideation: 2-4 weeks ago

Suicidal Ideation Duration: Fleeting - a few seconds or minutes

Suicidal Ideation Frequency: Once a week

Protective Elements Stopping Suicidal Actions: Family, Fear of failing

Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A

Patient with access to weapons: No

Recent Outcome Measures (last 30 days)

BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)

PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)

GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)

PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)

PCL-C: N/A

AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)

CSI: N/A

ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)

BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017)

TREATMENT

PLAN UPDATE Treatment team met today to discuss treatment plan for this pt. Present were Dr. Pourzand, Ms Smith, Ms. Donkin, Ms. Van Fossen, Ms. Buford and Dr. Deutsch. Medication reconciliation completed per Dr. Pourzand (see medication list). SM was admitted 29 AUG No changes in treatment plan.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1609 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1609 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 30 Aug 2017 1609

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29484711 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Aug 2017 1251 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1400 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 30 Aug 2017 1251 EDT LST

S/O Note Written by SMITH, JESSICA ANN @ 30 Aug 2017 1445 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check in for Afternoon Programming 1230-1430

5 min Check in at: 1230

Program Track:

(x) Comprehensive Recovery Program (CRP)

() Interpersonal Recovery Program (IRP)

() Trauma Recovery Program (TRP)

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by VANFOSSEN, MALLORY B @ 30 Aug 2017 1514 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Art Therapy (1230-1400) Facilitated by Mallory Van Fossen ATR-BC, LCPAT, Art Therapist; and Maggie Hardy, LCSW-C, Social Worker. This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding. Pts were provided with a topic, and then instructed to create the corresponding artwork based upon thoughts and images that came to mind in response. The artwork directive was to "make a drawing containing a door". Pts were asked to consider how the topics of opportunity, obstacles, inside, outside, and functionality could be related to the topic. Pts were also asked to think about how the imagery of a door could depict a theme as a symbol or a metaphor, and focus on making meaning from the image. Ultimately, pts were encouraged to make their own meaning from the topic, and set their own intention for how they would like to communicate this. 2D materials were used, consisting of pastels, pencils, markers, or chalks. Pts were given 60 minutes to independently work. Discussion followed, in order to process any issues or content that may have been prompted by artmaking. Topics consisted of viewing the door as a barrier versus an opportunity, the nature of having to choose between multiple paths, if keeping things out also functions to keep things in and whether or not this is ideal, doors relating to protection, and who if anyone- including us- are able to pass through the door we have depicted. There was no indication of SI/HI. Next art therapy session will be held 31 August, 2017.

S/O Note Written by HARDY, MARGARET L @ 30 Aug 2017 1523 EDT

History of present illness

The Patient is a 32 year old male.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Art Therapy (1230-1400) Facilitated by: Mallory Van Fossen, ATR-BC, LCPAT, Art Therapist;

Co-facilitated by Margaret Hardy, LCSW-C, Social Worker

OBJECTIVE- This session provided pts with the opportunity to visually process thoughts, emotions and therapeutic concepts, and to utilize art making as a means of grounding.

SUMMARY OF PROMPT- Group instruction was to create something using any of the materials in the art room with a door. Pts were encouraged to not only consider the subject matter (what is actually drawn- colors, lines, shapes, symbols) but their approach to the materials (the process of artmaking, technique, organization, apprehension or openness) as being meaningful, and able to provide them with insight.

This writer co-facilitated art therapy in order to provide clinical support, contribute to discussion by offering therapeutic feedback, and provide additional resources in order to assist service members manage stressors and prevent crisis situations. There was no indication of SI/HI. Next Art Therapy session will be Thursday, 31 AUG 2017.

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1532 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check out for Afternoon Programming 1230-1430

5 min Check out at:1400

Plan for Next Day of Programming

(x) Attend IOP Program tomorrow morning

() Other

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x

) No.

A/P Last updated by POURZAND,MIRIAM @ 31 Aug 2017 1401 EDT

1. Generalized anxiety disorder: 1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY,MARGARET L;
VANFOSSEN,MALLORY B

Disposition Written by POURZAND,MIRIAM @ 31 Aug 2017 1401 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1401

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND, MIRIAM @ 31 Aug 2017 1401 EDT:

The A/P section was last updated by POURZAND, MIRIAM @ 31 Aug 2017 1401 EDT - see above. Previous Version of A/P section was entered/updated by HARDY, MARGARET L @ 30 Aug 2017 1525 EDT.

1. Generalized anxiety disorder F41.1

Procedure(s):

-(90853) Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): HARDY, MARGARET L; VANFOSSEN, MALLORY B

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29481531 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Aug 2017 1031 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1354 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		FOR ABDOMINAL PAIN #0 RF3		
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CLOPPER, TAMMY J @ 30 Aug 2017 1031 EDT
CES

Appointment Comments: Written by CLOPPER, TAMMY J @ 30 Aug 2017 1031 EDT
TB

S/O Note Written by CLOPPER, TAMMY J @ 30 Aug 2017 1215 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Purpose: Alpha Stim Therapy 0950-1020 Registered Nurse met with the SM today for an initial Alpha-Stim session. The Alpha-Stim device was sought as an alternative therapy to target anxiety, depression, & sleep problems. The pt was given directions about completing the Alpha-Stim session. Before the initiation of the protocol, SM reported 7 hours of interrupted sleep last night with one nightmare, depression 8/10, anxiety 10/10, 1/10 pain in stomach, 1/10 anger at this time. During the initial stages of the Alpha-Stim session the intensity was adjusted from 0 uA to 4.0 uA. After completion of the session, pt denied side effects (i.e. dizziness, headache). The pt was asked to monitor the amount and quality of his symptoms that night and report on his progress the following day. The pt was scheduled for a follow-up appointment tomorrow.

A/P Last Updated by CLOPPER, TAMMY J @ 30 Aug 2017 1216 EDT

1. Generalized anxiety disorder

Procedure(s): -Psych Ther Indiv Psychophysiological W/ Biofeedback Approx 30 Minutes x 1 ADDITIONAL
PROVIDER(S): CLOPPER, TAMMY J

Disposition Written by POURZAND, MIRIAM @ 31 Aug 2017 1354 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1354

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

30 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29476160 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Aug 2017 0741 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 31 Aug 2017 1312 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

		FOR ABDOMINAL PAIN #0	
		RF3	
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3 10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3 28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1 28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 30 Aug 2017 0741 EDT
IOP

S/O Note Written by DEUTSCH, ANNE MARIE @ 30 Aug 2017 1025 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: 0800-0850: Positive Psychology group, cofacilitated by Dr. Deutsch, psychologist, and Ms. Gardner, psychiatric technician. This group is designed to help members learn ways to increase well-being, meaning, and joy in their lives using research-based methods of positive psychology. Today's group was based on the acronym PERMA as developed by Seligman: Positive Emotion, Engagement, Positive Relationship, Meaning, Accomplishment. Today's discussion focused on relationships and life meaning. Members discussed what constitutes a relationship and appreciating the value that they bring to our lives. We then moved to exploring what brings purpose to our lives. This SM was attentive and well engaged in the discussion. There was no evidence of SI/HI. Next Positive Psychology group meets in one week. SM released without limitations.

S/O Note Written by MILLER, PENNY E @ 30 Aug 2017 1121 EDT

Reason for Visit

Visit for: (0900 - 0930) Sensible Thinking Group This group is facilitated by Jessica Smith, social worker and supported by this writer Penny Miller, recreation therapist

Purpose: This group teaches the principles of cognitive behavioral therapy and helps patients to reexamine their thoughts and core beliefs in order to exhibit more positive behaviors.

Activity: CBT concepts were presented focusing on cognitive distortions. Pt's discussed how to cope with irrational thinking in the military and civilian structure using CBT concepts. This writer served as a support to the group therapy process.

participation: Pt participated in the group process. Pt left around 0930 and did not return due to being called out of the session by Dr. Pourzand, nurse practitioner. Next Sensible Thinking group is scheduled for Wednesday September 6, 2017. No indications of suicidal or homicidal ideation, intent, or plan.

(This note was written by Penny Miller, CTRS, LCSW-C recreation therapist).

S/O Note Written by SMITH, JESSICA ANN @ 30 Aug 2017 1329 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: IOP Group: Sensible Thinking: 0900-0950: Group facilitators: Jessica Smith LCSW and Penny Miller, CTRS LCSW

Purpose: To provide psycho education on cognitive behavioral therapy, cognitive distortions, and application to current situations. Facilitate discussion on how thoughts influence behavior and helpful/unhelpful thinking patterns. Intervention: Handout provided on common cognitive distortions. Facilitated discussion of negative thinking patterns such as generalization, black and white thinking, personalization, etc and how those thinking patterns influence emotions. Discussed how thinking patterns can be challenged and adjust to create different emotional responses. Participation: Patient was attentive throughout psycho education and participated in group discussion. Patient was receptive to peer feedback.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1335 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: Reason for Visit

Check in for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-In at :0740

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal Ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1349 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information:

Reason for Visit

Check out for Intensive Outpatient Program (IOP) 0800-1100

5 min Check-Out at :1050

Immediate Future Plans:

(x) Comprehensive Recovery Program (CRP) 1230-1430

() Interpersonal Recovery Program (IRP) 1230-1430

() Trauma Recovery Program (TRP) 1230-1430

() Attend IOP Program tomorrow morning

() Other -

Disposition: (x) Released without limitations.

0 Pain level (0-10) 0

Psychiatric Exam:

Thought Content: ? Homicidal ideations () Yes (x) No Suicidal Ideation () Yes (x) No.

S/O Note Written by SMITH,JESSICA ANN @ 30 Aug 2017 1401 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Encounter Background Information: INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES:

This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

A/P Last updated by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN
-Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Disposition Written by POURZAND,MIRIAM @ 31 Aug 2017 1347 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 1347

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 31 Aug 2017 1313 EDT - see above. Previous Version of A/P section was entered/updated by SMITH,JESSICA ANN @ 30 Aug 2017 1401 EDT.

1. Generalized anxiety disorder

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 30 Minutes x 2 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN
-INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1 ADDITIONAL PROVIDER(S): SMITH,JESSICA ANN

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29468286 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **29 Aug 2017 1202 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 30 Aug 2017 1359 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Loading...

Reason for Appointment: Written by CHELLAPPA, MARY R @ 29 Aug 2017 1202 EDT
 CRP

S/O Note Written by DONKIN, LAURA G @ 29 Aug 2017 1353 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Intensive Anger Group 1230-1320 29 August, 2017 Facilitator: Laura Donkin, LCSW-C and Ms. Gardiner

Purpose: The purpose of this group is to help people understand the effect that anger has on their lives. Members will be taught techniques to reduce their anger and learn alternate ways of expressing their thoughts and feelings in a safe and supportive environment. This will be achieved by encouraging them to learn ways to identify the triggers and precipitants that lead to anger and frustration.

Topic: "I Know You Are But What Am I?" Patients were asked to draw a picture that best describes their character when they are angry. They were then asked to explain their drawings and the characteristics of the animal they chose, to the group. Group members reacted positively to this exercise, and lively discussion ensued. Patient drew a picture of a cub and a bear. He said that when he becomes angry, the cub turns into a bear. Next group will be held on next Tuesday, 5 September. No indications of

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

suicidal/homicidal ideation, intent, or plan present.

S/O Note Written by LOWENSTEIN, HELEN T @ 29 Aug 2017 1442 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Stress Management Group (1330-1430) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW.

PURPOSE: The purpose of this group is for patients to discuss possible stress triggers as well as strategies or plans to cope with them. This group focuses on methods patients can implement in their lives to reduce stress in short-term and long term situations.

TOPIC: Today's group focused on "Self-Care Assessment" that explores stress reduction methods consisting of avoid, alter, accept and adapt. This writer served as co-facilitator of this group, checking on reactions of individual members, following up with members who showed distress or confusion, and checking for safety with members who leave the room.

PARTICIPATION: This writer served as an observer to help with any patients that may be in distress. No evidence of distress. No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/5/2017.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1458 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A AFTERNOON CHECK IN:

Pt checked in to afternoon programming at 1200.

Pt denies SI/HI.

Pt reports the following appts this afternoon: none.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1459 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information:

TEAM A AFTERNOON CHECK OUT:

Pt checked out from afternoon program at 1430.

Pt denies SI/HI.

Pt reports following appts on tomorrow, Wednesday 30 August: 1100 VA appt in Bldg 11.

Pt will return to program tomorrow at regularly scheduled time.

S/O Note Written by PRATT, NARCEDALIA @ 29 Aug 2017 1510 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Comprehensive Recovery Program (CRP), Emotional Regulation, Stress Management Group (1330-1430) - Staff Present: Narcedalia Pratt, LCSW-C and Helen Lowenstein LCSW.

PURPOSE: The purpose of this group is for patients to discuss possible stress triggers as well as strategies or plans to cope with them. This group focuses on methods patients can implement in their lives to reduce stress in short-term and long term situations.

TOPIC: Today's group began with introductions and identifying a self-care thing that they have done this week to take care of themselves. All service members participated. Service members were introduced to the "Self-Care Assessment", exploring 3 out of the 6 areas of self-care; physical, psychological, emotional, spiritual, relationship and workplace self-care. Patients filled in a worksheet for each of the aforementioned domains rating tasks according to how well they think they were doing each. A discussion was facilitated regarding how often each patient participates in each task. Beliefs, values, and barriers to self-care were explored.

PARTICIPATION: SM actively participated by completing the worksheet and in the group discussion.

No evidence of suicidal ideation, homicidal ideation, plan or intent noted. Next session is scheduled for Tuesday 9/5/17.

A/P Last updated by POURZAND, MIRIAM @ 30 Aug 2017 1359 EDT

1. Generalized anxiety disorder: 32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

Disposition Written by POURZAND,MIRIAM @ 30 Aug 2017 1400 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 30 Aug 2017 1400

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 30 Aug 2017 1359 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 30 Aug 2017 1359 EDT - see above.Previous Version of A/P section was entered/updated by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT.

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Group Interview x 2 ADDITIONAL PROVIDER(S): PRATT,NARCEDALIA

The following A/P Note Was Overwritten by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT:

The A/P section was last updated by PRATT,NARCEDALIA @ 29 Aug 2017 1511 EDT - see above.Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 29 Aug 2017 1355 EDT.

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Group Interview x 1

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by DEUTSCH, ANNE MARIE

Encounter ID: BETH-29464176 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Aug 2017 0933 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **FTR**
 Provider: **DEUTSCH, ANNE MARIE**

AutoCites Refreshed by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant melanoma of the skin (General FHx)
- family history of father is alive (General FHx)
- family history of heart disease (General FHx)
- family history of cancer (General FHx)
- family history of mother is alive (General FHx)
- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- no family history of chronic liver disease (General FHx)

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY	1 of 1	06 Jun 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	MOUTH EVERY DAY #0 RF1 CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET 3 of 3 UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY 3 of 3 DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 3 of 3 HOURS FOR CONGESTION #0 RF3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) 1 of 1 EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016- 17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR 14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015- 16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR 05 Oct 2015

Reason for Appointment: Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT
TESTING

S/O Note Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0933 EDT

History of present illness

The Patient is a 32 year old male.
He reported: Encounter Background Information: Daniel Merwin 29 AUG
Follow-Up Data Only
Psychological testing - Reviewed and interpreted psychological tests from BHDP. These are only one source of data and should be interpreted in the context of the patient's entire presentation. The BHDP scales are reported and briefly interpreted as follows.

Behavioral Health Vitals (patient reported):
Overall health reported as: Good
Pain Level (0-10): 3 Currently treated: Yes
Suicidal Ideation Risk - C-SSRS score: 3 Past/Prep Behavior last 3 months: No
past attempts as of 09/06/2016: 3
Most recent Suicidal Ideation: 2-4 weeks ago
Suicidal Ideation Duration: Fleeting - a few seconds or minutes
Suicidal Ideation Frequency: Once a week
Protective Elements Stopping Suicidal Actions: Family, Fear of failing
Harm Others Risk over next week as of 8/29/2017 - None Active Plan: N/A
Patient with access to weapons: No
Recent Outcome Measures (last 30 days)
BASIS24 - Score: 3.1 - High levels of general distress reported (8/29/2017)
PHQ9 - Score: 22 - Severe depressive symptoms reported. Evaluation indicated. (8/29/2017)
GAD7 - Score: 21 - Severe anxiety symptoms reported. Evaluation indicated. (8/29/2017)
PCL-5 - Score: 65 - Significant PTSD symptoms reported (8/29/2017)
PCL-C: N/A
AUDIT - Score: 20 - Probable Alcohol Dependence, consider treatment/ASAP referral (8/29/2017)
CSI: N/A
ISI - Score: 25 - Clinical insomnia (severe) (8/29/2017)
BAM: Risk/Protection/Use (subscales) - Score: 14/16/0 - Moderate-High Protection (8/29/2017).

A/P Last Updated by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0935 EDT

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Generalized anxiety disorder

Procedure(s): -Psychologic Testing And Report Administered By Computer x 1

Disposition Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0935 EDT

Released w/o Limitations

Follow up: as needed .

Signed By DEUTSCH, ANNE MARIE (Clinical Psychologist, WRAMC) @ 29 Aug 2017 0935

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

29 Aug 2017 at WRNMMC, Psych Day Hosp Be by POURZAND, MIRIAM

Encounter ID: BETH-29460247 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Aug 2017 0715 EDT**
 Clinic: **PSYCH DAY HOSP BE**

Appt Type: **SPEC**
 Provider: **POURZAND, MIRIAM**

AutoCites Refreshed by POURZAND, MIRIAM @ 30 Aug 2017 1337 EDT**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE
MEMBER PERIODIC HEALTH
ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- No Known Allergies

Other PMHs

No Other PMHs Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED	3 of 3	10 May 2017

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	FOR ABDOMINAL PAIN #0 RF3 TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by CHELLAPPA, MARY R @ 29 Aug 2017 0715 EDT
INTAKE

S/O Note Written by DEUTSCH, ANNE MARIE @ 29 Aug 2017 0906 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: MORNING GROUP THERAPY SUMMARY NOTE 0730-1100: HCPCS CODE S9480:

INTENSIVE OUTPATIENT PROGRAM (IOP)-PSYCHIATRIC SERVICES: This HCPCS code issued per MHS and MEDCOM IOP guidance to capture RVU credit for all group therapy services provided in the morning. The first half of this daily IOP program is comprised of a full morning program from 0730 to 1130.

S/O Note Written by LOWENSTEIN, HELEN T @ 29 Aug 2017 1143 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: Distress Tolerance Group 1000-1050 facilitated by Ms. Helen Lowenstein LCSW.

Purpose: To teach patients skills to identify potential distressing events and to teach them to manage negative emotions/negative experiences without exacerbation of a perceived crisis. Patients will also be encouraged to become aware of ways they escape severe emotional pain through destructive behaviors and/or relationships. Time will also be spent helping patients learn to tolerate the distress.

Topic: Patients were provided a hand out titled Things that influence Stress Tolerance Level. It listed five categories: Support network, sense of control (internal vs external), attitude and outlook, ability to deal with your emotions (Recognition and recovery), and Knowledge and preparation. The patients were asked to identify ones they have been utilizing in their life already for positive coping, and areas they may need to incorporate. Patients went around the room and shared what they have been or need to start to do and what areas cause them more distress than others. This is to help empower patients that they may have or will have a tool box of coping skills to pull from when in distress and adopt healthier coping patterns and behaviors.

PARTICIPATION: PT was an active throughout the group. PT shared that having set routines is helpful for him with feeling in control and goals. No evidence of SI/HI. Next group to meet 09/05/17 at 1000.

S/O Note Written by VANFOSSEN, MALLORY B @ 29 Aug 2017 1248 EDT

History of present illness

The Patient is a 32 year old male.

He reported: Encounter Background Information: TEAM A MORNING CHECK OUT:

Pt is new intake this morning for Team A.

Pt checked out from morning programming at 1045.

Pt denies SI/HI.

Pt will return after lunch.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

S/O Note Written by DONKIN, LAURA G @ 29 Aug 2017 1518 EDT**Personal history**

PT CONTACT INFORMATION

Contact #: [REDACTED]

Email Address:

Unit/Command: NSA, Ft Meade

Command Telephone #: 443-479-6067

CO/OIC/Supervisor: CDR Yuskoe

OCCUPATIONAL / SPECIAL / MILITARY HISTORY

Branch of Service: Navy E-5, recently demoted from E-6

Status: ☒ Active Duty ☐ Retired ☐ Family Member☐ Other

Job Description (MOS / AFSC): Network security

Special Duty:

☐ ...PRP, SCI, or PSP (describe):☐ ...Active Flying Status☐ ...Diving Duty☐ ...SMOD☐ ...Other

DEPLOYMENT HISTORY

of Deployments: 0

Locations:

Total time deployed:

Job during deployment:

SUBSTANCE USE AND TREATMENT HISTORY

Tobacco and other Nicotine products: denies

Alcohol: Patient currently seen at ATS at WRNMMC. Pt admits to alcohol consumption starting in Middle School. Pt has already had significant alcohol treatment including inpatient at Ft. Belvoir.

Caffeine: Pt denies recent consumption of coffee or other stimulants.

Illicit / prescription drug abuse: denies

SOCIAL / DEVELOPMENTAL / SPIRITUAL HISTORY

Pt is 32 year old single Caucasian male with almost 12 yrs TIS, Navy E-5 (recently demoted from E-6), MOS cyber security. Pt reports that he was born in California to very young, unmarried parents, who later married and then divorced. Pt reports that he has 2 sisters, who are ages 30 and 29. He also has a half brother, and half sister who he does not have contact with. Pt reports that father had custody for most of childhood, and mother had to pay support. Both parents were physically abusive. Father was on welfare and frequently negligent of his parental duties. Pt states that father's excessive discipline was to make them fearful. Pt reports 2 incidents of sexual trauma from unwanted contact. Once by older cousin and another time in middle school with friend grabbing him. Pt was moved numerous times during childhood. Pt said that there were times when he was living in a ghetto due to father living off welfare and spending all their money. Pt appears to currently have emotional support from mother and sisters. He has a very contentious relationship with father, thus recently changing his name. Pt said that he barely passed high school, and had a 2.2 GPA. He attributes this to his struggle with IBS, excessive running schedule and not doing homework. He joined the Navy immediately following high school. He has difficulty with relationships and is not currently in one. He denies religious affiliation.

LEGAL / DISCIPLINARY / FINANCIAL / OTHER STRESSORS & PROBLEMS

Pt reports recent demotion due to accusation of social media harassment of another SM. Pt also admits to serious financial debt due to excessive spending.

SEXUAL HISTORY

Pt reports history of hypersexuality, but reports Effexor is currently helpful with this. He states that he does not like being touched in certain ways and has trouble emotionally connecting with partners.

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 13 Nov 2017

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

...

Family history**FAMILY PSYCHIATRIC, SUBSTANCE USE AND MEDICAL HISTORY**

Mother is diagnosed with Bipolar disorder. Younger sister also diagnosed with Bipolar disorder. Youngest sister diagnosed with depression. Both sisters have had multiple suicide attempts. Maternal grandmother also Bipolar.

...

S/O Note Written by POURZAND.MIRIAM @ 30 Aug 2017 1358 EDT**History of present illness**

The Patient is a 32 year old male.

He reported: Feeling tired (fatigue).

Drowsiness.

Insomnia.

MEDICATION RECONCILIATION AND COMPLIANCE

☒ ...Medication reconciliation completed. Risks, benefits, major/common side effects, and alternatives reviewed with patient who stated an understanding and agreement with plan.

☒ Yes..... ☐ No.....Compliant with medications.....Comments:

....

SUICIDE RISK ASSESSMENT:**WARNING SIGNS:**

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Suicidal ideation:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Suicidal plans: childhood via hanging
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Suicidal intent:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Suicidal communication:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Access to lethal means:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Seeking access to lethal means:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Preparations for suicide:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Substance abuse: hx of ETOH to include detox hx
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Hopelessness:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Purposelessness:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Anger:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Reckless/Impulsive:hx of risky behavior
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Feeling trapped:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Social withdrawal:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Mood changes:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep disturbance:
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Guilt or shame:

Comments:

HOMICIDAL OR VIOLENT THOUGHTS OR ACTIONS

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Past homicidal thoughts:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Past homicidal actions:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Current homicidal thoughts:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Past violent episodes:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Current violent thoughts / urges:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Intent to act on thoughts / urges:

COMMENT ON RISK OF HARM TO OTHERS:

...

CONTRIBUTING RISK FACTORS:

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Family h/o suicide attempts: siblings attempted
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Family h/o mental illness:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Loss (loved one, relative, relationship, status):
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Suicide of relative/peer/famous person:
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Stressful life event (acute):
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Chronic stressors (financial, legal, etc.):
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Psychological trauma (current):

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

☒ Yes ☐ No Childhood trauma (sexual, emotional, physical):
☐ Yes ☒ No Stressful medical condition:
☐ Yes ☒ No Chronic pain:
☐ Yes ☒ No Physical functional impairment:
☒ Yes ☐ No Military related stress:

Comments:

PROTECTIVE:

☒ Yes ☐ No Good social support system:
☒ Yes ☐ No Positive personal traits:
☒ Yes ☐ No Access to health care:

Comments:

...

Review of systems**Systemic:** No recent weight loss and no recent weight gain.**Head:** No headache.**Eyes:** No blurry vision.**Gastrointestinal:** Appetite not decreased. No diarrhea.**Endocrine:** No decreased libido.**Musculoskeletal:** No muscle aches, no localized joint pain, and no limb pain.**Neurological:** No dizziness, no motor disturbances, and no tremor. No gait abnormality. No sensory disturbances.**Psychological:** No nightmares and no bulimic episodes. No social isolation.**Skin:** No rash.**Assessment**

ASSESSMENT AND DIAGNOSIS

Patients strengths: resilient

Potential obstacles to treatment: anxiety d/o

Prognosis: ☐ Excellent.....☐ Good.....☐ Fair.....☒ Guarded.....☐ Poor

....

PROFILE STATUS: reports in process of MEB

...

Visit is not deployment-related.

Plan

TREATMENT GOALS AND OBJECTIVES

Patients goals

1. Figure out how to cope with prior life events
2. Move on from things

Treatment objectives

1. Improve psychological functioning
2. Decrease number of episodes of trichotillomania
3. Reduction in symptoms as evidence by self reported measures BHDP by 20% post completion of program

TREATMENT PLAN AND STRATEGY

Medication: Effexor 150 mg daily

Psychotherapy: 2 x per week

Referrals: watch pad sleep study, Alpha-Stim, BFA

Estimated Frequency and Duration of Treatment: 4 wks

Other:

- ☒ Treatment Options and Education: Diagnosis and treatment options - including risks, benefits, side effects, and choice to decline treatment, were discussed with the patient who expressed an understanding of the diagnosis and plan.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

[x] Treatment plan was collaboratively discussed with the patient.

[x] Yes [] No...Patient agrees with plan? If not, what part?

DATE: 8/29/17

....

S/O Note Written by CLOPPER,TAMMY J @ 30 Aug 2017 1414 EDT**Chief complaint**

The Chief Complaint is:

Continued stress and anxiety.

Reason for Visit

NEW EVALUATION.

The Patient was seen by a staff member.

(0900-1000): Present at intake: Dr. Pourzand, Mrs. Donkin, LCSW-C, Ms. Buford, RN.

General overall feeling - Fair.

Difficulty doing work, taking care of things at home, or getting along with other people -- Very difficult.

Limits of confidentiality reviewed with the patient who verbally expressed an understanding, signature was obtained. (See [Add Note] for any scanned in documents.).

Referred here

Appointment is voluntary.

....

Patient was not escorted.

Referred here by - Other.

Source of information was self.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in the TSWF BH Spec AIM form>>

HISTORY OF PRESENT ILLNESS:

Pt is a 32 y/o single Caucasian male ADN E5 with almost 12 years TIS, HDS: Ft. Meade, MOS: Network Intelligence, referred to PCS by outpatient provider at WRNMMC d/t continued symptoms of anxiety and depression. SM reports he has not worked in one month, has lost access to the building, and was demoted from E6 to E5 in 7/2017 d/t social media sexual harassment sent to a female co-worker. SM reports having anxiety symptoms as far back as childhood d/t his father. In 2008, SM started picking his scalp (neurotic excoriation) while deployed aboard a ship d/t stress and anxiety. SM also developed MRSA. SM reports in 2010 he had a bad 2 year relationship breakup with a woman whom was an alcoholic and taking medication. SM states in 2012 he started seeing behavioral health d/t having suicidal ideation, being discontent with life, and the bad breakup. SM endorses guilt, decreased appetite and fear of gaining weight and losing 10 lbs. in the last month (stating he does not want to look like his father as well as end up with diabetes as he has), states feels as though he has sleep paralysis and at times sleeps too much but other times difficulty falling and staying asleep, +anxiety and worrying, reports being hypersexual stating he could have intercourse daily as well as ejaculate three times a day, +anger/irritability, +isolation, states does not like sun exposure, fantasizes about life-space things, watches television a lot which in turn creates increased anxiety (example: watches Game of Thrones and Walking dead but does not look at it as just a TV show, fantasizes that it is real). SM states he works on computer gaming and enjoys cooking. Reports he was in debt for \$35,000 but sold one of his homes and now debt has decreased to \$19,000. States his debt was from buying his brother a car and giving his family money. SM denies AVH and OCD.

ADDITIONAL HPI

SM has no religious preference. SM was deployed near Japan on a ship from 3/2006-4/2009 denying combat exposure and stating he felt safe. SM reports fleeing SI with no plan/intent, currently denying active SI/HI. SM to attend both IOP/CRP programs.

**PHYSICAL PAIN SEVERITY 3/ 10.
PAIN ASSESSMENT**

Location: stomach (IBS)

Duration:

Quality:

Factors that correlate with onset:

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Frequency:
 Average level:
 Worst level:
 Least level:
 What makes it better:
 What makes it worse:

...
 Patient IS NOT currently in a situation where he/she is being verbally or physically hurt, threatened, or made feel afraid.

LEARNING / NEEDS ASSESSMENT

Date Updated:

What is your preferred method of learning?.....[] Verbal.....[] Written.....[] Visual.....[X] Other (Specify): hands-on
 Preferred Language (written or spoken):.....[X] English.....[] Other:
 [] Yes...[X] No...Learning disability, language barrier, hearing/vision deficit.. (If Yes, Specify):
 [] Yes...[X] No...Cultural or religious beliefs that may affect care..... (If Yes, Specify):
 [] Yes...[X] No...Patient or a family member is in the EFMP Program(If Yes, Specify):
 [] Yes...[X] No...Patient using community resources (e.g. chaplain, family services, etc.) (If Yes, Specify):
 [] Yes...[X] No...Needs help obtaining more community resources/support. If yes, specify:
 [] Yes...[X] No...Patient would like family members involved in care.
 [] Yes...[X] No...Advance Directives completed?
 [] Yes...[X] No...Copy of the Advance Directive in the record?

NUTRITIONAL ASSESSMENT

Date Updated:

[] Yes...[X] No...Illness or condition has led to a change in kinds or amounts of food or made it hard to eat
 [X] Yes...[] No...Fewer than two meals per day
 [] Yes...[X] No...Unintended loss of ten or more pounds in the last six months

Personal history**PAST MEDICAL HISTORY**

IBS; PRK; tonsillectomy; childhood asthma; neurotic excoriation (scalp picking);
 PSYCHIATRIC HISTORY

Suicide attempt as a child by taking bottle of aspirin d/t conflict with father, vomited but no treatment; age 17 suicide attempt via consuming large quantity of alcohol, no treatment; 6/16/2014 Integrated Health WRNMMC x 2 visits d/t anxiety; 8/2014-10/2014 WRNMMC outpatient BH d/t anxiety; 4/2015-11/2015 WRNMMC outpatient BH d/t depression/anxiety, also attended CBTI group; 8/2016 Integrative Health WRNMMC d/t mood swings/anxiety x 1 visit; 9/2016 started seeing outpatient BH WRNMMC d/t mood swings/anxiety. MEDICATIONS HAVE BEEN RECONCILED to include current medications, OTC, and supplements. Previously trialed meds: Zoloft (increased fatigue), melatonin, lexapro (felt flat), Unisom, Wellbutrin XL (increased anxiety), and Lunesta (ineffective). SM currently taking: Effexor 150 mg daily and Naltrexone 50 mg daily.

A/P Last updated by POURZAND, MIRIAM @ 30 Aug 2017 1357 EDT

1. Generalized anxiety disorder:

32 year old single Caucasian male United States Navy E5, TIS 12 yrs, duty assignment Ft. Meade intel lost access one month ago, currently working in admin. Reports childhood problems primarily related to his father. Reports in 2008 relationship problems, and in 2012 sought behavioral health care for job and relationship stress. Additionally has hx of alcohol use d/o requiring inpatient detox. Sm reports anxiety disorder to impair daily functioning, reports poor coping continues with trichotillomania. Sm presents for additional support and to learn and implement safe/ Positive coping mechanisms.

Competency/Risk:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan:

The patient has been educated on various treatment modalities for depression/anxiety/PTSD including individual psychotherapy, group psychotherapy, and medication management. Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Diagnostic Evaluation Initial x 1
 -Psychiatric Diagnostic Evaluation With Medical Evaluation And Management x 1

Disposition Last Updated by POURZAND,MIRIAM @ 30 Aug 2017 1359 EDT

Released w/o Limitations

Follow up: 1 day(s) in the PSYCH DAY HOSP BE clinic or sooner if there are problems. - Comments: The patient agrees to seek treatment at or call the NMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By POURZAND, MIRIAM (Psychiatric Nurse Practitioner, BHS, WRNMMC) @ 31 Aug 2017 0742

CHANGE HISTORY

The following A/P Note Was Overwritten by POURZAND,MIRIAM @ 30 Aug 2017 1357 EDT:

The A/P section was last updated by POURZAND,MIRIAM @ 30 Aug 2017 1357 EDT - see above. Previous Version of A/P section was entered/updated by DONKIN,LAURA G @ 29 Aug 2017 1516 EDT.

1. Generalized anxiety disorder

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1
 -Psychiatric Diagnostic Evaluation Initial x 1

The following A/P Note Was Overwritten by DONKIN,LAURA G @ 29 Aug 2017 1516 EDT:

The A/P section was last updated by DONKIN,LAURA G @ 29 Aug 2017 1516 EDT - see above. Previous Version of A/P section was entered/updated by DEUTSCH,ANNE MARIE @ 29 Aug 2017 0907 EDT.

1. Generalized anxiety disorder

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

22 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29388088 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Aug 2017 0800 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE,DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 22 Aug 2017 1004 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Realizations

S) SM reported that he wanted to drink on Friday due to stress from command. He stated that command had a legal representative notify him that they were counting his referral as a command referral and he was at risk for administrative separation due to this being his second referral. Treatment failure processes were reviewed with SM who acknowledged understanding. SM stated he would prefer to continue treatment at WR ATS as opposed to transferring to WNY SARP due to continuity of care and integration of care. SM stated that he went home on Friday and watched a movie and the cravings dissipated. SM discussed his weight loss, decrease in IBS symptoms and financial gains since he quit drinking. SM also stated he is developing a closer relationship with his family now that he is sober. SM reported that he did not go to a meeting last week but committed to attending one this week. SM also stated he would begin making a gratitude list daily to see if this helped to ground him in the present in order to decrease his anxiety. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP. SM would benefit from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker in three weeks.

A/P Last Updated by HANGEMANOLE,DESPINA C @ 22 Aug 2017 0852 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 22 Aug 2017 0856 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in 3 weeks.
 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 22 Aug 2017 1004

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

22 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29408977 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Aug 2017 0700 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 23 Aug 2017 1141 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 12
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

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DoD ID: 1286180538

Created: 13 Nov 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used:** CBT**Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he continues to have issues with his command and is concerned about returning to the environment post IOP. He stated that he learned that his department had an all-hands meeting regarding him and why his clearance was removed. He feels that other sailors now have a negative impression of him and has noticed that they interact with him differently. Therapist and patient processed his feelings about this. Patient stated that he has been working on socializing and getting out of his home. Patient relayed recent outings. Therapist expressed concern regarding an outing that patient had with another sailor. Therapist encouraged patient to be mindful of social interactions with others in his department related to all the concerns they've had about his boundaries and behavior. Patient agreed that this was not a positive outlet for socialization. Further conversation focused on patient's re-investment into his family relationships. He stated that he is working on trying to build normal healthy relationships even though he does not feel innately warm and secure in these relationships. Therapist and patient discussed how to balance internal growth and relationship growth. Patient is identifying future oriented plans. Patient has no suicidal plan or intent but fleeting ideation. Patient will start IOP next week.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal

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Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Resilience: Yes
 Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 22 August 2017

Reviewed with patient on: 22 August 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Referrals made today:Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.A/P Written by PAUL, SHERIN @ 23 Aug 2017 1144 EDT**1. Generalized anxiety disorder****2. Major depressive disorder, recurrent, moderate**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 23 Aug 2017 1144 EDT**Released w/o Limitations****Follow up:** 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 23 Aug 2017 1144

***** End of Previous Encounters *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Clinical Notes***08 Nov 2017 1330 GMT at by RAGLAND, MARY***

Title:	BEHAVIORAL HEALTH	Original Date:	08 Nov 2017 1330 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	13 Nov 2017 1455 GMT
Facility:		Document ID:	9260337592
Clinician:	RAGLAND, MARY		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 08 Nov 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: RAGLAND, MARY

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 08 Nov 2017 0730 EST Appt Type:

GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

ADULT BEProvider: RAGLAND,MARY

Patient Status: Outpatient

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by DAVIS,KRISTEN KATHLEEN @ 08 Nov 2017 1418 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group (0730-0845)

S: Topics discussed: Introductions; differences between military branches, communities and commands; the impact of alcohol use on stress. SM discussed with other group members the differences between their commands and feelings of frustration regarding administrative procedures. SM shared in detail what brought him to ATS this time and the first time. SM acknowledged that his alcohol use contributed to the work stress he experienced prior to entering treatment. The session ended with group members sharing their plans for the holiday weekend and if they had concerns to present to the group. SM stated that he is having friends over this weekend and identified grilling as one of his triggers. He reported that his house is dry and that his girlfriend is no longer drinking.

O: SM arrived late to group. SM was oriented x3.

Appearance: AppropriateBehavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: StableAffect: Congruent

Insight: GoodJudgment: Good

SI/HI: None CurrentMed/Pain Issues: None expressed

A: SM is sharing openly and honestly with the group. SM provides appropriate feedback and appears committed to his recovery.

P: SM will continue with group as assigned.

.eg

ebody

ebody

S/O Note Written by HANGEMANOLE,DESPINA C @ 09 Nov 2017 0834 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

SM was not present for Finding Meaning group 1000-1045.eg

ebody

ebody

Note Written by RAGLAND,MARY @ 08 Nov 2017 1326 EST

Mind-Body Group, Session #1: Meditation 1100-1155

S: Psychoeducation re: meditation. This therapist taught definition and principles of meditation. Facilitator instructed participants in three basic sitting postures with variations. Practiced 20 minutes of sitting meditation, participants instructed to focus on counting their breath while maintaining erect yet relaxed posture. Discussed this experience.

O: Ct arrived on time for group. Alert/oriented x 3.

Appearance: CleanBehavior: Appropriate

Speech: WNL Thoughts: Logical

Mood: Stable Affect: Congruent

Insight: Good Judgment: Good

SI/HI: None Med/Pain Issues: None

A: Ct participated appropriately in discussion and activity.

P: Ct will attend next group as scheduled.

A/P Written by RAGLAND,MARY @ 13 Nov 2017 0949 EST

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by RAGLAND,MARY @ 13 Nov 2017 0950 EST

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic.

Signed By RAGLAND, MARY (Physician) @ 13 Nov 2017 0950

Verified by: RAGLAND,MARY 13 Nov 2017@0955

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

06 Nov 2017 1900 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	06 Nov 2017 1900 GMT
Document Type:	Consultation	AHLTA Entry Date:	06 Nov 2017 1858 GMT
Facility:		Document ID:	9247298544
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 06 Nov 2017@13:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 06 Nov 2017 1300 EST Appt Type:
 FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C
 Patient Status: Outpatient

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Reason for Appointment:

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 06 Nov 2017 1352 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Focus Of Session: Judgement & Fellowship

S) SM stated he had been thinking about a gardening invention and planned to spend some time working on this in the future. SM stated he has found himself being more productive and distracted by healthy hobbies recently. SM reported that he doesn't feel he's getting as much out of IOP due to the redundancy. SM and this writer discussed ways to reframe this thought as to stay as engaged as possible. SM acknowledged that redundancy is necessary for learning and that something was missing from his first effort at recovery which is why he was unable to sustain it. SM identified that missing piece as support and stated that he now has support from his family, girlfriend and a couple friends. SM reported that he was unsure as to why sober support specifically is important in recovery but agreed to think about it and have some thoughts to discuss next session. SM denied any alcohol use or thoughts about drinking. SM denied SI/HI.

O) SM reported to session on time and was dressed casually. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM is thoughtful when discussing his support system and relationships. SM demonstrates a lack of knowledge of parts of recovery as evidenced by his inability to identify why sober support is necessary in recovery, however, SM demonstrates good judgement in offering to brainstorm on this for homework.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin continue with ATS groups as scheduled.

.eg

ebody

ebody

A/P Written by HANGEMANOLE,DESPINA C @ 06 Nov 2017 1340 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE,DESPINA C @ 06 Nov 2017 1342 EST

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)
@ 06 Nov 2017 1352

Verified by: HANGEMANOLE,DESPINA C 06 Nov 2017@1357

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Nov 2017 1330 GMT at by BURTON, CARA N

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	06 Nov 2017 1330 GMT
Document Type:	Consultation	AHLTA Entry Date:	09 Nov 2017 1607 GMT
Facility:		Document ID:	9256547506
Clinician:	BURTON, CARA N		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 06 Nov 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: BURTON, CARA N

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 06 Nov 2017 0730 EST Appt Type:
 GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: BURTON, CARA N

Patient Status: Outpatient

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

IOP

Appointment Comments:

ctc

S/O Note Written by BURTON,CARA N @ 06 Nov 2017 1021 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Morning Process Group (0730-0845):

S: Today's session was begun by completing introductions as there were two new group members beginning the IOP Program today. Each group member took turns sharing their names, military history as well as what led to their engagement in substance abuse treatment. Additional time was spent discussing attendance at meetings, including both AA and SMART Recovery. Group members also spent some time sharing how their mental health symptoms (such as PTSD, depression and anxiety) have increased in early sobriety. Group members engaged easily with one another and appeared to relate well and share spontaneously throughout the session. This SM shared openly about his titration off his medicine and also shared about potential triggers with drinking. He was actively engaged throughout the session.

O: SM arrived on time for group and was oriented x3.

Appearance: Neat, clean, dressed appropriately to season in civilian clothing

Behavior: Appropriate, engaged, talkative

Speech: WNL

Thoughts: WNL

Mood: Euthymic, stable

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None reported

Med/Pain Issues: None expressed

A: SM is engaged during sessions and can sometimes go off topic for some time but is easily redirected. He appears motivated to maintain abstinence.

P: SM will continue with IOP groups as scheduled.eg

ebody

ebody

S/O Note Written by LESKO,STACEY BETH @ 07 Nov 2017 0731 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Risky Drinking Group: 1115-1200

S: The group reviewed the concept of risky drinking and what constitutes 'low risk' drinking vs. 'high risk' drinking. Group members watched the second part of HBO's documentary 'Risky Drinking' that highlighted a man's struggle with excessive drinking and the impact on his family and overall wellbeing. Group members discussed what they viewed in relation to the consequences of high-risk drinking and related it to their own life experiences.

O: SM arrived on time for group. SM was oriented x3.

Appearance: AppropriateBehavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: EuthymicAffect: Congruent

Insight: GoodJudgment: Good

SI/HI: None CurrentMed/Pain Issues: None expressed

A: SM actively engaged in discussion and provided and received feedback appropriately.

P: SM will continue with IOP as planned.eg

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

ebody

ebody

S/O Note Written by FOBIZSHI,MACANGELO M @ 07 Nov 2017 1146 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session. Today's group topic was focused identifying healthy and unhealthy relationship beliefs and learning how to cultivate a healthy relationship. The group members reviewed the relationship beliefs listed in the handout and discussed the ones that they could relate to. SM reports poor communication skills in the past. SM states that he never took time to understand situations and make better decisions. SM states that this affected his relationship with his roommate. SM reports effort to improve communication skills and healthy relationship. The group discussed how to change some of the unhealthy belief to improve their relationship and fortify their recovery. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P.eg

ebody

ebody

S/O Note Written by HARDIN,JAMES G @ 09 Nov 2017 1009 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Relapse Prevention Group~Focus of Session: Managing Stress

S) SM participated in the group discussion about stress, coping with stress, and how stress can impact physical/psychological health and decision making. We discussed the idea of having a "background" stress level and how to decrease it. SM talked about past experiences with meditation and how it has helped. We discussed how by making a consistent effort we can improve our stress levels so that we are less likely to experience difficult events as a crisis.~O) Appearance: uniform Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: fair

Affect: Congruent

Insight: Fair/good Judgment: fair/good

SI/HI: None Current

Med/Pain Issues: None

A) SM seems invested in the group at this time.

P) Next relapse prevention group will discuss effective communication

.eg

ebody

ebody

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

A/P Last Updated by BURTON,CARA N @ 06 Nov 2017 1028 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by BURTON,CARA N @ 06 Nov 2017 1028 EST

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue attending groups.

Signed By BURTON, CARA N (Licensed Clinical Social Worker) @ 09 Nov 2017 1102

Verified by: BURTON,CARA N 09 Nov 2017@1107

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

03 Nov 2017 1230 GMT at by LESKO, STACEY B

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	03 Nov 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	08 Nov 2017 1851 GMT
Facility:		Document ID:	9254042961
Clinician:	LESKO, STACEY B		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 03 Nov 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: LESKO, STACEY BETH

 HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:
 Note:
 NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 03 Nov 2017 0730 EST Appt Type: GRP
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: LESKO, STACEY BETH
 Patient Status: Outpatient
 AutoCites Refreshed by LESKO, STACEY B @ 03 Nov 2017 1024 EST

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Allergies

?No Known Allergies

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by LESKO,STACEY BETH @ 03 Nov 2017 1024 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group: 0730-0845

S: The group discussed several topics today to include job challenges, incorporating a community program into one's recovery, and the impact of a life changing event (suicide attempt and car accident) on their thinking moving forward. Lastly, some discussion around the idea of putting oneself in high risk situations and how eventually the ability to abstain may get harder and harder.

O: SM arrived on time for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: Euthymic Affect: Congruent

Insight: Fair Judgment: Fair

SI/HL: None Current Med/Pain Issues: None expressed

A: SM participated appropriately in group today, both giving and receiving feedback.

P: SM will continue with IOP groups as planned.eg

ebody

ebody

S/O Note Written by LESKO,STACEY BETH @ 03 Nov 2017 1024 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Educational Group: Recovery

Toolbox 0900-0945

Session #1: Types of Community Recovery Support Meetings

S: Psychoeducation re: what are Community Recovery Support Group meetings, types of 12-step groups, SMART Recovery and Celebrate Recovery. Lists of available meetings provided, as well as how to locate meetings. Discussed purpose of Community Recovery Support Groups, differences between treatment and Community Recovery Support Groups, and members' prior experiences with Community Recovery Support Groups.

O: SM arrived on time for group.

Appearance: Clean Behavior: Appropriate

Speech: WNL Thoughts: Logical

Mood: Stable Affect: Congruent

Insight: Good Judgment: Good

SI/HL: None Med/Pain Issues: None

A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.

P: SM will attend next group as scheduled.eg

ebody

ebody

S/O Note Written by FOBIZSHI,MACANGELO M @ 06 Nov 2017 0654 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background Information: Creative Art Therapy Group

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was painting. The Instructor explained how painting could be used as therapeutic recreation to release emotions and tension. The instructor provided art material and allowed the group member time to paint. The group discussed their individual paintings and its significance.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI. P: SM will continue group next week. eg
ebody

ebody

S/O Note Written by DELEON, PATRICK D. @ 08 Nov 2017 1156 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

S: Intensive Outpatient Program Seeking Safety group, topic "Healing from Anger." Time 1000-1100. Discussion of constructive vs. destructive forms of anger, unmet needs that often/usually underlie anger, skills and strategies for managing anger without acting out in ways that make it worse. SM reports ongoing sobriety, identifies himself as having a significant anger problem both towards others and towards himself. SM discussed manageable level of stress with girlfriend moving into his apartment, communication about potential issues, set commitment to cook, plan meals for the week, finish painting rooms in his house over the weekend.

O: Client arrived on time to session. Alert and oriented x 3.

Appearance: Appropriate

Behavior: Appropriate

Speech: Within Normal Limits

Thoughts: Logical, linear, goal-directed

Mood: Anxious

Affect: Congruent

Insight: Fair

Judgment: Fair

SI/HI: None reported

Med/Pain Issues: Irritable Bowel Syndrome

A: SM actively engaged in group discussion, thoughtful about larger causes of anger and childhood experiences and trauma that influence him today, as well as specific strategies to address present.

P: Continue in Intensive Outpatient Program, next Seeking Safety group 6

Nov.eg

ebody

ebody

A/P Last Updated by LESKO, STACEY B @ 03 Nov 2017 1027 EST

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM

x 1

Disposition Written by LESKO, STACEY B @ 08 Nov 2017 1346 EST

Released w/o Limitations

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Follow up: in the ATS ADULT BE clinic.

Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 08 Nov 2017
1346

Verified by: LESKO, STACEY BETH 08 Nov 2017@1351

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

02 Nov 2017 1400 GMT at by NAVARRO, CARA A

Title:	OCCUPATIONAL THERAPY MTF BE	Original Date:	02 Nov 2017 1400 GMT
Document Type:	Consultation	AHLTA Entry Date:	02 Nov 2017 1532 GMT
Facility:		Document ID:	9239451296
Clinician:	NAVARRO, CARA A		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: PAUL, SHERIN
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170927-21861
 MCP Referral #: 20171726532
 No. of Visits: 1
 Referral Authorized Until: 27 Oct 2017
 Reason for Consult:
 Rec Therapy: Patient would benefit from additional coping skills and building positive monitored socialization skills.
 Priority: ROUTINE
 Provisional Diagnosis:
 Major depressive disorder, recurrent, moderate
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 02 Nov 2017@09:00:00
 Requesting HCP: PAUL, SHERIN
 Clinic: OCCUP THERAP TBI BE
 Consulting HCP: NAVARRO, CARA A

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 02 Nov 2017 0900 EST Appt Type: PROC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: OCCUP THERAP TBI BE
 Provider: NAVARRO, CARA A
 Patient Status: Outpatient

AutoCites Refreshed by NAVARRO, CARA A @ 02 Nov 2017 1105 EST

Family History

?family medical history (General FHx)

?paternal aunt's history of reason for visit [use for free text] (Paternal

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Aunt)

?not maternal uncle's history of referred here (Maternal Uncle)

?family history of supplemental HPI [use for free text] (General FHx)

?no family history of malignant melanoma of the skin (General FHx)

?family history of father is alive (General FHx)

?family history of heart disease (General FHx)

?family history of cancer (General FHx)

?family history of mother is alive (General FHx)

?no family history of malignant neoplasm of large intestine (General FHx)

?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)

?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)

?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)

?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)

?paternal history of preliminary background HPI [use for free text] (Father)

?family history of test conclusions [Use for free text] (General FHx)

?family history of diabetes mellitus (General FHx)

?family history of mental illness (not retardation) (General FHx)

?family history of the options include referral (General FHx)

?family history of patient counseling (General FHx)

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)

?no family history of chronic liver disease (General FHx)

Reason for Appointment:

rec therapy

Appointment Comments:

can

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 02 Nov 2017 1105 EST

Questionnaires

A/P Written by NAVARRO,CARA A @ 02 Nov 2017 1122 EST

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x

2

Disposition Written by NAVARRO,CARA A @ 02 Nov 2017 1125 EST

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by NAVARRO,CARA A @ 02 Nov 2017 1122 EST

Recreational Therapy

Recreational Therapy Program

Name: Anderson, Daniel P02

Date: 02 Nov 2017

Time: 97537 x 30 MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

SM arrives on time, groomed well and presents in a pleasant mood.

SM discusses current stressors and strategies he is using for managing himself. SM declines Recreational Therapy services at this time due to the stress of travel and trying to implement lifestyle changes on his own. SM was provided with community recommendations and mindfulness app to try on his phone. SM appreciated resources and has Rec Therapist contact information if needing services in the future.

PLAN:

1. Patient will not receive Recreational Therapy services at this time.

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist,
Occupational Therapy WRNMMC) @ 02 Nov 2017 1126

Verified by: NAVARRO, CARA A 02 Nov 2017@1132

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

01 Nov 2017 1230 GMT at by DELEON, PATRICK D.

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	01 Nov 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	03 Nov 2017 1915 GMT
Facility:		Document ID:	9243709820
Clinician:	DELEON, PATRICK D.		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appt Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 01 Nov 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: DELEON, PATRICK D.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:
 Note:
 NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 01 Nov 2017 0730 EST Appt Type: GRP
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: DELEON, PATRICK D.
 Patient Status: Outpatient

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by DAVIS,KRISTEN KATHLEEN @ 03 Nov 2017 0756 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group (0730-0845)

S: Topics discussed: Introductions, recovery programs and goals for recovery.

Group members discussed the different aspects of their recovery programs, if they are currently being developed or goals they have regarding recovery. SM

arrived late to group and stated it was because of health reasons. SM was

engaged in the group for the remainder of the session, offering constructive

feedback to other group members. SM stated that right now in his recovery process, he is looking to deepen his relationships and is working to prevent opportunities of isolation.

O: SM arrived 30 minutes late for group. SM was oriented x3.

Appearance: Appropriate Behavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: Stable Affect: Congruent

Insight: Good Judgment: Good

SI/HL: None Current Med/Pain Issues: None expressed

A: SM arrived late for group and was engaged in the group for the remainder of the session. SM is sharing openly and honestly with the group. SM gives appropriate feedback and appears dedicated to his recovery.

P: SM will continue with group as assigned.

.eg

ebody

ebody

S/O Note Written by HANGEMANOLE,DESPINA C @ 03 Nov 2017 0844 EST

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Educational Group: Finding Meaning 1000-1045

Focus of Session: Defining Spirituality~S: The group discussed what

spirituality means to them. SM explored basic issues of spirituality and how addiction affects spirituality. He shared that his definition of spirituality

are similar to military values such as honesty and integrity. SM explored the practical applications of spirituality and acknowledged that practicing spirituality may be beneficial for recovery.

O: SM arrived on time for group.

Appearance: Clean Behavior: Appropriate

Speech: WNL Thoughts: Logical

Mood: Stable Affect: Congruent

Insight: Good Judgment: Good

SI/HL: None Med/Pain Issues: None~A: SM interacted effectively

with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.~P: SM will attend next group as scheduled.

.eg

ebody

ebody

Note Written by RAGLAND,MARY @ 01 Nov 2017 1306 EST

Mind-Body Group, Session #6: Walking Meditation 1100-1145

S: Psychoeducation re: purposes of walking meditation, how walking and sitting meditation differ and compare. Watched video of Thich Nhat Hanh describing walking meditation. Group then went to lawn north of America Building to

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

practice walking meditation for 20 min. Group discussed experience of walking meditation.

O: SM arrived on time for session. SM alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: WNL

Thoughts: WNL

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: SM participated in exercise and discussion.

P: SM to continue with group/IOP Tx.

A/P Written by DELEON,PATRICK D. @ 03 Nov 2017 1509 EST

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON,PATRICK D. @ 03 Nov 2017 1509 EST

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive

Outpatient Program, next groups 3 Nov

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 03 Nov 2017 1509

Verified by: DELEON,PATRICK D. 03 Nov 2017@1515

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

30 Oct 2017 1700 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	30 Oct 2017 1700 GMT
Document Type:	Consultation	AHLTA Entry Date:	31 Oct 2017 1610 GMT
Facility:		Document ID:	9233333767
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 30 Oct 2017@12:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 30 Oct 2017 1200 EDT Appt Type:
 FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C

Patient Status: Outpatient

Reason for Appointment:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

f/u

Appointment Comments:

jbf

Note Written by HANGEMANOLE,DESPINA C @ 31 Oct 2017 1204 EDT

Focus Of Session: Work Stress/Risky Behaviors

S) SM stated that he completed TAPS last week and continues to experience stress related to work. SM stated he is experiencing conflict with his chain of command as they are requiring that he drive back and forth between WR and Ft. Meade between appointments. SM stated that he hopes to get transferred to WR to eliminate this stress. SM reported that he has been diagnosed with sleep apnea, which is relieving for him as he has been struggling with sleep issues for years. SM reported that he has moved in with his girlfriend of a few months, who also has an alcohol problem. SM described his relationship as supportive and stated that they have already agreed on a plan if their relationship doesn't work out. SM reported that she has self identified an alcohol problem but has been abstinent from alcohol for an extended time and plans to continue abstinence. SM reported an increased in anxiety related to work stress but a decrease in depressive symptoms since dating this person. SM reported that once IOP is over he will begin taking leave as to avoid having to be at work during his MEB process. SM stated that he will be speaking with a GI provider regarding possibly starting Marinol. SM acknowledged the risks of relapse and cross addiction. SM stated that he continues to have flare ups and nothing he has tried so far has worked to alleviate his discomfort. SM reported his pain as a 4/10 from his IBS. SM reported he attended one AA meeting this week and plans to return to Smart Recovery meetings now that he is back in the Glen Burnie area. SM denied any alcohol use or thoughts about drinking. SM denied SI/HI.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM is thoughtful when discussing his support system and relationships. SM demonstrates good judgement by attending all appointments and participating appropriately. SM lacks insight in some of his decisions around his relationship and his IBS treatment. SM will be at greater risk of relapse if he begins taking Marinol, and given that SM was unable to sustain sobriety after his last treatment this appears to be high risk behavior.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin continue with ATS groups as scheduled.

A/P Last Updated by HANGEMANOLE,DESPINA C @ 30 Oct 2017 1357 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 30 Oct 2017 1357 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)
@ 31 Oct 2017 1204

Verified by: HANGEMANOLE,DESPINA C 31 Oct 2017@1209

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

30 Oct 2017 1230 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	30 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	03 Nov 2017 1137 GMT
Facility:		Document ID:	9241929634
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 30 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:
 Note:
 NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 30 Oct 2017 0730 EDT Appt Type: GRP
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: HANGEMANOLE, DESPINA C
 Patient Status: Outpatient

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Reason for Appointment:

IOP

Appointment Comments:

ctc

S/O Note Written by FOBIZSHI,MACANGELO M @ 31 Oct 2017 0628 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session.

Today's group topic was "signs of danger versus safety". The group session was focused identifying red flags during their recovery process, as well as, green flags that will further their recovery. The group members selected both red and green flags from the handout that they could relate to. The provider asked the group members to create a safety plan for the red flags they selected. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P.eg

ebody

ebody

S/O Note Written by HANGEMANOLE,DESPINA C @ 31 Oct 2017 0712 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

S: The group discussed drinking history and meetings. SM introduced himself to the group stating that he has finally been diagnosed with sleep apnea, after years of having sleep problems. SM gave a brief but detailed history of his alcohol use over his lifetime, sharing that his alcohol use became out of control when he moved to the area a few years ago secondary to depression and anxiety. SM discussed his MEB starting, and the some of the decisions he's made regarding his career thus far. SM reported that he enjoys SMART recovery meetings more than AA meetings but does relate to the 12 Step philosophy as a whole. ~O: SM arrived on time for group. SM was oriented x3.~Appearance:

AppropriateBehavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: EuthymicAffect: Congruent

Insight: FairJudgment: Good

SI/HI: None CurrentMed/Pain Issues: None expressed~A: SM is sharing openly and honestly with the group. SM gave appropriate feedback and asked thoughtful questions of other group members. SM is open to community recovery, though it is not clear why SM does not enjoy AA meetings. ~P: SM will continue with IOP groups as scheduled.

.eg

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

ebody

ebody

A/P Last Updated by HANGEMANOLE,DESPINA C @ 30 Oct 2017 0955 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 30 Oct 2017 0956 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue with groups as scheduled.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)

@ 03 Nov 2017 0732

Verified by: HANGEMANOLE,DESPINA C 03 Nov 2017@0737

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

20 Oct 2017 1230 GMT at by HARDIN, JAMES G

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	20 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	25 Oct 2017 1504 GMT
Facility:		Document ID:	9219652399
Clinician:	HARDIN, JAMES G		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 20 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HARDIN, JAMES G

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 20 Oct 2017 0730 EDT Appt Type: GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: HARDIN, JAMES G

Patient Status: Outpatient

Reason for Appointment:

IOP

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Appointment Comments:

ctc

S/O Note Written by FOBIZSHI,MACANGELO M @ 23 Oct 2017 0621 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background

Information: Creative Art Therapy Group

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The Instructor explained how poetry could be used as a platform to express emotions and thoughts. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P: SM will continue group next week.eg

ebody

ebody

S/O Note Written by HARDIN,JAMES G @ 25 Oct 2017 1015 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Process group: 0730-0845

Focus of Session: weekend planning, role of sponsors

S) The group discussed their plans for the weekend and the need to keep their time structured. We talked about the dangers of boredom and too much free time. Members talked about their relationships with others in the self-help community and the role of sponsors. SM fully participated in the discussion.

O) Appearance: normalBehavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: calm

Affect: consistent

Insight: fair Judgment: fair

SI/HI: None Current

Med/Pain Issues: None

A) SM was invested in group today.

P) Next process group will be same time Monday.

.eg

ebody

ebody

Note Written by RAGLAND,MARY @ 24 Oct 2017 0725 EDT

Educational Group: Recovery Toolbox

Session #5: Sponsorship in Community Recovery Support Groups

S: Psychoeducation re: what is sponsorship, how does one obtain a sponsor, ways to work with a sponsor for recovery. Participants discussed prior experiences with sponsors.

O: SM arrived on time for group.

Appearance: Clean Behavior: Appropriate

Speech: WNL

Thoughts: Logical

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Mood: Stable

Affect: Congruent

Insight: Good

Judgment: Good

SI/II: None

Med/Pain Issues: None

A: SM interacted effectively with the group. SM gave and accepted feedback positively. SM demonstrates commitment to recovery.

P: SM will attend next group as scheduled.

A/P Last Updated by HARDIN,JAMES G @ 25 Oct 2017 1016 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HARDIN,JAMES G @ 25 Oct 2017 1016 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse Program, WRAMC) @ 25 Oct 2017 1016

Note Written by DELEON,PATRICK D. @ 25 Oct 2017 1042 EDT

(Added after encounter was signed.)

S: Intensive Outpatient Program Seeking Safety group, topic ?Honesty.? Time 1000-1100. Discussion of the role of honesty in recovery, ways in which honesty gets impacted in active substance abuse, and situations which make honesty more difficult. Particular discussion of honesty with children and with therapists, and both the difficulties and benefits of open direct communication when emotions are high. SM actively engaged in group discussion, processed difficulties with AA, spoke about feeling judged and that things get oversimplified in AA. Peers and this SW acknowledging ?absolute? talk in AA while also reframing that as having basic principles which are helpful in time of crisis, and that can be explored more fully and individually in treatment and/or with sponsor.~

O: Client arrived on time to session. Alert and oriented x 3.~

Appearance: Appropriate~

Behavior: Appropriate~

Speech: Within Normal Limits~

Thoughts: Logical, linear, goal-directed~

Mood: Depressed~

Affect: Congruent~

Insight: Fair~

Judgment: Fair~

SI/II: None reported~

Med/Pain Issues: Irritable Bowel Syndrome~

A: SM active participant in group, open to feedback~

P: Continue in Intensive Outpatient Program, next Seeking Safety group 23 Oct

Verified by: HARDIN,JAMES G 25 Oct 2017@1104

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

18 Oct 2017 1230 GMT at by DELEON, PATRICK D.

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	18 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	23 Oct 2017 1135 GMT
Facility:		Document ID:	9212546987
Clinician:	DELEON, PATRICK D.		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 18 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: DELEON, PATRICK D.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 18 Oct 2017 0730 EDT Appt Type:
 GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: DELEON, PATRICK D.

Patient Status: Outpatient

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

IOP

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 18 Oct 2017 1146 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

SM was not in Finding Meaning Group 1000-1045.eg

ebody

ebody

S/O Note Written by DAVIS,KRISTEN KATHLEEN @ 18 Oct 2017 1338 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Process Group0730 - 0845

S: Topics discussed: Introductions, feeling words, and six categories of emotion. Group members described how they are feeling and where these feelings would fall in the six categories (mad, glad, sad, hurt, afraid and guilt/shame). SM identified feeling mad/sad for having to work last night and glad that the process is moving along for him to sell his house. SM helped orient new members when making introductions.

O: SM arrived late to group. SM was oriented x3.

Appearance: AppropriateBehavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: StableAffect: Congruent

Insight: FairJudgment: Fair

SI/HI: None CurrentMed/Pain Issues: None expressed

A: SM participated appropriately in discussion. SM demonstrates commitment to sobriety/recovery.

P: SM will continue with groups as assigned.

.eg

ebody

ebody

Note Written by RAGLAND,MARY @ 19 Oct 2017 0959 EDT

Mind-Body Group, Session #4: Yoga 1100-1155

SM did not attend this group.

A/P Written by DELEON,PATRICK D. @ 23 Oct 2017 0729 EDT

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM

x 1

Disposition Written by DELEON,PATRICK D. @ 23 Oct 2017 0730 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive

Outpatient Program, next groups 20 Oct

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 23 Oct 2017 0730

Verified by: DELEON,PATRICK D. 23 Oct 2017@0735

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

16 Oct 2017 1230 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	16 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	17 Oct 2017 1608 GMT
Facility:		Document ID:	9199716349
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 16 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 16 Oct 2017 0730 EDT Appt Type:
 GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C

Patient Status: Outpatient

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

IOP

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1113 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

S: The group discussed addictive behaviors, meetings and relationship with command. SM reported that he does not interact as regularly with his command as many others in group but mostly does not get adverse reactions from them about his need for treatment. SM stated that he could understand how many in leadership may not understand addiction or the need for treatment just based on their lack of life experience with it. SM reported that he could understand how people may engage in addictive behaviors other than substance abuse and acknowledged that it's likely an outward manifestation of something going on internally with that person. ~O: SM arrived on time for group. SM was oriented x3. ~Appearance: Appropriate Behavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: Anxious Affect: Congruent

Insight: Fair Judgment: Fair

SI/HI: None Current Med/Pain Issues: None expressed ~A: SM is sharing openly and honestly with the group. SM gives appropriate feedback and appears engaged in group. SM can be tangential but is conscious of this and appears to be actively working to be more concise. ~P: SM will continue with IOP groups as scheduled.

.eg

ebody

ebody

S/O Note Written by FOBIZSHI,MACANGELO M @ 17 Oct 2017 0630 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group Group 1000-1115:

S: SM actively participated in the seeking safety group. SM reviewed coping skills, and commitments made at the previous group session. SM denies substance use or any unsafe behavior since the last group session. The group topic was "Safety". The group focused on learning healthy safe coping skills. The group members identified safe and unsafe coping skills they have been using. The provider explained the three stages of healing from PTSD and substance abuse; safety, mourning and reconnection. The group members discussed what safety means to them and the signs of recovery. The group reviewed the examples of safe coping skills in the handout and identified some safe coping skills to practice. At the end of the group session, the group members were asked to fill out a commitment sheet: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI. P: SM will continue group next week. eg

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

ebody

ebody

S/O Note Written by HARDIN,JAMES G @ 17 Oct 2017 1026 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Relapse Prevention Group (0900-0945)

Focus of Session: Identifying Triggers

S) SM participated in a group discussion about identifying triggers. SM reported that both internal and external factors can be triggers, with negative emotions being among the main triggers. SM listened as other suggested ways to cope and identified attending meetings and therapy appointments as his best ways to cope with triggers. SM participated actively in the group process.

O) SM arrived on time for group. SM was dressed casually. SM's mood was calm and affect was congruent.

A) SM seems invested in group at this time.

P) Next relapse prevention group: Managing thoughts

.eg

ebody

ebody

S/O Note Written by HANGEMANOLE,DESPINA C @ 17 Oct 2017 1202 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

SM did not attend service dog training as he was put on SIQ orders for symptoms related to withdrawal from his psychotropic medication.eg

ebody

ebody

A/P Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1113 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 16 Oct 2017 1114 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will continue with groups as scheduled.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)
@ 17 Oct 2017 1203

Verified by: HANGEMANOLE,DESPINA C 17 Oct 2017@1208

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

13 Oct 2017 1230 GMT at by HARDIN, JAMES G

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	13 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	19 Oct 2017 1156 GMT
Facility:		Document ID:	9205537817
Clinician:	HARDIN, JAMES G		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 13 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HARDIN, JAMES G

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 13 Oct 2017 0730 EDT Appt Type: GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: HARDIN, JAMES G

Patient Status: Outpatient

Reason for Appointment:

IOP

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Appointment Comments:

jbf

S/O Note Written by FOBIZSHI,MACANGELO M @ 13 Oct 2017 1303 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Seeking Safety Group

Group 1000-1115:

S: SM actively participated in the seeking safety group. Patient reviewed the check in" handout at the start of the session. Patient shared all coping skills, and commitments completed since the previous group meeting. Patient denies any alcohol or substance use and any unsafe behaviors since the last group. Today's group today focused on harshness versus compassion. The group reviewed the handout provided by the therapist. The group members reviewed the examples of harsh self-talk and compassionate self-talk in the handout and discussed the ones they related to. The therapist discussed how harshness relates to PTSD and substance abuse. The group collectively talked about how compassion promotes growth and harshness prevents growth. The patient discussed ways to increase compassion in sobriety. At the end of the group session, the group members filled out a commitment sheet to be reviewed at the next group session: good coping skills and a commitment they will complete before the next group session.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI.P: SM will continue group next week.eg

ebody

ebody

S/O Note Written by FOBIZSHI,MACANGELO M @ 13 Oct 2017 1342 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Encounter Background

Information: Creative Art Therapy Group

Group 1115 - 1200:

S: SM actively participated in the Creative Art Therapy Group. The group activity was poetry. The group members discussed the "What secret we keep and "Kintsugi" poems. The Instructor explained how creative writing could be used as a platform to express emotions and thoughts. The group member discussed the poems provided and what it meant to them. The instructor asked the group to write a poem or free writing, to express their thoughts and emotions. The group members shared their individual art and how they felt after expressing those emotions in writing.

O: Group member reported on time. SM was interactive in the group.

Behavior: Appropriate

Psychosis: None evident

Speech: WNL

Thoughts: Clear, organized

Mood: Positive

Affect: Congruent

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

SI/HI: None expressed

Pain: None indicated

A: SM appeared open to the training environment and attempted to execute commands. No evidence of SI/HI. P: SM will continue group next week. eg

ebody

ebody

S/O Note Written by HARDIN, JAMES G @ 17 Oct 2017 1021 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Process group: 0730-0845

Focus of Session: motivation, "nature vs nurture" re substance abuse

S) The group discussed their past experiences in treatment, mostly inpatient treatment, and what worked for them. We discussed "getting serious" about recovery as opposed to simply sitting in meetings, not paying attention. We talked about "identifying in" vs. "identifying out". Members talked about the moment when they realized they truly had an alcohol/drug problem. SM fully participated in the discussion.

O) Appearance: normal Behavior: Appropriate

Speech: WNL

Thoughts: WNL

Mood: calm

Affect: consistent

Insight: fair Judgment: fair

SI/HI: None Current

Med/Pain Issues: None

A) SM was invested in group today.

P) Next process group will be same time next week.

.eg

ebody

ebody

A/P Written by HARDIN, JAMES G @ 19 Oct 2017 0751 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by HARDIN, JAMES G @ 19 Oct 2017 0751 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By HARDIN, JAMES G (Clinical Social Worker, Army Substance Abuse

Program, WRAMC) @ 19 Oct 2017 0751

Verified by: HARDIN, JAMES G 19 Oct 2017 @ 0756

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

11 Oct 2017 1900 GMT at by NAVARRO, CARA A

Title:	OCCUPATIONAL THERAPY MTF BE	Original Date:	11 Oct 2017 1900 GMT
Document Type:	Consultation	AHLTA Entry Date:	12 Oct 2017 1931 GMT
Facility:		Document ID:	9190002796
Clinician:	NAVARRO, CARA A		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: PAUL, SHERIN
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170927-21861
 MCP Referral #: 20171726532
 No. of Visits: 1
 Referral Authorized Until: 27 Oct 2017
 Reason for Consult:
 Rec Therapy: Patient would benefit from additional coping skills and building positive monitored socialization skills.
 Priority: ROUTINE
 Provisional Diagnosis:
 Major depressive disorder, recurrent, moderate
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 11 Oct 2017@14:00:00
 Requesting HCP: PAUL, SHERIN
 Clinic: OCCUP THERAP TBI BE
 Consulting HCP: NAVARRO, CARA A

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 11 Oct 2017 1400 EDT Appt Type:
 PROC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: OCCUP
 THERAP TBI BE Provider: NAVARRO, CARA A

Patient Status: Outpatient

AutoCites Refreshed by NAVARRO, CARA A @ 12 Oct 2017 1517 EDT

Family History

?family medical history (General FHx)

?paternal aunt's history of reason for visit [use for free text] (Paternal
 Aunt)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

?not maternal uncle's history of referred here (Maternal Uncle)
 ?family history of supplemental HPI [use for free text] (General FHx)
 ?no family history of malignant melanoma of the skin (General FHx)
 ?family history of father is alive (General FHx)
 ?family history of heart disease (General FHx)
 ?family history of cancer (General FHx)
 ?family history of mother is alive (General FHx)
 ?no family history of malignant neoplasm of large intestine (General FHx)
 ?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
 ?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
 ?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
 ?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
 ?paternal history of preliminary background HPI [use for free text] (Father)
 ?family history of test conclusions [Use for free text] (General FHx)
 ?family history of diabetes mellitus (General FHx)
 ?family history of mental illness (not retardation) (General FHx)
 ?family history of the options include referral (General FHx)
 ?family history of patient counseling (General FHx)
 ?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
 ?no family history of chronic liver disease (General FHx)

Reason for Appointment:

Major depressive disorder, recurrent, moderate

Appointment Comments:

can

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 12 Oct 2017 1517 EDT

Questionnaires

A/P Written by NAVARRO,CARA A @ 12 Oct 2017 1518 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x

2

Disposition Written by NAVARRO,CARA A @ 12 Oct 2017 1525 EDT

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by PALAD,NOLAN @ 11 Oct 2017 1247 EDT

Consult Order

Referring Provider:PAUL, SHERIN

Date of Request:27 Sep 2017

Priority:Routine

Provisional Diagnosis:

Major depressive disorder, recurrent, moderate

Reason for Request:

Rec Therapy: Patient would benefit from additional coping skills and building positive monitored socialization skills.

Note Written by NAVARRO,CARA A @ 12 Oct 2017 1524 EDT

Recreational Therapy

Recreational Therapy Program

Name: Anderson, Daniel P02

Date: 11 Oct 2017

Time: 97537 x 30 MIN

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building

positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

SM arrives on time, groomed well and tired, stating he has not been sleeping well.

SM completed homework and reported goals he has to improve interpersonal relationships, decrease isolation and tolerate the community without being overwhelmed. Due to SM schedule he will not participate in Recreational Therapy programs till November.

Pending Appointments: 02 Nov 2017

PLAN:

1. Patient will attend follow up session on 02 Nov to set POC

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist, Occupational Therapy WRNMMC) @ 12 Oct 2017 1525

Verified by: NAVARRO, CARA A 12 Oct 2017 @ 1530

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

11 Oct 2017 1230 GMT at by DELEON, PATRICK D.

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	11 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	17 Oct 2017 1327 GMT
Facility:		Document ID:	9198987424
Clinician:	DELEON, PATRICK D.		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 11 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: DELEON, PATRICK D.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 11 Oct 2017 0730 EDT Appt Type:
 GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: DELEON, PATRICK D.

Patient Status: Outpatient

Reason for Appointment:

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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 INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

IOP

Appointment Comments:

jbf

S/O Note Written by BURTON,CARA N @ 11 Oct 2017 1217 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: Educational Group: Finding Meaning (1000-1100): Spirituality and Personality

S: The focus of today's session was the connection between personality and spirituality. Group members were encouraged to assess their personalities during active substance use and at the current point of their recovery. They also reflected on how their personalities have changed since being sober.

This SM shared openly about the ways in which substance use allowed him a release from his cares or ongoing frustrations. He engaged actively throughout the session and commented on what others shared appropriately.

O: SM arrived on time for group, was oriented x4 and engaged actively during the group exercises and discussion.

Appearance: Neat, clean, dressed appropriately to season

Behavior: Appropriate, engaged

Speech: WNL

Thoughts: Logical, WNL

Mood: Stable

Affect: Congruent, full range

Insight: Fair

Judgment: Fair

SI/II: None reported

Med/Pain Issues: None reported

A: SM interacted with group members and facilitators. He demonstrated an understanding of the concepts presented.

P: SM will attend the next group as scheduled.eg

ebody

ebody

Note Written by RAGLAND,MARY @ 16 Oct 2017 0952 EDT

Process Group 0730-0845

S: Topics discussed: Introductions (Name, relationship to the military, substance of choice, sobriety date, and what brought Ct to ATS), Review of Group Rules/Expectations. Demonstrated understanding of Group Rules and assisted in explaining to new group members. Ct again spoke of his father's emotional abandonment of him and it's impact on his emotions--did not connect this to his substance use..

O: Ct arrived over 30 minutes late for group. Ct alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/II: None reported

Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

Note Written by RAGLAND,MARY @ 16 Oct 2017 1156 EDT

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Mind-Body Group, Session #3: Breath Work 1100-1150

S: Psychoeducation re: purposes of using breath work (slowing thought process, slowing physiological processes, increase focus and concentration relaxation, linking body and mind), types of breath work (Counting, Mantras, Body focus, Guided/Imagery, Breathing while moving intentionally). Practiced several different types of breath work chosen by participants.

O: SM arrived on time for group. Alert/oriented x 3.

Appearance: Clean Behavior: Appropriate

Speech: WNL Thoughts: Logical

Mood: Stable Affect: Congruent

Insight: Good Judgment: Good

SI/II: None Med/Pain Issues: None

A: SM participated appropriately in discussion and activity.

P: SM will attend next group as scheduled.

A/P Written by DELEON,PATRICK D. @ 17 Oct 2017 0921 EDT

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(S9480) INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM x 1

Disposition Written by DELEON,PATRICK D. @ 17 Oct 2017 0921 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic. - Comments: Continue in Intensive

Outpatient Program, next groups 13 Oct

Signed By DELEON, PATRICK D. (Social Work Case Manager) @ 17 Oct 2017 0922

Verified by: DELEON,PATRICK D. 17 Oct 2017@0927

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

06 Oct 2017 1230 GMT at by LESKO, STACEY B

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	06 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	06 Oct 2017 1738 GMT
Facility:		Document ID:	9178944187
Clinician:	LESKO, STACEY B		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 06 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: LESKO, STACEY BETH

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 06 Oct 2017 0730 EDT Appt Type: GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: LESKO, STACEY BETH
 Patient Status: Outpatient

AutoCites Refreshed by LESKO, STACEY B @ 06 Oct 2017 1330 EDT
 Allergies

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

?No Known Allergies

Reason for Appointment:

process grou

Appointment Comments:

ctc

S/O Note Written by LESKO,STACEY BETH @ 06 Oct 2017 1330 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

He reported: Encounter Background Information: S: The group discussed several topics today to include the how childhood family dynamics has impacted their addiction and recovery. Group members talked about trying new community support meetings and what they liked/didn't like about them. Lastly, members shared what they were doing over the 3-day weekend to stay safe and support their sobriety.

O: SM arrived on time for group. SM was oriented x3.

Appearance: AppropriateBehavior: Appropriate

Speech: WNL Thoughts: WNL

Mood: EuthymicAffect: Congruent

Insight: GoodJudgment: Good

SI/HI: None CurrentMed/Pain Issues: None expressed

A: SM participated appropriately in group today, both giving and receiving feedback.

P: SM will continue with process groups as planned.eg

ebody

ebody

A/P Written by LESKO,STACEY B @ 06 Oct 2017 1332 EDT

1. Alcohol dependence, uncomplicated F10.20

Procedure(s): -(90853) Psychiatric Therapy Group Interactive x 1

Disposition Written by LESKO,STACEY B @ 06 Oct 2017 1333 EDT

Released w/o Limitations

Follow up: in the ATS ADULT BE clinic.

Signed By LESKO, STACEY B (Medical Social Worker, 301-319-7824) @ 06 Oct 2017 1333

Verified by: LESKO,STACEY BETH 06 Oct 2017@1338

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

05 Oct 2017 1800 GMT at by NAVARRO, CARA A

Title:	OCCUPATIONAL THERAPY MTF BE	Original Date:	05 Oct 2017 1800 GMT
Document Type:	Consultation	AHLTA Entry Date:	06 Oct 2017 1220 GMT
Facility:		Document ID:	9177814745
Clinician:	NAVARRO, CARA A		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: POURZAND, MIRIAM
 Requesting Location: PSYCH DAY HOSP BE
 Order ID number: 170913-09025
 MCP Referral #: 20171629681
 No. of Visits: 1
 Referral Authorized Until: 13 Oct 2017
 Reason for Consult:
 SM suffers from significant anxiety with avodiance would benefit from recreation therapy program please evaluate. sm cell [REDACTED]
 Priority: ROUTINE
 Provisional Diagnosis:
 Generalized anxiety disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 05 Oct 2017@13:00:00
 Requesting HCP: POURZAND, MIRIAM
 Clinic: OCCUP THERAP TBI BE
 Consulting HCP: NAVARRO, CARA A

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 05 Oct 2017 1300 EDT Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: OCCUP THERAP TBI BE Provider: NAVARRO, CARA A

Patient Status: Outpatient

AutoCites Refreshed by NAVARRO, CARA A @ 06 Oct 2017 0732 EDT

Family History

?family medical history (General FHx)

?paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

?not maternal uncle's history of referred here (Maternal Uncle)
 ?family history of supplemental HPI [use for free text] (General FHx)
 ?no family history of malignant melanoma of the skin (General FHx)
 ?family history of father is alive (General FHx)
 ?family history of heart disease (General FHx)
 ?family history of cancer (General FHx)
 ?family history of mother is alive (General FHx)
 ?no family history of malignant neoplasm of large intestine (General FHx)
 ?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
 ?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
 ?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
 ?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
 ?paternal history of preliminary background HPI [use for free text] (Father)
 ?family history of test conclusions [Use for free text] (General FHx)
 ?family history of diabetes mellitus (General FHx)
 ?family history of mental illness (not retardation) (General FHx)
 ?family history of the options include referral (General FHx)
 ?family history of patient counseling (General FHx)
 ?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
 ?no family history of chronic liver disease (General FHx)

Reason for Appointment:

Generalized anxiety disorder

Appointment Comments:

can

Questionnaire AutoCites Refreshed by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT

Questionnaires

A/P Last Updated by NAVARRO,CARA A @ 06 Oct 2017 0753 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Phys Ther Ed Community Reintegration Training - Per 15 Min x

6

Disposition Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT

Released w/o Limitations

Follow up: as needed . - Comments: continue with services

Note Written by NAVARRO,CARA A @ 06 Oct 2017 0732 EDT

Consult Order

Referring Provider:POURZAND, MIRIAM

Date of Request:13 Sep 2017

Priority:Routine

Provisional Diagnosis:

Generalized anxiety disorder

Reason for Request:

SM suffers from significant anxiety with avodiance would benefit from recreation therapy program please evaluate. sm cell [REDACTED]

Note Written by NAVARRO,CARA A @ 06 Oct 2017 0814 EDT

Recreational Therapy

SUBJECT

Recreational Therapy Program

Name: Anderson, Daniel P02

Last 4: [REDACTED]

Date: 05 Oct 2017

Time: 97537 x 90MIN

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Place: Occupational Therapy Clinic

Intervention: Recreational Therapy Initial assessment

Diagnosis: MDD

Pain: SM reports 4/10 in intestinal/stomach due to IBS

Fall Risk: no

Education/ Counseling: Patient educated on sports and recreation adaptive equipment, techniques and resources pre and post rehabilitation.

Referring Provider: Dr. Paul

Provisional Diagnosis: Major depressive disorder, recurrent, moderate

Reason for Request: Patient would benefit from additional coping skills and building

positive monitored socialization skills

Phone: [REDACTED]

Email: [REDACTED]@gmail.com

Branch / Rank: Navy/ P02

OBJECTIVE

Patient was seen today for education, planning and training in prep for participation in Recreational Therapy programs.

ACTION

Patient was educated on application, agenda, safety, and program expectations for participation in upcoming Recreational Therapy programs. SM's homework is to write goals for Recreational therapy and what programs he can use to best practice the skills he is developing/learning. Patient was receptive to education and motivated with TX. Patient is in agreement with plan.

Assessment: Alert and oriented x 4. Presents to be in a pleasant mood although displayed signs of anxiety as evidenced by excessive talking and having scattered thoughts. SM was not able to identify personal goals for post military and has homework to complete prior to next session. SM relates challenges back to his childhood and contradicts self with what does and does not matter to him. SM was educated on what the scope of practice is for Recreational Therapy and how writer is not able to change or help SM with certain areas of his life. During conversation SM requires redirection to answer questions. Learning style- Combined Patient tolerated session well.

Barriers to learning: none

Community Reintegration: Isolates self in his home, refuses to go to a gym because ?it's dirty?

Leisure Barriers: social avoidance due to indifference towards others, IBS challenges

Pending Appointments: 11 Oct 2017

Leisure interests include: cooking, video games, movies, TV shows

Learning Style: combined

Precautions: pain

Interventions Recommended:

☒ Aquatic ☒ Relaxation ☐ Physical conditioning ☐

Horticulture

☐ Arts & Craft☐ Adaptive Sports☐ 1:1 session ☒ Social Activities☒ Outdoor Activities ☒ Leisure counseling☐ Cognitive Activities ☐ Paddling☒ Yoga ☐ Archery ☒ Community Reintegration☐ Hunting/Fishing ☐ Cooking Group ☐ Therapeutic

Riding

Adaptive Equipment Utilized and/or recommended:

☐ Scissors (loop) ☐ Pencil Grip ☐ Knives/spoons/fork

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

☐ Cookware
☐ Magnifying glass ☐ Talking books ☐ Ski/snowboard
☐ Bicycle
☐ Prosthetics ☐ W/C, Rollator
☐ Assistive Tech ☐ Vehicle
☐ Lift Systems(s) ☐ IDEO Brace
 Leisure & Community Reintegration Barriers:
☐ Cognitive Skills ☒ Social Skills ☐ Communication
☐ Paralysis
☐ Financial ☐ General Weakness ☐ ROM
 limitations ☐ Mobility
☐ Perceptual Prob ☐ Grasp / Release ☒ Fears /
 Phobias ☐ Hearing Deficits
☐ Visual Acuity ☒ Motivation
☐ Spasticity ☒ Pain
☒ Attitude ☒ Self-confidence ☐ Transportation

PLAN:

1. Patient will attend follow up session on 11 Oct with completed homework and set POC

Discharge Recommendations:

☐ Utilization of Community Resources
☐ Adaptive equipment requested
☐ Continue program at home
☒ Encouragement of social / leisure participation

Signed By NAVARRO, CARA A (Certified Therapeutic Recreation Specialist,
Occupational Therapy WRNMMC) @ 06 Oct 2017 0815

Verified by: NAVARRO, CARA A 06 Oct 2017 @0820

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

05 Oct 2017 0100 GMT at by KHRAMTSOV, ANDREI N

Title:	SLEEP DISORDERS	Original Date:	05 Oct 2017 0100 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	05 Oct 2017 1231 GMT
Facility:		Document ID:	9174509170
Clinician:	KHRAMTSOV, ANDREI N		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170727-03882
 MCP Referral #: 20171332279
 No. of Visits: 1
 Referral Authorized Until: 26 Aug 2017
 Reason for Consult:
 32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also
 intermittent headaches. Please evaluate for sleep disorder. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 R/o obstructive sleep apnea
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 04 Oct 2017@20:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: SLEEP (PULM) CL BE
 Consulting HCP: KHRAMTSOV, ANDREI N.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 04 Oct 2017 2000 EDT Appt Type:
 PROC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: SLEEP
 (PULM) CL BE Provider: KHRAMTSOV, ANDREI N.

Patient Status: Outpatient

Reason for Appointment:

split w 3% per Dr. K

A/P Last Updated by IRVINE, RAYMOND W @ 05 Oct 2017 0423 EDT

1. Sleep disorder, unspecified

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Procedure(s): -Polysomnography With 4+ Add'l Sleep Parameters Age 6 Years Or Older x 1 (TC-TECHNICAL COMPONENT) ADDITIONAL PROVIDER(S): PETRI,ROEL -
This note pertains to polysomnography data collection only. The physician interpretation is appended to a separate procedure note. If there are no additional procedure notes visible within the electronic medical record, please call 301-295-4547 and ask to speak with one of the physician staff.
Disposition Last Updated by IRVINE,RAYMOND W @ 05 Oct 2017 0423 EDT
Released w/o Limitations
Follow up: as needed . - Comments: Please don't drive if sleepy.
Note Written by IRVINE,RAYMOND W @ 05 Oct 2017 0419 EDT
Consult Order
Referring Provider:TOBAR, EDEN
Date of Request:27 Jul 2017
Priority:Routine
Provisional Diagnosis:
R/o obstructive sleep apnea
Reason for Request:
32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.
Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 05 Oct 2017 0826
Verified by: ANDREI N KHRAMTSOV 05 Oct 2017@0831

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 1600 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	04 Oct 2017 1600 GMT
Document Type:	Consultation	AHLTA Entry Date:	05 Oct 2017 0406 GMT
Facility:		Document ID:	9174047511
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 04 Oct 2017@11:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 04 Oct 2017 1100 EDT Appt Type:
 FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C

Patient Status: Outpatient

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

F/U

Appointment Comments:

CTC

S/O Note Written by HANGEMANOLE,DESPINA C @ 04 Oct 2017 1324 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Focus Of Session: CBT/Work Stress

S) SM reported that he has been feeling bad the last two days due to some stress with his direct supervisor. SM stated that he feels angry but was able to identify feeling disrespected as the main reason for his anger. SM and this writer used CBT techniques to work through the beliefs and emotional consequences of the conflict at work. SM explored how he can use cognitive reframing and expectation adjustment to reduce the stress around this conflict. SM stated that he had forgotten to do his gratitude list for the last couple days until his family reminded him to do it and stated he was happy for the accountability. SM reported group went well and he attended one SMART recovery meeting last week which he enjoyed. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to be thinking critically about his recovery and is open to feedback. SM seems to be open minded to using concrete techniques to address his depression and anxiety and is reflective and thoughtful in session.

Alcohol Use D/O, Severe

P) SM will follow up with social worker in two weeks. SM will begin continue with ATS groups as scheduled.

.eg

ebody

ebody

A/P Written by HANGEMANOLE,DESPINA C @ 04 Oct 2017 1325 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by HANGEMANOLE,DESPINA C @ 04 Oct 2017 1325 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)

@ 04 Oct 2017 1326

Verified by: HANGEMANOLE,DESPINA C 04 Oct 2017@2118

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

04 Oct 2017 1230 GMT at by RAGLAND, MARY

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	04 Oct 2017 1230 GMT
Document Type:	Consultation	AHLTA Entry Date:	05 Oct 2017 1252 GMT
Facility:		Document ID:	9174576273
Clinician:	RAGLAND, MARY		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 04 Oct 2017@07:30:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: RAGLAND, MARY

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 04 Oct 2017 0730 EDT Appt Type: GRP

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS ADULT BE
 Provider: RAGLAND, MARY
 Patient Status: Outpatient
 Reason for Appointment:
 process group

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Appointment Comments:

ctc

Note Written by RAGLAND,MARY @ 04 Oct 2017 1007 EDT

Process Group 0730-0845

S: Topics discussed: Introductions, stressors which impacted drinking and/or recovery. Ct shared openly about his prior treatment experiences for alcohol, his recent relapse episode which led to this ATS referral. Ct shared very openly about negative childhood experiences related to being the child of divorced parents. Ct described recent trouble for "sexual harrassment presented in a way as warning the other group members not to "post photos of yourself on social media" or "ask a civilian to speak outside of work". Ct related to another peer about SMART Recovey and they determined they lived near each other. Ct suggested they carpool to meetings.

O: Ct arrived on time for group SM alert and oriented x 3.

Appearance: Appropriate for weather /situation

Behavior: Appropriate, engaged

Speech: Within Normal Limits

Thoughts: Logical, Linear, Goal-Directed

Mood: Euthymic

Affect: Congruent

Insight: Intact

Judgment: Intact

SI/HI: None reported

Med/Pain Issues: None reported

A: Ct participated appropriately in discussion. Ct demonstrates commitment to sobriety/recovery.

P: Ct to continue with groups as assigned.

A/P Written by RAGLAND,MARY @ 05 Oct 2017 0847 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by RAGLAND,MARY @ 05 Oct 2017 0847 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic.

Signed By RAGLAND, MARY (Physician) @ 05 Oct 2017 0847

Verified by: RAGLAND,MARY 05 Oct 2017@0852

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

02 Oct 2017 1500 GMT at by KHRAMTSOV, ANDREI N

Title:	SLEEP DISORDERS	Original Date:	02 Oct 2017 1500 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	12 Oct 2017 1707 GMT
Facility:		Document ID:	9189313841
Clinician:	KHRAMTSOV, ANDREI N		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170727-03882
 MCP Referral #: 20171332279
 No. of Visits: 1
 Referral Authorized Until: 26 Aug 2017
 Reason for Consult:
 32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also
 intermittent headaches. Please evaluate for sleep disorder. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 R/o obstructive sleep apnea
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 02 Oct 2017@10:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: SLEEP (PULM) CL BE
 Consulting HCP: KHRAMTSOV, ANDREI N.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 02 Oct 2017 1000 EDT Appt Type:
 SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: SLEEP
 (PULM) CL BE Provider: KHRAMTSOV, ANDREI N.

Patient Status: Outpatient

AutoCites Refreshed by KHRAMTSOV, ANDREI N @ 02 Oct 2017 1019 EDT

Problems

Loading... Family History

?family medical history (General FHx)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

?paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)

?not maternal uncle's history of referred here (Maternal Uncle)

?family history of supplemental HPI [use for free text] (General FHx)

?no family history of malignant melanoma of the skin (General FHx)

?family history of father is alive (General FHx)

?family history of heart disease (General FHx)

?family history of cancer (General FHx)

?family history of mother is alive (General FHx)

?no family history of malignant neoplasm of large intestine (General FHx)

?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)

?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)

?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)

?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)

?paternal history of preliminary background HPI [use for free text] (Father)

?family history of test conclusions [Use for free text] (General FHx)

?family history of diabetes mellitus (General FHx)

?family history of mental illness (not retardation) (General FHx)

?family history of the options include referral (General FHx)

?family history of patient counseling (General FHx)

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)

?no family history of chronic liver disease (General FHx)

Allergies

Loading...

Active Medications

Active Medications Status Sig Refills Left Last Filled

DULOXETINE HCL, 60 MG, CAPSULE DR, ORAL Ordered TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1 1 of 1 27 Sep 2017

Sodium Carboxymethylcellulose 0.5%, Solution, Ophthalmic Ordered INSTILL 1

DROP IN EACH EYE FOUR TIMES A DAY AS NEEDED FOR DRYNESS #0 RF2 2 of 2 27 Sep 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL Refill TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1 0 of 1 06 Sep 2017

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL Active TAKE 2 BY MOUTH EVERY DAY #0 RF3 2 of 3 06 Sep 2017

PROBIOTIC (VSL#3) DS--PO PACK Active TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1 1 of 1 06 Jun 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL Active CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 2 of 2 18 May 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL Active DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3 3 of 3 10 May 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral Active TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3 3 of 3 10 May 2017

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1 1 of 1 28 Apr 2017

FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE Active NR 14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Labs

26 Sep 2017 0736

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

26 Sep 2017 0736

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE negative <i> (Negative)

Barbiturates URINE negative <i> (Negative)

Benzodiazepines URINE negative <i> (Negative)

Cocaine URINE negative <i> (Negative)

Opiates URINE negative <i> (Negative)

Phencyclidine, UA URINE negative <i> (Negative)

Cannabinoids URINE negative <i> (Negative)

Methadone URINE negative <i> (Negative)

Oxycodone URINE negative <i> ng/mL (Negative)

22 Sep 2017 0745

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

22 Sep 2017 0745

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE negative <i> (Negative)

Barbiturates URINE negative <i> (Negative)

Benzodiazepines URINE negative <i> (Negative)

Cocaine URINE negative <i> (Negative)

Opiates URINE negative <i> (Negative)

Phencyclidine, UA URINE negative <i> (Negative)

Cannabinoids URINE negative <i> (Negative)

Methadone URINE negative <i> (Negative)

Oxycodone URINE negative <i> ng/mL (Negative)

19 Sep 2017 0720

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

19 Sep 2017 0720

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE negative <i> (Negative)

Barbiturates URINE negative <i> (Negative)

Benzodiazepines URINE negative <i> (Negative)

Cocaine URINE negative <i> (Negative)

Opiates URINE negative <i> (Negative)

Phencyclidine, UA URINE negative <i> (Negative)

Cannabinoids URINE negative <i> (Negative)

Methadone URINE negative <i> (Negative)

Oxycodone URINE negative <i> ng/mL (Negative)

12 Sep 2017 0819

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

12 Sep 2017 0819

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE negative <i> (Negative)

Barbiturates URINE negative <i> (Negative)

Benzodiazepines URINE negative <i> (Negative)

Cocaine URINE negative <i> (Negative)

Opiates URINE negative <i> (Negative)

Phencyclidine, UA URINE negative <i> (Negative)

Cannabinoids URINE negative <i> (Negative)

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Methadone URINE negative <i> (Negative)

Oxycodone URINE negative <i> ng/mL (Negative)

05 Sep 2017 0915

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <i> ng/mL Cutoff=250

05 Sep 2017 0915

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE negative <i> (Negative)

Barbiturates URINE negative <i> (Negative)

Benzodiazepines URINE negative <i> (Negative)

Cocaine URINE negative <i> (Negative)

Opiates URINE negative <i> (Negative)

Phencyclidine, UA URINE negative <i> (Negative)

Cannabinoids URINE negative <i> (Negative)

Methadone URINE negative <i> (Negative)

Oxycodone URINE negative <i> ng/mL (Negative)

Vitals

Vitals Written by VELMA,SHEDRICK D @ 02 Oct 2017 0940 EDT

BP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO2: 95%, BMI: 23.63,

BSA: 1.879 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats

Vitals Written by MARCIULIONIS,MANTAS @ 29 Sep 2017 0958 EDT

BP: 133/94, HR: 72, T: 97.5 F, HT: 69 in, WT: 163 lbs, SpO2: 96%, BMI:

24.07, BSA: 1.894 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Vitals Written by NDEGWAH,DOROTHY J @ 27 Sep 2017 1054 EDT

BP: 137/93, HR: 82, RR: 16, T: 97.9 F, HT: 69 in, WT: 160 lbs, BMI: 23.63,

BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No,

Pain Scale: 0 Pain Free

Vitals Written by WESLEY,LATASHA @ 26 Sep 2017 0859 EDT

BP: 135/94, HR: 79, RR: 18, T: 97.9 F, HT: 69 in, WT: 160 lbs, SpO2: 96%,

BMI: 23.63,

BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10

Severe, Pain Scale Comments: headache- dull

Reason for Appointment:

R/o obstructive sleep apnea

Appointment Comments:

dttp/irmac pt waived atc

Vitals

Vitals Written by VELMA,SHEDRICK D @ 02 Oct 2017 0940 EDT

BP: 132/88, HR: 79, RR: 14, HT: 69 in, WT: 160 lbs, SpO2:

95%, BMI: 23.63, BSA: 1.879 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Allergic to cats

S/O Note Written by KHRAMTSOV,ANDREI N. @ 12 Oct 2017 1254 EDT

bodybodyChief complaint g1

The Chief Complaint is:

Difficulty staying asleep.eg

History of present illness g2

The Patient is a 32 year old male.

He reported: Military service in the Navy and currently on active duty.

Patient reports gasping , witnessed apnea, difficulty staying asleep , non

refreshing sleep, hypersomnia, feeling tired, See paper note .eg

Past medical/surgical history g4

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Diagnoses:

No coronary artery disease

No congestive heart failure.

No hypertension

No pulmonary hypertension.

No diabetes mellitus.

Cerebral artery thrombosis - without cerebral infarction.

Depression Anxiety, Patient denies suicidal or homicidal ideation

Personal history g5

Behavioral: No caffeine use mild excessive and not a current smoker.

Alcohol: Alcohol use H/o EOH abuse.eg

Review of systems g16

Encounter Background Information: Medication list reviewed.

Otolaryngeal: No nasal passage blockage (stuffiness), no snoring, and snoring not exacerbated by nasal congestion.

Gastrointestinal: Heartburn.

Genitourinary: Nocturia.

Endocrine: Decreased libido.

Musculoskeletal: The legs do not feel restless.

Psychological: Total Epworth Sleepiness score for likelihood of falling asleep during the day 19/24 Driving problems secondary EDS.- yes and middle-night awakening with a choking sensation.

See paper note.eg

Physical findings g8

Vital Signs:

Current vital signs reviewed.

General Appearance:

Awake. Alert. In no acute distress.

Neck:

Appearance: ? Neck circumference 38 cm.

Obstructions:

Obstructions: ? Airway was partially obstructed Mallampati class 2.

Lungs:

Clear to auscultation is without wheezes, rales or ronchi.

Cardiovascular:

Heart Rate And Rhythm: Normal are normal, no murmurs, gallops or rubs appreciated.

Edema: Pretibial pitting edema not bilateral.

Neurological:

? Not oriented to time, place, and person. System: normal is grossly normal. Normal gait.eg

Objective g9

Assessment/Plan: The patient presents with some symptoms suggestive of Obstructive Sleep Apnea. y. Polysomnography/split has been ordered.

Discussed with patient OSA, Insufficient Sleep Syndrome (ISS) and nasal congestion. The patient was counseled to maintain an ideal body weight to reduce the severity of the disease and related complications. The risks of alcohol and other sedatives were discussed. The patient was educated on positional therapy. The patient was counseled to avoid driving while excessively sleepy.(was stressed to patient with hypersomnia) !!!eg

ebody

ebody

A/P Written by KHRAMTSOV,ANDREI N @ 02 Oct 2017 1033 EDT

1. Sleep disorder, unspecified

Medication(s): -ESZOPICLONE--PO 3MG TAB - TAKE ONE TABLET BY MOUTH EVERY

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

NIGHT AS NEEDED FOR SLEEP #1 RF0

Disposition Written by KHRAMTSOV, ANDREI N @ 12 Oct 2017 1302 EDT

Released w/o Limitations

Follow up: as needed in the SLEEP (PULM) CL BE clinic. - Comments: meds. recon/immun.add

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Given the multidisciplinary variables that have been considered in the evaluation and management of this patient's sleep complaints the medical decision making is of moderate to high complexity. The diagnostic procedures and therapeutic interventions are of high technical complexity thereby the overall data complexity for this patient's evaluation is moderate to high. At least 30 minutes were spent face to face with this patient (10 minutes reviewing questionnaire and history, 5 minutes reviewing medical record, 10 minutes educating and counseling on good sleep practices and strategies and 5 minutes coordinating care). PATIENT COUNSELED NOT TO OPERATE MOTOR VEHICLES IF FEELING TIRED.

Note Written by WILLIAMS, FELICIA P @ 02 Oct 2017 0928 EDT

Consult Order

Referring Provider: TOBAR, EDEN

Date of Request: 27 Jul 2017

Priority: Routine

Provisional Diagnosis:

R/o obstructive sleep apnea

Reason for Request:

32 y/o USN PO2 with chronic daytime fatigue despite adequate sleep time. Also intermittent headaches. Please evaluate for sleep disorder. Thank you.

Note Written by TERRY, SETH M @ 12 Oct 2017 1100 EDT

Questionnaire

Signed By KHRAMTSOV, ANDREI N (Staff Physician, Sleep Disorders Center, WRAMC) @ 12 Oct 2017 1302

Verified by: ANDREI N KHRAMTSOV 12 Oct 2017@1307

Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

29 Sep 2017 1300 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	29 Sep 2017 1300 GMT
Document Type:	Consultation	AHLTA Entry Date:	29 Sep 2017 1539 GMT
Facility:		Document ID:	9161717585
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT**Order Request for ANDERSON, DANIEL**

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 29 Sep 2017@08:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 29 Sep 2017 0800 EDT Appt Type:
 FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C

Patient Status: Outpatient

Reason for Appointment:

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 29 Sep 2017 1133 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Focus Of Session: Treatment Planning

S) SM reported that he has been busy with appointments and will be finishing up with the VA this week. SM stated he had a sleep study on Monday and acknowledged he will be starting IOP process groups on Wednesday and then full IOP on 11 October. SM stated that he went to an AA meeting but walked out and spent time in his car trying to figure out why he had such a problem with AA. SM expressed that he felt the people in AA were of lower intelligence and didn't have much motivation to work on their problems behaviorally, though they verbalized a desire to change. SM stated he then went to a SMART recovery meeting and felt much more engaged there. SM stated he appreciates the CBT focus. SM was encouraged to keep an open mind about AA and he acknowledged there were many things about AA philosophy that he agreed with but that the meetings just didn't resonate with him. SM stated that he would need to be vigilant regarding the tendency to rationalize a return to drinking when he is "feeling better". SM stated that he feels he is working on the spiritual bankruptcy of addiction by connecting with his family and trying to connect more with friends. SM and this writer reviewed treatment planning goals. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed casually. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM was insightful in developing his treatment plan. SM appears to be thinking critically about his recovery and is open to feedback.

Alcohol Use D/O, Severe

P) SM will follow up with social worker next week. SM will begin ATS groups on 4 October.

.eg

ebody

ebody

A/P Last Updated by HANGEMANOLE,DESPINA C @ 29 Sep 2017 0842 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 29 Sep 2017 0843 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)
@ 29 Sep 2017 1133

Verified by: HANGEMANOLE,DESPINA C 29 Sep 2017@1139

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

19 Sep 2017 2030 GMT at by BHUSHAN, ANITA

Title:		Original Date:	19 Sep 2017 2030 GMT
	GASTROENTEROLO GY MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	22 Sep 2017 1623 GMT
Facility:		Document ID:	9145300539
Clinician:	BHUSHAN, ANITA		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160413-07484
 MCP Referral #: 20160660564
 No. of Visits: 1
 Referral Authorized Until: 13 May 2016
 Reason for Consult:
 SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 19 Sep 2017@15:30:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: GI CL BE
 Consulting HCP: BHUSHAN, ANITA

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL DENNIS Date: 19 Sep 2017 1530 EDT Appt Type: FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: GI CL
 BE Provider: BHUSHAN, ANITA

Patient Status: Outpatient

Reason for Appointment:

follow up

Appointment Comments:

dtp/irmac pt waived atc

Vitals

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Vitals Written by NG,ANDREW J @ 19 Sep 2017 1515 EDT

BP: 137/87, HR: 76, RR: 14, T: 97.9 F, HT: 69 in, WT:

164.2 lbs, SpO2: 95%, BMI: 24.25,

BSA: 1.9 square meters, Tobacco Use: No, Alcohol Use: No, Pain

Scale: 0 Pain Free

S/O Note Written by BRIDGES,EDWARD E @ 19 Sep 2017 1549 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Abdominal pain is worse with intake of insoluble fibers, although, this regimen does resolves his liquid stools producing semi formed stools.

Also worse during physical activity and with increased anxiety/stress. He has seen nutrition, adopted a low fodmap diet (no beer, no wine, no rum, no broccoli, no lettuce, no onions, no garlic, no beans, no spinach, no cabbage, no asparagus, no fruits, no sausage, no chorizo, no eggs), and found partial relief in frequency of pain and fecal urgency. He also reports similar relief in symptom frequency with avoiding dairy, caffeine, and sugar-substitutes. He reports reduced stool output with decreased oral intake. He previously tested for celiac serologies and inflammatory markers. Denies EIM's of IBD, as well family h/o IBD. Reports fecal staining twice in the setting diarrhea. Reports 5-15 minute urgency before defecating on every occasion. Denies post defecatory leakage.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

.eg

Allergies g24

Allergies Verified and Updated

NKDA

.eg

Current medication g3

Including OTC meds, vitamins, herbals, etc.

Effexor - started after previously diagnosed IBS-D (used for Anxiety/Depression)

Naltrexone started after previously diagnosed IBS-D (used for ETOH avoidance)

Simethicone qid.eg

Past medical/surgical history g4

Reported:

Medical: Reported medical history

Anxiety/depression

IBS-D

.

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

PRK

LaForte1 May 2017.eg

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Personal history g5

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

.eg

Family history g7

Family medical history

No malignant neoplasm of the gastrointestinal tract.

.eg

Physical findings g8

Vital Signs:

? Temperature: Reviewed. ? RR: Reviewed. ? PR: Reviewed. ? Blood pressure: Reviewed.

General Appearance:

Normal. Well developed. Well nourished. In no acute distress.

Neck:

Appearance: Of the neck was normal.

Eyes:

General/bilateral:

Sclera: Normal.

Lymph Nodes:

Submandibular lymph nodes were not enlarged.

Lungs:

Respiration rhythm and depth was normal.

Cardiovascular:

Heart Rate And Rhythm: Normal.

Abdomen:

Visual Inspection: Abdomen was not distended.

Musculoskeletal System:

Functional Exam:

General/bilateral: Mobility was not limited.

Other:

General/bilateral: No muscle tenderness.

Neurological:

Oriented to time, place, and person.

Psychiatric:

Mood: Euthymic.

Affect: Normal.

Skin:

Showed no ecchymosis. Temperature was normal. No skin lesions.eg

ebody

ebody

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1611 EDT

Tissue Transglutaminase Ab IgA+IgG PanelSite/Specimen06 Oct 2016 1307

Tissue Transglutaminase Ab IgASERUM<2 <i>

Tissue Transglutaminase Ab IgGSERUM<2 <i>

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT

IgASite/Specimen06 Oct 2016 1307

IgASERUM256

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT

Helicobacter pylori Ag EIA

Order #160511-04658 (NNMC Bethesda)

Filler #160606 NBL 374 (NNMC Bethesda)

Status:Final

Ordering Provider:SHAH, NISHA AMISH

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Priority:ROUTINE

Date Ordered:11 May 2016 0843

Date Resulted:10 Jun 2016 0857

COLLECT_SAMPLE:STOOL

Order Comment:to be done two weeks after stopping protonix

BACTERIOLOGY RESULT:OBSERVATION: Negative

Specimen:Feces

Collected:06 Jun 2016 1312

Results:

Final report

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1610 EDT

ESRSite/Specimen11 Apr 2016 1043

ESRBLOOD5

Lab Result Cited by BRIDGES,EDWARD E @ 19 Sep 2017 1300 EDT

Helicobacter pylori Ag EIA

Order #160511-04658 (NNMC Bethesda)

Filler #160606 NBL 374 (NNMC Bethesda)

Status:Final

Ordering Provider:SHAH, NISHA AMISH

Priority:ROUTINE

Date Ordered:11 May 2016 0843

Date Resulted:10 Jun 2016 0857

COLLECT_SAMPLE:STOOL

Order Comment:to be done two weeks after stopping protonix

BACTERIOLOGY RESULT:OBSERVATION: Negative

Specimen:Feces

Collected:06 Jun 2016 1312

Results:

Final report

A/P Last Updated by BRIDGES,EDWARD E @ 19 Sep 2017 1646 EDT

1. Irritable bowel syndrome with diarrhea: 32WM with IBS-D predominant symptoms complicated fecal urgency/soiling, with some element of FODMAP associated osmotic diarrhea. Comprehensive evaluation has otherwise been unremarkable.

- Will refer for ARM, possibly followed by biofeedback given reported history of urgency with every bowel movements and occasional fecal soiling (twice)
- Continue dietary modification as noted, including low fodmap and low fructose

- Will trial OTC citrucel to increase stool bulk

- Would suggest Nortryptiline or cymbalta for psychiatry to prescribe to attenuate his IBS related cramping

Disposition Last updated by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT

I saw and evaluated the patient, and agree with the above findings and plan.

Discussed the plan with patient at length. All questions answered. Pt v/u and agrees.

Signed By BHUSHAN, ANITA (Physician) @ 22 Sep 2017 1218

CHANGE HISTORY

The following Disposition Note Was Overwritten by BHUSHAN,ANITA @ 22 Sep 2017

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

1218 EDT:

Disposition section was last updated by BHUSHAN,ANITA @ 22 Sep 2017 1218 EDT - see above. Previous Version of Disposition section was entered/updated by BRIDGES,EDWARD E @ 19 Sep 2017 1647 EDT.

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

40 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Verified by: BHUSHAN,ANITA 22 Sep 2017@1223

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

13 Sep 2017 1600 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	13 Sep 2017 1600 GMT
Document Type:	Consultation	AHLTA Entry Date:	13 Sep 2017 1633 GMT
Facility:		Document ID:	9122695847
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT**Order Request for ANDERSON, DANIEL**

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 13 Sep 2017@11:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL D
 Date: 13 Sep 2017 1100 EDT
 Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR
 Clinic: ATS ADULT BE
 Provider: HANGEMANOLE, DESPINA C
 Patient Status: Outpatient
 Reason for Appointment:
 f/u

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Appointment Comments:

jbf

Note Written by HANGEMANOLE,DESPINA C @ 13 Sep 2017 1227 EDT

Focus Of Session: Recent Cravings

S) SM reported that he has been having less frequent IBS episodes but reported that when they do happen they are more intense. SM stated that he has been doing the gratitude list as a family text and while sometimes it's difficult to find things to be grateful for it is forcing dialogue with his family. SM reported he's been less successful with his 'to do list' goals, but agreed to step back from trying to accomplish one goal a day and try to accomplish 2-3 goals per week instead. SM stated he went to one meetings in the last 3 weeks and found it 'ok'. SM agreed to continue going to one meeting per week. SM reported he is not sure if PCS is helpful and is not learning many new skills but is finding some self discovery through group discussion. SM reported he has two weeks of groups left and then he will continue getting TMS through PCS for another 2 weeks. SM stated he's been having more cravings and shared that his BH provider may switch him from Naltrexone to Campral. SM stated he's been getting through the cravings by eating and sleeping. He stated his anxiety is also increasing and was able to identify some of the reasons this may be happening. SM reported he had a preliminary sleep study which resulted in a consult to the sleep clinic. SM reported he is hopeful that if his sleep improves his anxiety, cravings and concentration issues may also improve. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that are being addressed through PCS and BH. SM would benefit from engaging in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week. SM will work on treatment planning goals as homework.

A/P Last Updated by HANGEMANOLE,DESPINA C @ 13 Sep 2017 1153 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 13 Sep 2017 1159 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)
@ 13 Sep 2017 1228

Verified by: HANGEMANOLE,DESPINA C 13 Sep 2017@1233

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

08 Sep 2017 1300 GMT at by BENTON, JIKESHA R

Title:	PSY DIAGNOSTIC TESTING MTF BE	Original Date:	08 Sep 2017 1300 GMT
Document Type:	Consultation	AHLTA Entry Date:	14 Sep 2017 1922 GMT
Facility:		Document ID:	9113773157
Clinician:	BENTON, JIKESHA R		

CONSULT REPORT

Order Request for ANDERSON, DANIEL

Requesting HCP: PAUL, SHERIN
 Requesting Location: PSYCHIATRY BE
 Order ID number: 161208-20980
 MCP Referral #: 20162154263
 No. of Visits: 1
 Referral Authorized Until: 07 Jan 2017
 Reason for Consult:
 Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.
 Priority: ROUTINE
 Provisional Diagnosis:
 Generalized anxiety disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 08 Sep 2017@08:00:00
 Requesting HCP: PAUL, SHERIN
 Clinic: PSYCHOLOGY ASSESSMENT BE
 Consulting HCP: BENTON, JIKESHA R

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: ANDERSON, DANIEL D Date: 08 Sep 2017 0800 EDT Appt Type: PROC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

PSYCHOLOGY ASSESSMENT BE Provider: BENTON, JIKESHA R

Patient Status: Outpatient

AutoCites Refreshed by BENTON, JIKESHA R @ 08 Sep 2017 1440 EDT

Problems

?Generalized anxiety disorder F41.1

?Counseling, unspecified Z71.9

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Created: 13 Nov 2017

?EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225

?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

?MAJOR DEPRESSION RECURRENT MODERATE

?ANXIETY DISORDER NOS

?Left ankle joint pain

?NEUROTIC EXCORIATION

?ANKLE SPRAIN LEFT

?ESSENTIAL HYPERTRIGLYCERIDEMIA

?ANOMALIES OF SKIN

?Abdominal pain

?ASTHMA

?POSTSURGICAL STATE OF EYE AND ADNEXA

?Difficulty breathing (dyspnea)

?SKIN NEOPLASM UNCERTAIN BEHAVIOR

?Removal Of Sutures

?ASTHMA EXTRINSIC

?ROSACEA

?PERIPHERAL RETINAL DEGENERATION - LATTICE

?REFRACTIVE ERROR - MYOPIA

?ALLERGIC RHINITIS

Family History

?paternal aunt's history of reason for visit [use for free text] (Paternal Aunt)

?not maternal uncle's history of referred here (Maternal Uncle)

?family medical history (General FHx)

?family history of supplemental HPI [use for free text] (General FHx)

?no family history of malignant melanoma of the skin (General FHx)

?family history of father is alive (General FHx)

?family history of heart disease (General FHx)

?family history of cancer (General FHx)

?family history of mother is alive (General FHx)

?no family history of malignant neoplasm of large intestine (General FHx)

?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)

?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)

?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)

?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)

?paternal history of preliminary background HPI [use for free text] (Father)

?family history of test conclusions [Use for free text] (General FHx)

?family history of diabetes mellitus (General FHx)

?family history of mental illness (not retardation) (General FHx)

?family history of the options include referral (General FHx)

?family history of patient counseling (General FHx)

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)

?no family history of chronic liver disease (General FHx)

Allergies

?No Known Allergies

Active Medications

Active Medications Status Sig Refills Left Last Filled

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL Ordered TAKE ONE CAPSULE WITH ONE 150 MG CAPSULE FOR A TOTAL OF 225 MG BY MOUTH EVERY MORNING #0 RF3 3 of 3

Anderson, Daniel Dennis

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Created: 13 Nov 2017

06 Sep 2017

NALTREXONE HCL, 50 MG, TABLET, ORAL Refill TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1 0 of 1 06 Sep 2017

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL Active TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1 0 of 1 06 Sep 2017

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL Active TAKE 2 BY MOUTH EVERY DAY #0 RF3 2 of 3 06 Sep 2017

PROBIOTIC (VSL#3) DS--PO PACK Active TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1 1 of 1 06 Jun 2017

SIMETHICONE, 80 MG, TAB CHEW, ORAL Active CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2 2 of 2 18 May 2017

HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL Active DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3 3 of 3 10 May 2017

Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral Active TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3 3 of 3 10 May 2017

Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL Active DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3 3 of 3 28 Apr 2017

IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL Active DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1 1 of 1 28 Apr 2017

FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE Active NR 14 Oct 2016

AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

Reason for Appointment:

F/U Testing

Appointment Comments:

CAC

S/O Note Written by BRYANT,JASMINE RESHAE @ 08 Sep 2017 0846 EDT

bodybodyObjective g9

Assessment: 2 hours. SM was escorted by writer from PDS lobby to RM 4116 for continued DX testing. Testing was completed 8 DEC 2016. SM was sociable, paranoid, and cooperative during testing AEB asking if he could "get into trouble over testing answers?" SM reported "abusing prescribed medications in order to "feel high" and stated he was worried about "being honest." SM was redirected and continued with testing. SM stated mood was "anxious, energetic, and content" and his affect was bright and congruent with mood. SM reported 2-3 weeks of increased "anxiety" due to "everyday" triggers. SM reported a "normal" appetite with 1-2 small meal consumption throughout the day. SM reports having chronic IBS and is currently MEDBRD out of the military due to its "discomfort." SM reported a significant weight loss of 12lbs within a 60 day period. SM reports he is reframing from alcohol and it could be his "main contributor" to his recent weight loss. SM reported a poor sleep pattern with difficulty staying asleep with a possible sleep disorder. SM reports 6-7 hours of restless sleep per night with a medication aid to "slight" effect and relief. SM reported experiencing sleep paralysis on a "frequent" basis and vivid nightmares about "real life situations." SM denied to clarify. SM is currently awaiting a sleep study with the Sleep Clinic here at Walter Reed. SM reports a 2/10 intestinal pain. SM also has a H/O of headaches/migraines but, did not experience any while testing. SM currently denies any SI/HI/AVH. SM escorted himself back to IOP and was advised to speak with social worker before resuming scheduled activities. Writer informed front desk of SM arrival.eg

Tests g10

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

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1985

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DoD ID: 1286180538

Created: 13 Nov 2017

PAI, AQ completed today

Testing completed 8 DEC 16 MMPI-II, MCMI, RISB

.eg

Plan g13

Limits of confidentiality was explained and understood by SM. Original documentation can be found in BLD 10 7C RM 7131. DX Interview to be scheduled and completed by Dr. Benton.eg

ebody

ebody

A/P Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT

1. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychologic Testing And Report Administered By Technician x

2

Disposition Last Updated by BENTON, JIKESHA R @ 08 Sep 2017 1442 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 08 Sep 2017 1442

Note Written by BENTON, JIKESHA R @ 14 Sep 2017 1516 EDT

(Added after encounter was signed.)

Psychological Evaluation Addendum

Name: Daniel Anderson (nee Merwin)

SSN: 20/8503

Page 1 of 3

WALTER REED NATIONAL MILITARY MEDICAL CENTER

8901 Rockville Pike, Bethesda, Maryland 20889-5600

DEPARTMENT OF BEHAVIORAL HEALTH CONSULTATION AND EDUCATIONAL SERVICES

PSYCHODIAGNOSTIC ASSESSMENT SERVICE

8901 Wisconsin Ave

Bethesda, MD 20889

PSYCHOLOGICAL EVALUATION ADDENDUM

NAME: Daniel Anderson (nee Merwin) RANK: PO2

SSN: 20/8503 DATE: 01AUG17

IDENTIFYING AND REFERRAL INFORMATION: SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

It should be noted SM received a psychological evaluation conducted by 2LT Hannah Martinez, Doctoral Practicum Student, with PsychoDiagnostic Assessment Services on 02FEB17. This writer served as a covering supervisor for the psychological evaluation. SM was referred for the psychological evaluation by Dr. Sherin Paul, Clinical Psychologist, with Adult Outpatient Behavioral Health for diagnostic clarification. The consult indicated SM has a history of undiagnosed Borderline Personality Disorder and Reactive Attachment Disorder. SM's family history is also significant for Bipolar Disorder.

On 08SEP17, SPC Jasmine Bryant administered the Personality Assessment Inventory (PAI) and Autism Spectrum Quotient (AQ). 2LT Hannah Martinez administered the Minnesota Multiphasic Personality Inventory-2nd edition (MMPI-2), Million Clinical Multiaxial Inventory-Third Edition (MCMI-III), and Rotter Incomplete Sentence Blanks (RISB) on 02FEB17. This writer conducted a collateral interview with Ms. Despina Hangemanole, Social Worker, with Addiction Treatment Services on 13SEP17. Dr. Benton conducted a collateral phone interview with Dr. Sherin Paul, Clinical Psychologist, with Adult

Anderson, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

Outpatient Behavioral Health on 14SEP17.

Please refer to AHLTA records and the original psychological evaluation for a comprehensive background history.

PSYCHOLOGICAL TEST RESULTS:

MMPI-2: The validity indicators suggested that SM endorsed test items in a manner to cry for help. SM is likely to present with extreme somatic problems or chronic pain and to complain of being physically ill although there may not be an organic basis to his problems. He is anxious, tense, nervous, restless, irritable, dysphoric, brooding, and unhappy. He has a loss of initiative. He reported depressed mood, social withdrawal, and reclusiveness. He is self-conscious in talking with others. Doubts about his abilities are common, as is vacillation and indecision about even minor matters. SM is hypersensitive to criticism.

MCMI-III: The validity indicators suggested that SM was being open and honest. SM does not have any close friends, so he tends to remain detached and isolated. There is evidence that SM strongly wishes to be liked and accepted by others on his terms. He is often guarded and experience social situations negatively. SM is apprehensive and nervous in social situation. SM usually avoids relating to others, which forces him to give up the support and affect that the relationship might have brought. Life is experienced as a conflict between taking a risk and accepting the discomfort of forming a relationship or retreating to the unfulfilling safety of isolation.

PAI: The results of the PAI were considered invalid. SM consistently endorsed items that portrayed him in an especially negative or pathological manner. The test results involved considerable distortion and does not reflect an inaccurate reflection of SM's psychological functioning.

AIQ: The Autism Spectrum Quotient is a questionnaire used to determine the extent to which an adult of normal intelligence has the traits associated with Autism spectrum conditions. A content analysis of the AIQ indicated SM elevated on the measure due to his endorsement of social avoidance; he did not endorse the developmental criteria of Autism and Asperger's Disorder.

FINDINGS AND CONCLUSIONS: SM is a 31 year old, single, male, Caucasian, AD USN, PO2, Cryptologist. SM was referred by Ms. Laura Donkin, Social Worker, with Psychiatric Continuity Services for diagnostic clarification of Autism and Borderline Personality Disorder.

Given all available information to include psychometric instruments, chart review, diagnostic interview, and collateral interviews, SM does not have Autism or Asperger's Disorder. SM does have relational apathy or a lack of emotional reciprocity but this is not enough to substantiate the disorder.

SM has the ability to cultivate age appropriate friends and relationships.

Furthermore, there is no impairment in the use of nonverbal behaviors.

There is no impairment in communication particularly selective mutism that is commonly found with these disorders. There is no evidence of inflexible adherence to routines or rituals. He has not demonstrated persistent preoccupation with parts of objects. This writer did not observe repetitive motor mannerisms. SM's social detachment and emotional numbness could represent a schizoid adjustment, a neurotic reaction, abuse history, or simply a lifestyle preference yet it is not Autism.

There is evidence from testing of Schizoid Personality traits characterized as lack of interest in social relationships, a tendency towards a solitary or sheltered lifestyle, secretiveness, emotional coldness, detachment, and apathy. There is research to support that Schizoid Personality traits are developed due to an insecure attachment in childhood. This is consistent with his prior history of Reactive Attachment Disorder. However, SM grew up

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

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Medical Record

Anderson, Daniel Dennis

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in an environment with physical, sexual, and emotional abuse. He was in a household with a father that had an authoritarian parenting style, which contributed to him being overly controlled, unable to express emotions, and living in fear. SM's emotional development is stunted due to the childhood environment he was reared. SM is emotionally immature; emotionally immature people can be extremely challenging to deal with, because their ability to interpret and react to the variety of life's challenges is often impaired.

When emotionally immature people do not get their way, they often respond to their circumstances in ways that are irrational. They need to control and this lack of control motivates them to act out. They pout, whine, cry, manipulate, or violate the object of their obsession, all the whilst believing they are entitled to behave this way.

SM has mood swings, anger outbursts, hyper sexuality, and suicidal ideations/gestures that can be function of his emotional immaturity. Although these behaviors can be symptoms of Borderline Personality Disorder, psychological test results do not support SM having a personality disorder.

The hallmark feature of Borderline Personality Disorder is the fear abandonment. SM does not have a fear of abandonment. SM is introverted, socially withdrawn, and prefers his own company. Typically, SM cuts people off when they become too close to him. This seems to be more of a function of his schizoid personality traits and attachment style. When his personal space is violated, he feels suffocated and desires independence. It should be noted that like individuals with schizoid personality traits, SM is capable of developing relationships when they are based on his terms. His terms do not include emotional intimacy. For example, he desires to connect with his family of origin but with self-imposed boundaries. Additionally, SM indicated he has a relationship with his neighbors in which he can come and go friendly into their home without demands or expectations. This is how he desires all of his interpersonal and romantic relationships. SM is happiest when people place few emotional and intimate demands on him. It is not people that SM wants to avoid, it is the emotions but since there are no emotionless people it is easier to socially withdraw.

RISK ASSESSMENT: SM has a history of suicidal ideation occurring approximately once a month since adulthood. His protective factors include his job, his hobby of creating video games, and wanting to find purpose in his life. SM has low social support, but this does not seem to be a significant stressor. SM does not have a history of attempts and denies access to lethal means. He denied current ideation, plan, or intent. SM is currently assessed at a mild risk for suicide, and should continue to be monitored by his healthcare providers.

DSM-5 Diagnoses:

Given the level of information obtained for this assessment, the following DSM-5 diagnoses are warranted:

Other Specified Trauma and Stressor Disorder

Schizoid Personality Traits

Reactive Attachment Disorder ? By History

If there is a need for further discuss of this case, please feel free to contact the undersigned at 301.400.0591.

Jikesha Benton, Psy.D.

Clinical Psychologist

Verified by: BENTON, JIKESHA R

14 Sep 2017@1522

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

22 Aug 2017 1300 GMT at by HANGEMANOLE, DESPINA C

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	22 Aug 2017 1300 GMT
Document Type:	Consultation	AHLTA Entry Date:	22 Aug 2017 1409 GMT
Facility:		Document ID:	9075002101
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 22 Aug 2017@08:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 22 Aug 2017 0800 EDT Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS
 ADULT BE Provider: HANGEMANOLE, DESPINA C
 Patient Status: Outpatient
 Reason for Appointment:

Anderson, Daniel Dennis

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1985

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Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 13 Nov 2017

f/u

Appointment Comments:

ctc

S/O Note Written by HANGEMANOLE,DESPINA C @ 22 Aug 2017 1004 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Focus Of Session: Realizations

S) SM reported that he wanted to drink on Friday due to stress from command.

He stated that command had a legal representative notify him that they were

counting his referral as a command referral and he was at risk for

administrative separation due to this being his second referral. Treatment

failure processes were reviewed with SM who acknowledged understanding. SM

stated he would prefer to continue treatment at WR ATS as opposed to

transferring to WNY SARP due to continuity of care and integration of care.

SM stated that he went home on Friday and watched a movie and the cravings

dissipated. SM discussed his weight loss, decrease in IBS symptoms and

financial gains since he quit drinking. SM also stated he is developing a

closer relationship with his family now that he is sober. SM reported that he

did not go to a meeting last week but committed to attending one this week.

SM also stated he would begin making a gratitude list daily to see if this

helped to ground him in the present in order to decrease his anxiety. SM

denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was

euthymic in session, affect congruent. SM's thoughts and behavior were

appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental

health issues that would be best addressed through PCS IOP. SM would benefit

from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social

worker in three weeks.

.eg

ebody

ebody

A/P Last Updated by HANGEMANOLE,DESPINA C @ 22 Aug 2017 0852 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 22 Aug 2017 0856 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with

social worker in 3 weeks.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling

and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)

@ 22 Aug 2017 1004

Verified by: HANGEMANOLE,DESPINA C 22 Aug 2017@1009

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1985

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

***** End of Clinical Notes *****

Medical Record

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 13 Nov 2017

Vitals

Date: 01 Nov 2017 Facility: WRNMMC Clinician: LO, BAO-KHANG C

Type	Value	Units
SBP	132	mmHg
DBP	70	mmHg
HR	82	beats/min
RR	16	breaths/min
HT	70	Inches
WT	200	Pounds
BMI	28.7	kg/mm
BSA	2.09	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 17 Oct 2017 Facility: WRNMMC Clinician: TASHU, BIRTUKA A

Type	Value	Units
SBP	141	mmHg
DBP	93	mmHg
HR	98	beats/min
RR	18	breaths/min
T	99.6	Fahrenheit
HT	69	Inches
WT	78.6	kg
BMI	25.59	kg/mm
BSA	1.94	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Pt stated that he has asthma/ cat allergies & irritable bowel pain. repat b/p on left arm 131/93	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments: + Depression / Anxiety		
Neg suicidal.		

Date: 02 Oct 2017 Facility: WRNMMC Clinician: VELMA, SHEDRICK D

Type	Value	Units
SBP	132	mmHg
DBP	88	mmHg
HR	79	beats/min
RR	14	breaths/min
HT	69	Inches
WT	160	Pounds
BMI	23.63	kg/mm
BSA	1.88	square meters
Oxygen Saturation	95	Percent Saturation
Pain Scale	0/10	Adult

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DoD ID: 1286180538

Created: 13 Nov 2017

Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Allergic to cats	

Date: 29 Sep 2017 Facility: WRNMMC Clinician: MARCIULIONIS, MANTAS

Type	Value	Units
SBP	133	mmHg
DBP	94	mmHg
HR	72	beats/min
T	97.5	Fahrenheit
HT	69	Inches
WT	163	Pounds
BMI	24.07	kg/mm
BSA	1.89	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 27 Sep 2017 Facility: WRNMMC Clinician: NDEGWAH, DOROTHY J

Type	Value	Units
SBP	137	mmHg
DBP	93	mmHg
HR	82	beats/min
RR	16	breaths/min
T	97.9	Fahrenheit
HT	69	Inches
WT	160	Pounds
BMI	23.63	kg/mm
BSA	1.88	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 26 Sep 2017 Facility: WRNMMC Clinician: WESLEY, LATASHA

Type	Value	Units
SBP	135	mmHg
DBP	94	mmHg
HR	79	beats/min
RR	18	breaths/min
T	97.9	Fahrenheit
HT	69	Inches
WT	160	Pounds
BMI	23.63	kg/mm
BSA	1.88	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	7/10	Adult
Pain Scale Comments	headache- dull	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Anderson, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Anderson, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 13 Nov 2017

Date: 19 Sep 2017 Facility: WRNMMC Clinician: NG, ANDREW J

Type	Value	Units
SBP	137	mmHg
DBP	87	mmHg
HR	76	beats/min
RR	14	breaths/min
T	97.9	Fahrenheit
HT	69	Inches
WT	164.2	Pounds
BMI	24.25	kg/mm
BSA	1.9	square meters
Oxygen Saturation	95	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

***** End of Vitals *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

MEDICAL RECORD

For
Merwin, Daniel Dennis

Report Criteria

From: [REDACTED] 1985 To: 16 Aug 2017
Operator: Williamson, Matthew J
Created On 16 Aug 2017 13:23:23
at WRNMMC

Comprehensive Information Report; INCLUDE HIV Lab Results: Requested

Report Summary

Sections	Domain Requested	Record Counts	Warnings
Allergies	✓	1	0
Problems	✓	51	0
Diagnosis History	✓	314	0
Medications	✓	134	0
Procedures	✓	37	0
Family History	✓	20	0
Resulted Labs	✓	175	0
Radiology	✓	16	0
Immunizations	✓	41	0
Previous Encounters	✓	242	0
Clinical Notes	✓	30	0
Vitals	✓	119	0
			*0

**Report generated with no warnings.*

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Table Of Contents

MEDICAL RECORD	1
Report Criteria.....	1
Report Summary	1
Table Of Contents	2
Demographics	13
Allergies	14
Nka	14
Problems	15
Active Problems	15
Generalized anxiety disorder on 25 Aug 2016.....	15
EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) on 22 Apr 2016	15
Counseling, unspecified on 22 Apr 2016	15
ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR on 19 Mar 2015	15
MAJOR DEPRESSION RECURRENT MODERATE on 21 Aug 2014	15
ANXIETY DISORDER NOS on 04 Aug 2014	16
Left ankle joint pain on 27 Jun 2014	16
NEUROTIC EXCORIATION on 16 Jun 2014	16
ANKLE SPRAIN LEFT on 16 Jun 2014	16
ESSENTIAL HYPERTRIGLYCERIDEMIA on 10 Apr 2013	16
ANOMALIES OF SKIN on 10 Apr 2013	16
Abdominal pain on 24 Oct 2012	17
ASTHMA on 26 Jul 2011	17
POSTSURGICAL STATE OF EYE AND ADNEXA on 22 Apr 2011	17
Difficulty breathing (dyspnea) on 16 Feb 2011	17
SKIN NEOPLASM UNCERTAIN BEHAVIOR on 24 Nov 2010	17
Removal Of Sutures on 04 Oct 2010	17
ASTHMA EXTRINSIC on 01 Sep 2010	18
ROSACEA on 14 Jun 2010	18
PERIPHERAL RETINAL DEGENERATION - LATTICE on 23 Apr 2010	18
REFRACTIVE ERROR - MYOPIA on 23 Apr 2010	18
ALLERGIC RHINITIS on 17 Mar 2010	18
Inactive Problems	18
Vaccines Prophylactic Need Against Bacterial Diseases on 05 Aug 2013	18
IMPAIRED FASTING GLUCOSE on 10 Apr 2013	19
Visit for: follow-up exam on 21 Mar 2013	19
Visit for: ears / hearing exam on 19 Mar 2013	19
Visit for: screening exam pulmonary tuberculosis on 19 Mar 2013	19
Need For Vaccination DTP + TAB on 19 Mar 2013	19
Need For Vaccination Typhoid on 19 Mar 2013	19
Visit for: screening exam STD on 28 Jan 2013	20
Need For Prophylactic Measure on 05 Nov 2012	20
Imaging Studies Nonspecific Abnormal Findings on 24 Oct 2012	20
Conditions influencing health status on 12 Oct 2012	20
VIRAL SYNDROME on 10 May 2012	20
SUPERFICIAL INJURY - ABRASION OF CORNEA on 04 May 2011	20
Aftercare Following Surgery Of Sense Organs on 22 Apr 2011	21
Visit for: preoperative exam on 29 Mar 2011	21
Visit for: screening exam malignant neoplasm skin on 24 Nov 2010	21
FOLLICULITIS on 20 Jul 2010	21
Visit for: occupational health / fitness exam on 17 Mar 2010	21

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vaccine needed prophylactically against bacterial diseases on 09 Mar 2010.....	21
Parent Education: Immunizations on 23 Sep 2009	22
Vaccines Prophylactic Need Against Influenza on 23 Sep 2009	22
Visit for: military services physical on 16 Sep 2009	22
Exposure to STD on 20 Aug 2009	22
Patient Education - HIV on 07 May 2009.....	22
Guidance: Concerns About Unsafe Sexual Practices on 07 May 2009	22
Visit for: administrative purpose on 07 May 2009	23
Inquiry And Counseling: Contraceptive Practices on 07 May 2009.....	23
Visit for: issue medical certificate fitness on 06 Mar 2006.....	23
Feared medical condition not demonstrated on 06 Mar 2006	23
Diagnosis History.....	24
Medications.....	37
Active Medications	37
Cancelled Medications	38
Discontinued Medications.....	39
Expired Medications	41
Procedures.....	48
Family History	54
Family medical history on 07 Aug 2017.....	54
Family history of supplemental HPI [use for free text] on 13 Jul 2017.....	54
No family history of malignant melanoma of the skin on 21 Jun 2017	54
Family history of cancer on 05 Apr 2017	54
Family history of heart disease on 05 Apr 2017	54
Family history of father is alive on 05 Apr 2017	54
Family history of mother is alive on 05 Apr 2017	55
No family history of malignant neoplasm of the gastrointestinal tract on 04 Oct 2016	55
No family history of malignant neoplasm of large intestine on 04 Oct 2016	55
Paternal grandmother's history of HPI [use for free text] on 25 Aug 2016	55
Paternal history of preliminary background HPI [use for free text] on 25 Aug 2016.....	56
Paternal grandfather's history of preliminary background HPI [use for free text] on 25 Aug 2016.....	56
Paternal grandmother's history of preliminary background HPI [use for free text] on 25 Aug 2016.....	56
Family history of test conclusions [Use for free text] on 11 Aug 2015	56
Family history of the options include referral on 28 Apr 2015.....	56
Family history of diabetes mellitus on 28 Apr 2015	56
Family history of patient counseling on 28 Apr 2015.....	57
Family history of mental illness (not retardation) on 28 Apr 2015.....	57
Fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] on 23 Apr 2015	57
No family history of chronic liver disease on 24 Oct 2012	57
Resulted Labs.....	58
Drug Abuse Screen on 15 Aug 2017.....	58
ETG/ETS, UA (250 Cut-Off) on 08 Aug 2017	59
Drug Abuse Screen on 08 Aug 2017.....	59
ETG/ETS, UA (250 Cut-Off) on 01 Aug 2017	61
Drug Abuse Screen on 01 Aug 2017.....	61
Vitamin B12 (Cyanocobalamin)+Folate Panel on 27 Jul 2017.....	63
Comment on 25 Jul 2017	63
Transferrin Carbohydrate Deficient on 25 Jul 2017.....	64
Gamma Glutamyl Transferase on 25 Jul 2017.....	64
Drug Abuse Screen on 06 Jul 2017	64
Urinalysis Panel on 06 Jul 2017	66
Urine Culture on 06 Jul 2017	66
Rapid Plasma Reagin on 06 Jul 2017.....	67
CBC W/Diff on 06 Jul 2017.....	67
Thyroid Stimulating Hormone on 06 Jul 2017.....	68

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Acetaminophen on 06 Jul 2017	68
Salicylates on 06 Jul 2017	68
Comprehensive Metabolic Panel on 06 Jul 2017	69
Ethanol on 06 Jul 2017	69
TISSUE EXAM on 21 Jun 2017	70
Hemoglobin A1c on 18 May 2017	71
Lipid Panel on 18 May 2017	72
ABO Group+Rh Type Confirmation on 27 Apr 2017	74
Type & Screen (with SF518) on 27 Apr 2017	74
Basic Metabolic Panel on 12 Apr 2017	74
CBC W/o Diff on 12 Apr 2017	75
Gamma Glutamyl Transferase on 04 Jan 2017	75
Hepatic Function Panel on 04 Jan 2017	75
Tissue Transglutaminase Ab IgA+IgG Panel on 06 Oct 2016	76
IgA on 06 Oct 2016	76
Thyroid Stimulating Hormone on 06 Sep 2016	76
Thyroxine Free on 06 Sep 2016	77
Troponin T Cardiac on 22 Jun 2016	77
Basic Metabolic Panel on 22 Jun 2016	78
Fibrin D-Dimer on 22 Jun 2016	78
CBC W/Diff on 22 Jun 2016	79
Helicobacter Pylori Antigen EIA on 06 Jun 2016	80
Zinc on 11 Apr 2016	80
Lyme Disease Ab Total Screen on 11 Apr 2016	80
Treponema pallidum Ab on 11 Apr 2016	81
Helicobacter pylori Ab IgG on 11 Apr 2016	82
ESR on 11 Apr 2016	82
Basic Metabolic Panel on 11 Apr 2016	82
CBC W/o Diff on 11 Apr 2016	83
Methylmalonic Acid on 16 Feb 2016	83
HIV-1/O/2 Ab on 16 Feb 2016	83
Homocysteine on 16 Feb 2016	84
Comprehensive Metabolic Panel on 16 Feb 2016	84
Vitamin B12 (Cyanocobalamin) on 16 Feb 2016	85
ETG/ETS, UA (250 Cut-Off) on 02 Feb 2016	85
Drug Abuse Screen on 02 Feb 2016	86
ETG/ETS, UA (250 Cut-Off) on 05 Jan 2016	87
Drug Abuse Screen on 05 Jan 2016	87
Reference Testing Miscellaneous on 04 Jan 2016	89
Drug Abuse Screen on 29 Dec 2015	89
ETG/ETS, UA (250 Cut-Off) on 08 Dec 2015	91
Drug Abuse Screen on 08 Dec 2015	91
ETG/ETS, UA (250 Cut-Off) on 01 Dec 2015	92
Drug Abuse Screen on 01 Dec 2015	93
ETG/ETS, UA (250 Cut-Off) on 17 Nov 2015	94
Drug Abuse Screen on 17 Nov 2015	94
Varicella Zoster Virus DFA on 29 Sep 2015	96
Herpes DFA on 29 Sep 2015	96
ETG/ETS, UA (500 Cut-Off) on 15 Sep 2015	97
Drug Abuse Screen on 15 Sep 2015	97
Herpes Virus Culture on 08 Sep 2015	98
HSV 1 & 2 Abs Indirect Panel on 08 Sep 2015	99
Chlamydia+Gonococcus DNA Panel NAAT on 08 Sep 2015	99
Herpes Simplex Virus 1+2 Ab IgG on 08 Sep 2015	100
Rapid Plasma Reagin on 08 Sep 2015	101

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

HIV Rapid on 08 Sep 2015	101
ETG/ETS, UA (250 Cut-Off) on 23 Jun 2015	102
Drug Abuse Screen on 23 Jun 2015	102
TISSUE EXAM on 23 Jun 2015	104
ETG/ETS, UA (250 Cut-Off) on 18 May 2015	105
Drug Abuse Screen on 18 May 2015	105
ETG/ETS, UA (250 Cut-Off) on 04 May 2015	107
Drug Abuse Screen on 04 May 2015	107
Comprehensive Metabolic Panel on 28 Apr 2015	109
ETG/ETS, UA (500 Cut-Off) on 20 Apr 2015	110
Drug Abuse Screen on 20 Apr 2015	110
ETG/ETS, UA (500 Cut-Off) on 13 Apr 2015	111
Drug Abuse Screen on 13 Apr 2015	111
ETG/ETS, UA (500 Cut-Off) on 06 Apr 2015	112
Drug Abuse Screen on 06 Apr 2015	113
Chlamydia+Gonococcus DNA Panel NAAT on 31 Mar 2015	114
ETG/ETS, UA (500 Cut-Off) on 30 Mar 2015	115
Drug Abuse Screen on 30 Mar 2015	115
Urinalysis Panel on 28 Mar 2015	116
Mephedrone, MDPV, Methyldone on 27 Mar 2015	117
Cannabinoids (THC), Synthetic on 27 Mar 2015	117
Chlamydia+Gonococcus DNA Panel NAAT on 27 Mar 2015	117
ETG/ETS, UA (250 Cut-Off) on 27 Mar 2015	118
Drug Abuse Screen on 27 Mar 2015	118
Urinalysis Panel on 27 Mar 2015	119
Urine Culture on 27 Mar 2015	120
Vitamin D, 1,25-Dihydroxy (Calcitriol) Panel on 27 Mar 2015	120
Vitamin B1 (Thiamine) on 27 Mar 2015	120
HIV-1/O/2 Ab on 27 Mar 2015	121
Rapid Plasma Reagin on 27 Mar 2015	121
Vitamin B12 (Cyanocobalamin)+Folate Panel on 27 Mar 2015	121
Homocysteine on 27 Mar 2015	122
Thyroid Stimulating Hormone on 27 Mar 2015	122
Magnesium on 27 Mar 2015	122
Gamma Glutamyl Transferase on 27 Mar 2015	122
Comprehensive Metabolic Panel on 27 Mar 2015	123
CBC W/Diff on 27 Mar 2015	124
Coagulation Panel 1 (PT+APTT) on 27 Mar 2015	124
HIV-1/O/2 Ab on 10 Apr 2014	125
Lipid Panel on 10 Apr 2014	125
Hemoglobin A1c on 04 Jun 2013	126
Basic Metabolic Panel on 04 Jun 2013	126
HIV-1/O/2 Ab on 19 Mar 2013	127
Lipid Panel on 19 Mar 2013	127
Chlamydia+Gonococcus DNA Panel NAAT on 28 Jan 2013	128
Urinalysis Panel on 28 Jan 2013	129
Herpes Simplex Virus 1+2 Ab IgG on 28 Jan 2013	129
Rapid Plasma Reagin on 28 Jan 2013	130
ESR on 12 Oct 2012	130
C-Reactive Protein on 12 Oct 2012	130
Phosphorus on 12 Oct 2012	131
Magnesium on 12 Oct 2012	131
Basic Metabolic Panel on 12 Oct 2012	131
CBC W/o Diff on 12 Oct 2012	132
TISSUE EXAM on 12 Oct 2012	132

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Neutrophil Cytoplasmic Ab (ANCA) on 11 Oct 2012.....	133
Neutrophil Cytoplasmic Ab (ANCA) Screen W/Reflex Titer on 11 Oct 2012	134
Carcinoembryonic Ag on 11 Oct 2012	135
Amylase on 11 Oct 2012	135
Phosphorus on 11 Oct 2012	135
Magnesium on 11 Oct 2012	135
Lipase on 11 Oct 2012	135
Comprehensive Metabolic Panel on 11 Oct 2012	136
CBC W/Diff on 11 Oct 2012.....	137
MRSA PCR on 11 Oct 2012	137
Amylase on 11 Oct 2012	138
Lipase on 11 Oct 2012	138
Comprehensive Metabolic Panel on 11 Oct 2012	138
CBC W/Diff on 11 Oct 2012.....	139
Infectious Mononucleosis Screen on 10 May 2012	140
CBC on 10 May 2012.....	140
Streptococcus Group A Ag Rapid on 10 May 2012.....	141
Throat Culture on 10 May 2012	141
HIV-1/O/2 Ab on 22 Feb 2012	141
Glucose Fasting on 22 Feb 2012	142
Lipid Profile on 22 Feb 2012	142
Lipid Profile on 02 Feb 2011	143
TISSUE EXAM on 24 Nov 2010.....	144
Wound Culture and Gram Stain on 28 Sep 2010	144
Acid Fast Bacilli Culture on 28 Sep 2010.....	145
Tissue Culture and Stain on 28 Sep 2010	145
Fungus Culture on 28 Sep 2010	146
TISSUE EXAM on 28 Sep 2010.....	146
HIV-1/O/2 Ab on 09 Mar 2010.....	147
Rapid Plasma Reagin on 09 Mar 2010.....	148
Lipid Profile on 09 Mar 2010.....	148
Lipid Profile on 15 Sep 2009	149
Chlamydia+Gonococcus DNA Panel NAAT on 20 Aug 2009.....	149
Rapid Plasma Reagin on 20 Aug 2009.....	150
Methicillin Resistant Staphylococcus aureus Culture on 01 Feb 2007	150
CBC W/Diff on 29 Nov 2005	151
Bleeding Time on 22 Nov 2005	151
Protime Panel on 22 Nov 2005	152
APTT on 22 Nov 2005	152
CBC W/Diff on 22 Nov 2005	152
Amylase on 19 Nov 2005	153
Liver Function Panel on 19 Nov 2005	153
Lipase on 19 Nov 2005	153
Basic Metabolic Panel on 19 Nov 2005	153
CBC W/Diff on 19 Nov 2005	154
Leukocyte Esterase on 03 Nov 2005.....	155
HIV-1 Ab on 03 Nov 2005.....	155
Glucose on 03 Nov 2005	155
Varicella Virus Ab on 03 Nov 2005.....	155
1523 Inprocessing Panel on 03 Nov 2005.....	156
Radiology.....	157
Chest PA And Lateral Upright Series Report on 22 Jun 2016.....	157
MRI Brain With And Without Contrast Report on 15 Apr 2016.....	157
Left Ankle (3 Views) Series Report on 16 Feb 2016.....	158
MRI Left Foot Report on 05 Oct 2014.....	159

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

MRI Left Ankle Report on 05 Oct 2014	161
Left Ankle (3 Views) Series Report on 06 May 2014.....	163
Left Foot (3 Views) Weight Bearing Series Report on 06 May 2014.....	163
Left Foot (3 Views) Series Report on 19 Apr 2014	164
Left Ankle (3 Views) Series Report on 19 Apr 2014.....	165
MRI - Abdomen Report on 02 Nov 2012	166
Acute Abdomen Series Report on 10 Oct 2012	167
CT Abdomen/Pelvis With Contrast Report on 11 Oct 2012	168
CT Abdomen/Pelvis With Contrast Report on 23 Nov 2005.....	169
Acute Abdomen Series Report on 19 Nov 2005	170
CT Abdomen/Pelvis Without Contrast Report on 19 Nov 2005.....	170
Acute Abdomen Series Report on 10 Nov 2005	171
Immunizations.....	173
Previous Encounters.....	175
14 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN.....	175
14 Aug 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	180
10 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	182
09 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	183
08 Aug 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	184
07 Aug 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN	192
31 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C.....	196
27 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	197
27 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN	202
27 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	206
25 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C	214
20 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	215
18 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	217
18 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	225
13 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M.....	230
12 Jul 2017 at WRNMMC, Integrative Hlth & Well BE by THOMAS, LAUREN A.....	237
10 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	239
10 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	247
10 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	249
07 Jul 2017 at WRNMMC, Psychiatry Be by WISE, JOSEPH E	254
07 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by MEADOR, KRISTINE P	256
06 Jul 2017 at WRNMMC, Psychiatry Consult Liaison Be by WORKS, LINDSAY K	257
06 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S	261
27 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	263
21 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by FINK, CAITLIN M.....	268
19 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	270
16 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by NICHOLAS, LUKE C	275
13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	277
13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	278
12 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	283
08 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	291
07 Jun 2017 at WRNMMC, Allergy Clinic Bethesda by PETERSEN, MAUREEN MICHELE	292
06 Jun 2017 at WRNMMC, Int Med CL C Medical Home BE by SMITH, MICKALYNN J	297
01 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	298
25 May 2017 at WRNMMC, Allergy Clinic Bethesda by BANKS, TAYLOR ALLEN.....	300
23 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	303
22 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	305
17 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M	306
16 May 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	311
16 May 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	316
19 Apr 2017 at WRNMMC, Int Med CL F Medical Home BE by SMITH, MICKALYNN J	324

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

13 Apr 2017 at WRNMMC, GI Clinic Bethesda by WONG, ROY KWOCK	325
05 Apr 2017 at WRNMMC, Medical Readiness Clinic Bethesda by RENTA, DANA K	328
16 Mar 2017 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	338
01 Mar 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	339
01 Mar 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	344
08 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R	352
02 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R	355
01 Feb 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	358
01 Feb 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	363
04 Jan 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN	371
04 Jan 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN	376
06 Dec 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN	384
05 Dec 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	389
28 Nov 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	397
15 Nov 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN	398
24 Oct 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	405
11 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	413
04 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	415
28 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	422
08 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	430
06 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN	431
25 Aug 2016 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M	438
23 Jun 2016 at WRNMMC, Int Med CL C Medical Home BE by ATCHERSON, KATHY A	442
22 Jun 2016 at WRNMMC, GI Clinic Bethesda by KWOK, RYAN M	443
15 Jun 2016 at WRNMMC, GI Clinic Bethesda by SHAH, NISHA AMISH	444
07 Jun 2016 at WRNMMC, Otolaryngology Clinic Bethesda by XYDAKIS, MICHAEL S	445
11 May 2016 at WRNMMC, GI Clinic Bethesda by LACZEK, JEFFREY T	447
22 Apr 2016 at WRNMMC, Medical Readiness Clinic Bethesda by TACKIE, DIANE A	451
18 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	460
12 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	464
11 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON	467
05 Apr 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J	470
07 Mar 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J	472
29 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	474
24 Feb 2016 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL	477
19 Feb 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J	479
16 Feb 2016 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	481
16 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by WILSON, BRYAN J	482
04 Feb 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	485
02 Feb 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	486
19 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	489
13 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	492
08 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	493
06 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	494
05 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	495
29 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	498
22 Dec 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	501
15 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	503
14 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	505
08 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	506
08 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	507
01 Dec 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	509
24 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	511
20 Nov 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	513
17 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	514

Merwin, Daniel Dennis

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12 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	516
10 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	518
09 Nov 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	521
03 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	524
03 Nov 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	527
27 Oct 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	531
01 Oct 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	534
30 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by CUNNINGHAM, RACHEL E	539
29 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA	541
29 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL	542
28 Sep 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	545
23 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M	550
18 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA	552
15 Sep 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	553
09 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by CORSO, MEGHAN L	555
08 Sep 2015 at WRNMMC, Int Med Cons/Spec Care Cl Be by FIACCO, NICHOLAS RYAN	556
27 Aug 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	558
25 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	562
25 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	564
18 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	565
11 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	567
11 Aug 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	569
28 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	573
21 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	575
15 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	577
14 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	579
08 Jul 2015 at WRNMMC, Dermatology Clinic Bethesda by TAYLOR, BRADLEY MICHAEL	580
30 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	582
26 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	584
25 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	585
23 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	586
22 Jun 2015 at WRNMMC, Dermatology Clinic Bethesda by STEARNS, LAUREL R	588
16 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	591
11 Jun 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	593
09 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D	597
02 Jun 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E	599
27 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	602
22 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	604
21 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	606
20 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	607
18 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	610
18 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	613
15 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	615
14 May 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	617
13 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	622
11 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	625
11 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	627
08 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	629
07 May 2015 at WRNMMC, Int Med CL C Medical Home BE by ARGUINZONI, JUAN B	631
06 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	635
06 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	637
05 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P	639
04 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	640
04 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	642
01 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	644

Merwin, Daniel Dennis

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DoD ID: 1286180538

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30 Apr 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M	646
29 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	648
28 Apr 2015 at WRNMMC, Medical Readiness Clinic Bethesda by PARSON, MARSHEA S	650
27 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	661
23 Apr 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA	663
22 Apr 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A	673
23 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	675
20 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	677
19 Mar 2015 at WRNMMC, Substance Abuse NY by ARITA, ANTHONY A	679
17 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES	683
30 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	685
23 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	692
22 Oct 2014 at WRNMMC, SRP CI Ki by JORDAN, TIMOTHY W	699
16 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	701
07 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by RINIS, DONNA L	708
01 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	713
26 Sep 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R	714
25 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	718
24 Sep 2014 at WRNMMC, Orthotics & Prosthetics Srv Be by ANDERSON, PETER P	729
24 Sep 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	730
18 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	733
11 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	740
21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	747
21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	748
08 Aug 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	749
04 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M	751
27 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by YORK, CARLA M	759
27 Jun 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C	762
16 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M	765
16 Jun 2014 at WRNMMC, Int Med CL A Medical Home BE by CLARK, THOMAS S	770
04 Jun 2014 at WRNMMC, Int Med Cons/Spec Care CI Be by DOUGHERTY, DIANA L	772
30 May 2014 at WRNMMC, AMH M01A Red Ki by COLEMAN, AUDREY G	774
19 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O	776
06 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O	783
30 Dec 2013 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C	791
12 Aug 2013 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O	792
07 Aug 2013 at WRNMMC, AMH M01A Red Ki by SLOAN, DAWN M	794
05 Aug 2013 at WRNMMC, Immunization Kimbrough by WRAY, KIM D	799
10 Apr 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	800
21 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR	805
19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR	806
19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR	807
19 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR	809
28 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	811
22 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	815
30 Nov 2012 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O	817
05 Nov 2012 at WRNMMC, AMH M01B Blue Ki by DING, YIMING	821
24 Oct 2012 at WRNMMC, SRP CI Ki by AHLTA SYSTEM ADMINISTRATOR	825
24 Oct 2012 at WRNMMC, SRP CI Ki by AHLTA SYSTEM ADMINISTRATOR	827
23 Oct 2012 at WRNMMC, GI Inflam Bowel Dis Be by COPSEY, HELEN C	828
23 Oct 2012 at WRNMMC, GI Inflam Bowel Dis Be by COPSEY, HELEN C	829
12 Oct 2012 at WRNMMC, Wounded Warrior GWOT by AGOSTO, ROBERT	836
14 May 2012 at NH Pensacola FL, Corry MHP by BRADLEY, RACHAEL NAOMI	837
10 May 2012 at NH Pensacola FL, Corry MHP by GUNTER, ROGER WILLIAM	841
06 Mar 2012 at NH Pensacola FL, Readiness Center by TREVEN, LAUREN A	844

Merwin, Daniel Dennis

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Created: 16 Aug 2017

02 Nov 2011 at NH Pensacola FL, Corry MHP by GRIMM, CHRISTOPHER T	846
07 Oct 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	847
27 Jul 2011 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	850
26 Jul 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T	853
06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	855
06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	857
04 May 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	860
26 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	863
22 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	865
21 Apr 2011 at 81st Medical Group, Refractive Surgery by ROPP, CORBY D	867
29 Mar 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D	871
17 Mar 2011 at NH Pensacola FL, Pulmonary Function Lab by LEWIS, CHRISTOPHER T	873
16 Mar 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	877
17 Feb 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	881
16 Feb 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T	884
08 Feb 2011 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S	887
24 Jan 2011 at NH Pensacola FL, Corry Prime Care by WIEDL, ERICA KITCHELL	890
24 Nov 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	893
15 Nov 2010 at NH Pensacola FL, Corry Prime Care by WILLIAMS, TREVOR MICHAEL	898
13 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	899
04 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	904
28 Sep 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P	905
01 Sep 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	908
25 Aug 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P	911
20 Jul 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P	914
14 Jun 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	918
21 Apr 2010 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W	921
17 Mar 2010 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S	925
09 Mar 2010 at NH Pensacola FL, Corry Prime Care by THOMAS, JOSHUA L	927
22 Dec 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	929
23 Sep 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM	930
16 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM	932
10 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM	934
20 Aug 2009 at NH Pensacola FL, Corry Prime Care by HEDARIA, ELIZABETH A	935
07 May 2009 at NH Pensacola FL, Corry Health Promotion And Wel by LINVILLE, TREVOR S	937
06 Mar 2006 at NH Pensacola FL, NATTC MHP by MAYNARD, PENELOPE A	938
Clinical Notes	939
09 Aug 2017 1300 GMT at by HANGEMANOLE, DESPINA C	939
16 Jun 2017 1430 GMT at by NICHOLAS, LUKE C	942
07 Jun 2017 1515 GMT at by PETERSEN, MAUREEN MICHELE	945
25 May 2017 1430 GMT at by BANKS, TAYLOR ALLEN	950
13 Apr 2017 2000 GMT at by WONG, ROY KWOCK	955
08 Feb 2017 1300 GMT at by BENTON, JIKESHA R	959
02 Feb 2017 1400 GMT at by BENTON, JIKESHA R	963
04 Oct 2016 2000 GMT at by COPSEY, HELEN C	967
22 Jun 2016 1540 GMT at by KWOK, RYAN M	975
07 Jun 2016 1800 GMT at by XYDAKIS, MICHAEL S	977
11 May 2016 1300 GMT at by LACZEK, JEFFREY T	980
11 Apr 2016 1330 GMT at by THOMPSON, DAVID HERRON	985
05 Apr 2016 1330 GMT at by BAHR, ROBERT J	989
07 Mar 2016 1430 GMT at by BAHR, ROBERT J	992
24 Feb 2016 1900 GMT at by MARQUART, JASON DANIEL	995
19 Feb 2016 1245 GMT at by BAHR, ROBERT J	997
29 Sep 2015 1814 GMT at WRNMMC by MITZMAN, NEIL	1000
29 Sep 2015 1500 GMT at by MARQUART, JASON DANIEL	1002

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

22 Jun 2015 1930 GMT at by STEARNS, LAUREL R	1007
23 Apr 2015 1400 GMT at by ZEMBRZUSKA, HANNA DOMINIKA	1010
24 Sep 2014 1600 GMT at by LAI, PHILOMENA C	1022
08 Aug 2014 1200 GMT at by LAI, PHILOMENA C	1026
27 Jun 2014 1200 GMT at by LAI, PHILOMENA C	1030
24 Oct 2012 1425 GMT at by	1034
15 Oct 2012 1543 GMT at WRNMMC by JORDAN, MARIA T.	1043
29 Mar 2011 2052 GMT at by	1046
25 Mar 2011 1831 GMT at by	1050
16 Feb 2011 1552 GMT at by	1052
20 Jul 2010 2204 GMT at by	1057
24 Dec 2005 0302 GMT at by	1062
Vitals	1064

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

Demographics

Name: Merwin, Daniel Dennis

SSN: ***-**- [REDACTED]

DoD ID: 1286180538

FMP/Sponsor SSN: 20/***-**- [REDACTED]

Date of Birth: [REDACTED] 1985

Sex: M

Race: White

Marital Status: Single, Never Married

Branch: N11 - United States Navy (USN) Active Duty (AD)

Rank: PETTY OFFICER FIRST CLASS (E5)

Medicare:

Religion: No Preference

PCM Location: 23664-HP0067

Addresses:

[REDACTED]

....

GLEN BURNIE, MD [REDACTED]

***** End of Demographics *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Allergies

Nka

Reaction:			
Onset:	25 May 2017	Info Source:	
Clinician:	ZZMIDTIER, GREAT	Facility:	WRNMMC
Allergy Type:	No known allergies	Origin:	Department of Defense
Comment:			

***** End of Allergies *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Problems

Active Problems

Generalized anxiety disorder on 25 Aug 2016

Date Onset:	Unknown	Date Reported:	25 Aug 2016
Source:	HICKEY, LINDSEY S	ICD:	F41.1
Comment:			
Encounter			
Comments:			

EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) on 22 Apr 2016

Date Onset:	Unknown	Date Reported:	22 Apr 2016
Source:	TACKIE, DIANE A	ICD:	DOD0225
Comment:			
Encounter			
Comments:			

Counseling, unspecified on 22 Apr 2016

Date Onset:	Unknown	Date Reported:	22 Apr 2016
Source:	TACKIE, DIANE A	ICD:	Z71.9
Comment:			
Encounter			
Comments:			

ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR on 19 Mar 2015

Date Onset:	Unknown	Date Reported:	19 Mar 2015
Source:	ARITA, ANTHONY A	ICD:	303.91
Comment:			
Encounter			
Comments:			

MAJOR DEPRESSION RECURRENT MODERATE on 21 Aug 2014

Date Onset:	Unknown	Date Reported:	21 Aug 2014
Source:	NILSEN, LINDA M	ICD:	296.32
Comment:			
Encounter			
Comments:			

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ANXIETY DISORDER NOS on 04 Aug 2014

Date Onset:	Unknown	Date Reported:	04 Aug 2014
Source:	NILSEN, LINDA M	ICD:	300.00
Comment:			
Encounter			
Comments:			

Left ankle joint pain on 27 Jun 2014

Date Onset:	Unknown	Date Reported:	27 Jun 2014
Source:	LAI, PHILOMENA C	ICD:	719.47
Comment:			
Encounter			
Comments:			

NEUROTIC EXCORIATION on 16 Jun 2014

Date Onset:	Unknown	Date Reported:	16 Jun 2014
Source:	OSULLIVAN, ROBIN RACHELLE	ICD:	698.4
Comment:			
Encounter			
Comments:			

ANKLE SPRAIN LEFT on 16 Jun 2014

Date Onset:	Unknown	Date Reported:	16 Jun 2014
Source:	CLARK, THOMAS S	ICD:	845.00
Comment:			
Encounter			
Comments:			

ESSENTIAL HYPERTRIGLYCERIDEMIA on 10 Apr 2013

Date Onset:	Unknown	Date Reported:	10 Apr 2013
Source:	Encounter	ICD:	272.1
Comment:			
Encounter			
Comments:			

ANOMALIES OF SKIN on 10 Apr 2013

Date Onset:	Unknown	Date Reported:	10 Apr 2013
Source:	Encounter	ICD:	757.39
Comment:			
Encounter			
Comments:			

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Abdominal pain on 24 Oct 2012

Date Onset:	Unknown	Date Reported:	24 Oct 2012
Source:	Encounter	ICD:	789.00
Comment:			
Encounter			
Comments:			

ASTHMA on 26 Jul 2011

Date Onset:	Unknown	Date Reported:	26 Jul 2011
Source:	Encounter	ICD:	493.90
Comment:			
Encounter			
Comments:			

POSTSURGICAL STATE OF EYE AND ADNEXA on 22 Apr 2011

Date Onset:	Unknown	Date Reported:	22 Apr 2011
Source:	Encounter	ICD:	V45.69
Comment:			
Encounter			
Comments:			

Difficulty breathing (dyspnea) on 16 Feb 2011

Date Onset:	Unknown	Date Reported:	16 Feb 2011
Source:	Encounter	ICD:	786.09
Comment:			
Encounter			
Comments:			

SKIN NEOPLASM UNCERTAIN BEHAVIOR on 24 Nov 2010

Date Onset:	Unknown	Date Reported:	24 Nov 2010
Source:	Encounter	ICD:	238.2
Comment:			
Encounter			
Comments:			

Removal Of Sutures on 04 Oct 2010

Date Onset:	Unknown	Date Reported:	04 Oct 2010
Source:	Encounter	ICD:	V58.3
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

ASTHMA EXTRINSIC on 01 Sep 2010

Date Onset:	Unknown	Date Reported:	01 Sep 2010
Source:	Encounter	ICD:	493.00
Comment:			
Encounter			
Comments:			

ROSACEA on 14 Jun 2010

Date Onset:	Unknown	Date Reported:	14 Jun 2010
Source:	Encounter	ICD:	695.3
Comment:			
Encounter			
Comments:			

PERIPHERAL RETINAL DEGENERATION - LATTICE on 23 Apr 2010

Date Onset:	Unknown	Date Reported:	23 Apr 2010
Source:	Encounter	ICD:	362.63
Comment:			
Encounter			
Comments:			

REFRACTIVE ERROR - MYOPIA on 23 Apr 2010

Date Onset:	Unknown	Date Reported:	23 Apr 2010
Source:	Encounter	ICD:	367.1
Comment:			
Encounter			
Comments:			

ALLERGIC RHINITIS on 17 Mar 2010

Date Onset:	Unknown	Date Reported:	17 Mar 2010
Source:	Encounter	ICD:	477.9
Comment:			
Encounter			
Comments:			

Inactive Problems**Vaccines Prophylactic Need Against Bacterial Diseases on 05 Aug 2013**

Date Onset:	Unknown	Date Reported:	05 Aug 2013
Source:	SLOAN, DAWN M	ICD:	V03.9
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

IMPAIRED FASTING GLUCOSE on 10 Apr 2013

Date Onset:	Unknown	Date Reported:	10 Apr 2013
Source:	UDE, ASSUMPTA O	ICD:	790.21
Comment:			
Encounter			
Comments:			

Visit for: follow-up exam on 21 Mar 2013

Date Onset:	Unknown	Date Reported:	21 Mar 2013
Source:	Encounter	ICD:	V67.9
Comment:			
Encounter			
Comments:			

Visit for: ears / hearing exam on 19 Mar 2013

Date Onset:	Unknown	Date Reported:	19 Mar 2013
Source:	SLOAN, DAWN M	ICD:	V72.19
Comment:			
Encounter			
Comments:			

Visit for: screening exam pulmonary tuberculosis on 19 Mar 2013

Date Onset:	Unknown	Date Reported:	19 Mar 2013
Source:	Encounter	ICD:	V74.1
Comment:			
Encounter			
Comments:			

Need For Vaccination DTP + TAB on 19 Mar 2013

Date Onset:	Unknown	Date Reported:	19 Mar 2013
Source:	Encounter	ICD:	V06.2
Comment:			
Encounter			
Comments:			

Need For Vaccination Typhoid on 19 Mar 2013

Date Onset:	Unknown	Date Reported:	19 Mar 2013
Source:	Encounter	ICD:	V03.1
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Visit for: screening exam STD on 28 Jan 2013

Date Onset:	Unknown	Date Reported:	28 Jan 2013
Source:	Encounter	ICD:	V75.9
Comment:			
Encounter			
Comments:			

Need For Prophylactic Measure on 05 Nov 2012

Date Onset:	Unknown	Date Reported:	05 Nov 2012
Source:	Encounter	ICD:	V07.9
Comment:			
Encounter			
Comments:			

Imaging Studies Nonspecific Abnormal Findings on 24 Oct 2012

Date Onset:	Unknown	Date Reported:	24 Oct 2012
Source:	Encounter	ICD:	793.9
Comment:			
Encounter			
Comments:			

Conditions influencing health status on 12 Oct 2012

Date Onset:	Unknown	Date Reported:	12 Oct 2012
Source:	SLOAN, DAWN M	ICD:	V49.9
Comment:			
Encounter			
Comments:			

VIRAL SYNDROME on 10 May 2012

Date Onset:	Unknown	Date Reported:	10 May 2012
Source:	Encounter	ICD:	079.99
Comment:			
Encounter			
Comments:			

SUPERFICIAL INJURY - ABRASION OF CORNEA on 04 May 2011

Date Onset:	Unknown	Date Reported:	04 May 2011
Source:	Encounter	ICD:	918.1
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Aftercare Following Surgery Of Sense Organs on 22 Apr 2011

Date Onset:	Unknown	Date Reported:	22 Apr 2011
Source:	Encounter	ICD:	V58.71
Comment:			
Encounter			
Comments:			

Visit for: preoperative exam on 29 Mar 2011

Date Onset:	Unknown	Date Reported:	29 Mar 2011
Source:	Encounter	ICD:	V72.84
Comment:			
Encounter			
Comments:			

Visit for: screening exam malignant neoplasm skin on 24 Nov 2010

Date Onset:	Unknown	Date Reported:	24 Nov 2010
Source:	Encounter	ICD:	V76.43
Comment:			
Encounter			
Comments:			

FOLLICULITIS on 20 Jul 2010

Date Onset:	Unknown	Date Reported:	20 Jul 2010
Source:	Encounter	ICD:	704.8
Comment:			
Encounter			
Comments:			

Visit for: occupational health / fitness exam on 17 Mar 2010

Date Onset:	Unknown	Date Reported:	17 Mar 2010
Source:	SLOAN, DAWN M	ICD:	V70.5
Comment:			
Encounter			
Comments:			

Vaccine needed prophylactically against bacterial diseases on 09 Mar 2010

Date Onset:	Unknown	Date Reported:	09 Mar 2010
Source:	Encounter	ICD:	V03.9
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Parent Education: Immunizations on 23 Sep 2009

Date Onset:	Unknown	Date Reported:	23 Sep 2009
Source:	SLOAN, DAWN M	ICD:	V65.49
Comment:			
Encounter			
Comments:			

Vaccines Prophylactic Need Against Influenza on 23 Sep 2009

Date Onset:	Unknown	Date Reported:	23 Sep 2009
Source:	Encounter	ICD:	V04.81
Comment:			
Encounter			
Comments:			

Visit for: military services physical on 16 Sep 2009

Date Onset:	Unknown	Date Reported:	16 Sep 2009
Source:	COLEMAN, AUDREY G	ICD:	V70.5
Comment:			
Encounter			
Comments:			

Exposure to STD on 20 Aug 2009

Date Onset:	Unknown	Date Reported:	20 Aug 2009
Source:	SLOAN, DAWN M	ICD:	V01.6
Comment:			
Encounter			
Comments:			

Patient Education - HIV on 07 May 2009

Date Onset:	Unknown	Date Reported:	07 May 2009
Source:	Encounter	ICD:	V65.44
Comment:			
Encounter			
Comments:			

Guidance: Concerns About Unsafe Sexual Practices on 07 May 2009

Date Onset:	Unknown	Date Reported:	07 May 2009
Source:	Encounter	ICD:	V65.45
Comment:			
Encounter			
Comments:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Visit for: administrative purpose on 07 May 2009

Date Onset:	Unknown	Date Reported:	07 May 2009
Source:	SLOAN, DAWN M	ICD:	V68.9
Comment:			
Encounter			
Comments:			

Inquiry And Counseling: Contraceptive Practices on 07 May 2009

Date Onset:	Unknown	Date Reported:	07 May 2009
Source:	SLOAN, DAWN M	ICD:	V25.09
Comment:			
Encounter			
Comments:			

Visit for: issue medical certificate fitness on 06 Mar 2006

Date Onset:	Unknown	Date Reported:	06 Mar 2006
Source:	Encounter	ICD:	V68.0
Comment:			
Encounter			
Comments:			

Feared medical condition not demonstrated on 06 Mar 2006

Date Onset:	Unknown	Date Reported:	06 Mar 2006
Source:	Encounter	ICD:	V65.5
Comment:	ABD PAIN RESOLVED- NO PATHOLOGY		
Encounter			
Comments:			

***** End of Problems *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Diagnosis History**<No description for K58.2 in Medcin database> (K58.2)**

Encounter Date	Clinic	Clinician	Facility
12 Jun 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC

Abdominal pain (789.00)

Encounter Date	Clinic	Clinician	Facility
23 Oct 2012	GI Inflam Bowel Dis Be	COPSEY, HELEN C	WRNMMC

Acquired absence of right leg below knee (Z89.511)

Encounter Date	Clinic	Clinician	Facility
19 Feb 2016	Phys Therapy CL BE	BAHR, ROBERT J	WRNMMC

Aftercare Following Surgery Of Sense Organs (V58.71)

Encounter Date	Clinic	Clinician	Facility
07 Oct 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
06 Jun 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
06 Jun 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
26 Apr 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
22 Apr 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL

ALCOHOL ABUSE - IN REMISSION (305.03)

Encounter Date	Clinic	Clinician	Facility
07 May 2015	Int Med CL C Medical Home BE	ARGUINZONI, JUAN B.	WRNMMC

Alcohol abuse, uncomplicated (F10.10)

Encounter Date	Clinic	Clinician	Facility
24 Nov 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
17 Nov 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
12 Nov 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
10 Nov 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC

ALCOHOL DEPENDENCE (ALCOHOLISM) (303.90)

Encounter Date	Clinic	Clinician	Facility
15 Sep 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
27 Aug 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
25 Aug 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
18 Aug 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
11 Aug 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
16 Jun 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
11 Jun 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
02 Jun 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
27 May 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
14 May 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
11 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
23 Apr 2015	Psychiatry Be	ZEMBRZUSKA, HANNA	WRNMMC

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

DOMINIKA

ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR (303.91)

Encounter Date	Clinic	Clinician	Facility
28 Jul 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
21 Jul 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
15 Jul 2015	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
30 Jun 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
23 Jun 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
09 Jun 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
22 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
20 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
18 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
15 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
13 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
08 May 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
06 May 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
06 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
04 May 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
01 May 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
29 Apr 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
27 Apr 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
22 Apr 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
23 Mar 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
20 Mar 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
19 Mar 2015	Substance Abuse NY	ARITA, ANTHONY A	WRNMMC

Alcohol dependence, uncomplicated (F10.20)

Encounter Date	Clinic	Clinician	Facility
14 Aug 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
10 Aug 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
09 Aug 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
07 Aug 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
31 Jul 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
25 Jul 2017	ATS Adult BE	HANGEMANOLE, DESPINA C	WRNMMC
15 Nov 2016	Psychiatry Be	PAUL, SHERIN	WRNMMC
04 Feb 2016	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
02 Feb 2016	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
19 Jan 2016	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
13 Jan 2016	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
08 Jan 2016	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
06 Jan 2016	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
05 Jan 2016	Substance Abuse NY	BROWN, CYNTHIA E	WRNMMC
29 Dec 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
22 Dec 2015	Substance Abuse NY	HILL, LARRY D	WRNMMC
15 Dec 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
14 Dec 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
08 Dec 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
08 Dec 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
01 Dec 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC
20 Nov 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
03 Nov 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

27 Oct 2015	Substance Abuse NY	GONZALEZZARAZUA, JORGE A	WRNMMC
-------------	--------------------	--------------------------	--------

ALLERGIC RHINITIS (477.9)

Encounter Date	Clinic	Clinician	Facility
24 Jan 2011	Corry Prime Care	WIEDL, ERICA KITCHELL	NH Pensacola FL
17 Mar 2010	Readiness Center	BROWN, TRAVIS S	NH Pensacola FL

Allergic rhinitis due to animal (cat) (dog) hair and dander (J30.81)

Encounter Date	Clinic	Clinician	Facility
07 Jun 2017	Allergy Clinic Bethesda	PETERSEN, MAUREEN MICHELE	WRNMMC

Alopecia (704.00)

Encounter Date	Clinic	Clinician	Facility
22 Jun 2015	Dermatology Clinic Bethesda	STEARNS, LAUREL R	WRNMMC

ALOPECIA AREATA (704.01)

Encounter Date	Clinic	Clinician	Facility
07 May 2015	Int Med CL C Medical Home BE	ARGUINZONI, JUAN B.	WRNMMC

ANKLE SPRAIN LEFT (845.00)

Encounter Date	Clinic	Clinician	Facility
07 Oct 2014	Int Med CL C Medical Home BE	RINIS, DONNA L	WRNMMC
16 Jun 2014	Int Med CL A Medical Home BE	CLARK, THOMAS S	WRNMMC
04 Jun 2014	Int Med Cons/Spec Care Cl Be	DOUGHERTY, DIANA L	WRNMMC
06 May 2014	AMH M01A Red Ki	UDE, ASSUMPTA O	WRNMMC

Anogenital (venereal) warts (A63.0)

Encounter Date	Clinic	Clinician	Facility
16 Jun 2017	Dermatology Clinic Bethesda	NICHOLAS, LUKE C	WRNMMC
17 May 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
24 Feb 2016	Dermatology Clinic Bethesda	MARQUART, JASON DANIEL	WRNMMC

ANOMALIES OF SKIN (757.9)

Encounter Date	Clinic	Clinician	Facility
10 Apr 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC

Anxiety (300.00)

Encounter Date	Clinic	Clinician	Facility
27 Jun 2014	Integrative Hlth & Well BE	YORK, CARLA M	WRNMMC

ANXIETY DISORDER NOS (300.00)

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
30 Oct 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
23 Oct 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
16 Oct 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
25 Sep 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
18 Sep 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
11 Sep 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
04 Aug 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC

Anxiety disorder, unspecified (F41.9)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Encounter Date	Clinic	Clinician	Facility
01 Feb 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
24 Oct 2016	Psychiatry Be	TOBAR, EDEN	WRNMMC
28 Sep 2016	Psychiatry Be	TOBAR, EDEN	WRNMMC
08 Sep 2016	Psychiatry Be	TOBAR, EDEN	WRNMMC
06 Sep 2016	Psychiatry Be	TOBAR, EDEN	WRNMMC

ARMED FORCES FITNESS FOR DUTY EXAM (V70.5)

Encounter Date	Clinic	Clinician	Facility
06 May 2014	AMH M01A Red Ki	UDE, ASSUMPTA O	WRNMMC

ASTHMA (493.90)

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
26 Jul 2011	Pulmonary Disease Clinic	LEWIS, CHRISTOPHER T	NH Pensacola FL

ASTHMA EXTRINSIC (493.00)

Encounter Date	Clinic	Clinician	Facility
08 Feb 2011	Readiness Center	BROWN, TRAVIS S	NH Pensacola FL
01 Sep 2010	Corry Prime Care	GUNTER, ROGER WILLIAM	NH Pensacola FL

Brace (V53.7)

Encounter Date	Clinic	Clinician	Facility
24 Sep 2014	Orthotics & Prosthetics Srv Be	ANDERSON, PETER P	WRNMMC

CHRONIC BRONCHITIS (491.9)

Encounter Date	Clinic	Clinician	Facility
28 Sep 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

CONDITIONS INFLUENCING HEALTH STATUS (V49.9)

Encounter Date	Clinic	Clinician	Facility
12 Oct 2012	Wounded Warrior GWOT	AGOSTO, ROBERT	WRNMMC

Counseling, unspecified (Z71.9)

Encounter Date	Clinic	Clinician	Facility
22 Apr 2016	Medical Readiness Clinic Bethesda	TACKIE, DIANE A	WRNMMC

Difficulty breathing (dyspnea) (786.09)

Encounter Date	Clinic	Clinician	Facility
17 Mar 2011	Pulmonary Function Lab	LEWIS, CHRISTOPHER T	NH Pensacola FL
16 Feb 2011	Pulmonary Disease Clinic	LEWIS, CHRISTOPHER T	NH Pensacola FL

Dyspnea, unspecified (R06.00)

Encounter Date	Clinic	Clinician	Facility
25 May 2017	Allergy Clinic Bethesda	BANKS, TAYLOR ALLEN	WRNMMC

Encounter for issue of other medical certificate (Z02.79)

Encounter Date	Clinic	Clinician	Facility
15 Jun 2016	GI Clinic Bethesda	SHAH, NISHA AMISH	WRNMMC

Encounter for issue of repeat prescription (Z76.0)

Encounter Date	Clinic	Clinician	Facility
16 Feb 2016	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

Encounter for other administrative examinations (Z02.89)

Encounter Date	Clinic	Clinician	Facility
14 Aug 2017	Psychiatry Be	DELSESTO, BARBARA S	WRNMMC
20 Jul 2017	Psychiatry Be	DELSESTO, BARBARA S	WRNMMC
13 Jul 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
10 Jul 2017	Psychiatry Be	DELSESTO, BARBARA S	WRNMMC
07 Jul 2017	Int Med CL F Medical Home BE	MEADOR, KRISTINE P	WRNMMC
06 Jul 2017	Psychiatry Be	DELSESTO, BARBARA S	WRNMMC
19 Jun 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
06 Jun 2017	Int Med CL C Medical Home BE	SMITH, MICKALYNN J	WRNMMC
19 Apr 2017	Int Med CL F Medical Home BE	SMITH, MICKALYNN J	WRNMMC
23 Jun 2016	Int Med CL C Medical Home BE	ATCHERSON, KATHY A	WRNMMC

Encounter for other general examination (Z00.8)

Encounter Date	Clinic	Clinician	Facility
17 May 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC

Epidermal cyst (L72.0)

Encounter Date	Clinic	Clinician	Facility
21 Jun 2017	Dermatology Clinic Bethesda	FINK, CAITLIN M	WRNMMC
16 Jun 2017	Dermatology Clinic Bethesda	NICHOLAS, LUKE C	WRNMMC

ESSENTIAL HYPERTRIGLYCERIDEMIA (272.1)

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
19 May 2014	AMH M01A Red Ki	UDE, ASSUMPTA O	WRNMMC
10 Apr 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC

EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) (DOD0225)

Encounter Date	Clinic	Clinician	Facility
05 Apr 2017	Medical Readiness Clinic Bethesda	RENTA, DANA K	WRNMMC
22 Apr 2016	Medical Readiness Clinic Bethesda	TACKIE, DIANE A	WRNMMC

Exposure to STD (V01.6)

Encounter Date	Clinic	Clinician	Facility
20 Aug 2009	Corry Prime Care	HEDARIA, ELIZABETH A	NH Pensacola FL

Feared medical condition not demonstrated (V65.5)

Encounter Date	Clinic	Clinician	Facility
06 Mar 2006	NATTC MHP	MAYNARD, PENELOPE A	NH Pensacola FL

FOLLICULITIS (704.8)

Encounter Date	Clinic	Clinician	Facility
30 Nov 2012	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC
27 Jul 2011	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL
13 Oct 2010	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL
28 Sep 2010	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL
25 Aug 2010	Dermatology Clinic	SMITH, ERIC P	NH Pensacola FL
20 Jul 2010	Dermatology Clinic	SMITH, ERIC P	NH Pensacola FL

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

FOLLICULITIS DECALVANS (704.09)

Encounter Date	Clinic	Clinician	Facility
29 Sep 2015	Dermatology Clinic Bethesda	MARQUART, JASON DANIEL	WRNMMC

Foot pain (soft tissue) (729.5)

Encounter Date	Clinic	Clinician	Facility
01 Oct 2014	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

Gastro-esophageal reflux disease without esophagitis (K21.9)

Encounter Date	Clinic	Clinician	Facility
07 Jun 2016	Otolaryngology Clinic Bethesda	XYDAKIS, MICHAEL S	WRNMMC

Generalized anxiety disorder (F41.1)

Encounter Date	Clinic	Clinician	Facility
14 Aug 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
08 Aug 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
07 Aug 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
27 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
27 Jul 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
27 Jul 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
18 Jul 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
18 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
10 Jul 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
10 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
07 Jul 2017	Psychiatry Be	WISE, JOSEPH E	WRNMMC
06 Jul 2017	Psychiatry Consult Liaison Be	WORKS, LINDSAY K	WRNMMC
27 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
13 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
13 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
08 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
16 May 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
16 May 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
01 Mar 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
01 Mar 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
08 Feb 2017	Psychology Assessment Be	BENTON, JIKESHA R	WRNMMC
02 Feb 2017	Psychology Assessment Be	BENTON, JIKESHA R	WRNMMC
01 Feb 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
04 Jan 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
04 Jan 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
06 Dec 2016	Psychiatry Be	PAUL, SHERIN	WRNMMC
15 Nov 2016	Psychiatry Be	PAUL, SHERIN	WRNMMC
25 Aug 2016	Integrative Hlth & Well BE	JARRETT, ERICA M	WRNMMC
03 Nov 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
01 Oct 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC

GENERALIZED ANXIETY DISORDER (300.02)

Encounter Date	Clinic	Clinician	Facility
27 Aug 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
11 Jun 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
18 May 2015	Psychiatry Be	MELTON, APRIL M	WRNMMC
14 May 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
11 May 2015	Psychiatry Be	MELTON, APRIL M	WRNMMC
07 May 2015	Int Med CL C Medical Home BE	ARGUINZONI, JUAN B.	WRNMMC
04 May 2015	Psychiatry Be	MELTON, APRIL M	WRNMMC

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

30 Apr 2015	Psychiatry Be	MELTON, APRIL M	WRNMMC
23 Apr 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC
16 Jun 2014	Integrative Hlth & Well BE	JARRETT, ERICA M	WRNMMC

Glossitis (K14.0)

Encounter Date	Clinic	Clinician	Facility
07 Jun 2016	Otolaryngology Clinic Bethesda	XYDAKIS, MICHAEL S	WRNMMC

Guidance: Concerns About Unsafe Sexual Practices (V65.45)

Encounter Date	Clinic	Clinician	Facility
28 Jan 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC
07 May 2009	Corry Health Promotion And Wel	LINVILLE, TREVOR S	NH Pensacola FL

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere (B96.81)

Encounter Date	Clinic	Clinician	Facility
11 May 2016	GI Clinic Bethesda	LACZEK, JEFFREY T	WRNMMC
12 Apr 2016	Otolaryngology Clinic Bethesda	THOMPSON, DAVID HERRON	WRNMMC

Imaging Studies Nonspecific Abnormal Findings (793.99)

Encounter Date	Clinic	Clinician	Facility
23 Oct 2012	GI Inflam Bowel Dis Be	COPSEY, HELEN C	WRNMMC

IMPAIRED FASTING GLUCOSE (790.21)

Encounter Date	Clinic	Clinician	Facility
10 Apr 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC

Inquiry And Counseling: Contraceptive Practices (V25.09)

Encounter Date	Clinic	Clinician	Facility
07 May 2009	Corry Health Promotion And Wel	LINVILLE, TREVOR S	NH Pensacola FL

Irritable bowel syndrome with diarrhea (K58.0)

Encounter Date	Clinic	Clinician	Facility
07 Aug 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
27 Jul 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
12 Jul 2017	Integrative Hlth & Well BE	THOMAS, LAUREN A	WRNMMC
01 Jun 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
17 May 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
13 Apr 2017	GI Clinic Bethesda	WONG, ROY KWOCK	WRNMMC
16 Mar 2017	GI Clinic Bethesda	COPSEY, HELEN C	WRNMMC
28 Nov 2016	GI Clinic Bethesda	COPSEY, HELEN C	WRNMMC
11 Oct 2016	GI Clinic Bethesda	COPSEY, HELEN C	WRNMMC
04 Oct 2016	GI Clinic Bethesda	COPSEY, HELEN C	WRNMMC
11 May 2016	GI Clinic Bethesda	LACZEK, JEFFREY T	WRNMMC

Laboratory Studies (V72.60)

Encounter Date	Clinic	Clinician	Facility
29 Sep 2015	Behavioral Health Qu	MANTANONALEE, CHRISTY LIA	WRNMMC
18 Sep 2015	Behavioral Health Qu	MANTANONALEE, CHRISTY LIA	WRNMMC
26 Jun 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
25 Jun 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
21 May 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
05 May 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lack of adequate sleep (V69.4)

Encounter Date	Clinic	Clinician	Facility
09 Sep 2015	Integrative Hlth & Well BE	CORSO, MEGHAN L	WRNMMC

Left ankle joint pain (719.47)

Encounter Date	Clinic	Clinician	Facility
26 Sep 2014	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC
24 Sep 2014	Phys Therapy CL BE	LAI, PHILOMENA C	WRNMMC
08 Aug 2014	Phys Therapy CL BE	LAI, PHILOMENA C	WRNMMC
27 Jun 2014	Phys Therapy CL BE	LAI, PHILOMENA C	WRNMMC
30 May 2014	AMH M01A Red Ki	COLEMAN, AUDREY G	WRNMMC

MAJOR DEPRESSION RECURRENT MODERATE (296.32)

Encounter Date	Clinic	Clinician	Facility
11 Aug 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
21 Aug 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC
21 Aug 2014	Psychiatry Be	NILSEN, LINDA M	WRNMMC

Major depressive disorder, recurrent, moderate (F33.1)

Encounter Date	Clinic	Clinician	Facility
14 Aug 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
27 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
18 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
10 Jul 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
06 Jul 2017	Psychiatry Consult Liaison Be	WORKS, LINDSAY K	WRNMMC
13 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC
13 Jun 2017	Psychiatry Be	PAUL, SHERIN	WRNMMC

Major depressive disorder, recurrent, unspecified (F33.9)

Encounter Date	Clinic	Clinician	Facility
01 Feb 2017	Psychiatry Be	TOBAR, EDEN	WRNMMC
05 Dec 2016	Psychiatry Be	TOBAR, EDEN	WRNMMC

Major depressive disorder, single episode, moderate (F32.1)

Encounter Date	Clinic	Clinician	Facility
07 Aug 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC
27 Jul 2017	Int Med CL F Medical Home BE	LINKER, MARTIN	WRNMMC

MOLLUSCUM CONTAGIOSUM (078.0)

Encounter Date	Clinic	Clinician	Facility
28 Sep 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

Need For Prophylactic Measure (V07.9)

Encounter Date	Clinic	Clinician	Facility
05 Nov 2012	AMH M01B Blue Ki	DING, YIMING	WRNMMC

Need For Vaccination DTP + TAB (V06.2)

Encounter Date	Clinic	Clinician	Facility
19 Mar 2013	Immunization Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC

Need For Vaccination Typhoid (V03.1)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Encounter Date	Clinic	Clinician	Facility
19 Mar 2013	Immunization Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC

NEUROTIC EXCORIATION (698.4)

Encounter Date	Clinic	Clinician	Facility
16 Jun 2014	Integrative Hlth & Well BE	JARRETT, ERICA M	WRNMMC

ORGANIC SLEEP APNEA (327.20)

Encounter Date	Clinic	Clinician	Facility
11 Aug 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

Other chest pain (R07.89)

Encounter Date	Clinic	Clinician	Facility
22 Jun 2016	GI Clinic Bethesda	KWOK, RYAN M	WRNMMC

Other hyperlipidemia (E78.4)

Encounter Date	Clinic	Clinician	Facility
23 May 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC

Other skin changes (R23.8)

Encounter Date	Clinic	Clinician	Facility
16 Feb 2016	Int Med CL C Medical Home BE	WILSON, BRYAN J	WRNMMC

Other specified counseling (Z71.89)

Encounter Date	Clinic	Clinician	Facility
01 Jun 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
22 May 2017	Int Med CL F Medical Home BE	RODAK, COLLEEN M	WRNMMC
05 Apr 2017	Medical Readiness Clinic Bethesda	RENTA, DANA K	WRNMMC

Pain in left ankle and joints of left foot (M25.572)

Encounter Date	Clinic	Clinician	Facility
05 Apr 2016	Phys Therapy CL BE	BAHR, ROBERT J	WRNMMC
07 Mar 2016	Phys Therapy CL BE	BAHR, ROBERT J	WRNMMC

Parageusia (R43.2)

Encounter Date	Clinic	Clinician	Facility
18 Apr 2016	Otolaryngology Clinic Bethesda	THOMPSON, DAVID HERRON	WRNMMC
29 Feb 2016	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC
16 Feb 2016	Int Med CL C Medical Home BE	WILSON, BRYAN J	WRNMMC
09 Nov 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

Parent Education: Immunizations (V65.49)

Encounter Date	Clinic	Clinician	Facility
15 Nov 2010	Corry Prime Care	WILLIAMS, TREVOR MICHAEL	NH Pensacola FL
22 Dec 2009	Corry Prime Care	GUNTER, ROGER WILLIAM	NH Pensacola FL
23 Sep 2009	Corry Prime Care	GUNTER, ROGER WILLIAM	NH Pensacola FL

Patient Education (V65.49)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC

Patient Education - HIV (V65.44)

Encounter Date	Clinic	Clinician	Facility
07 May 2009	Corry Health Promotion And Wel	LINVILLE, TREVOR S	NH Pensacola FL

Patient Education - Medication (V65.49)

Encounter Date	Clinic	Clinician	Facility
27 Aug 2015	Psychiatry Be	ZEMBRZUSKA, HANNA DOMINIKA	WRNMMC

Penile lesion (607.89)

Encounter Date	Clinic	Clinician	Facility
08 Sep 2015	Int Med Cons/Spec Care Cl Be	FIACCO, NICHOLAS RYAN	WRNMMC

PENILE WARTS (078.11)

Encounter Date	Clinic	Clinician	Facility
11 Aug 2015	Int Med CL C Medical Home BE	AUSTIN, MARIE R	WRNMMC

PERIPHERAL RETINAL DEGENERATION - LATTICE (362.63)

Encounter Date	Clinic	Clinician	Facility
16 Mar 2011	NASP Optometry	ZENT, JOHN W	NH Pensacola FL
21 Apr 2010	NASP Optometry	ZENT, JOHN W	NH Pensacola FL

POSTSURGICAL STATE OF EYE AND ADNEXA (V45.69)

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
07 Oct 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
06 Jun 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
06 Jun 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
26 Apr 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
22 Apr 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL

PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (799.9)

Encounter Date	Clinic	Clinician	Facility
18 Sep 2015	Behavioral Health Qu	MANTANONALEE, CHRISTY LIA	WRNMMC
26 Jun 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
25 Jun 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
21 May 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC
05 May 2015	Behavioral Health Qu	AILOR, LYNNE P	WRNMMC

REFRACTIVE ERROR - MYOPIA (367.1)

Encounter Date	Clinic	Clinician	Facility
21 Apr 2011	Refractive Surgery	ROPP, CORBY D	81st Medical Group
29 Mar 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL
16 Mar 2011	NASP Optometry	ZENT, JOHN W	NH Pensacola FL
17 Feb 2011	NASP Optometry	ZENT, JOHN W	NH Pensacola FL
21 Apr 2010	NASP Optometry	ZENT, JOHN W	NH Pensacola FL

Removal Of Sutures (V58.32)

Encounter Date	Clinic	Clinician	Facility
04 Oct 2010	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL

ROSACEA (695.3)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
14 Jun 2010	Corry Prime Care	GUNTER, ROGER WILLIAM	NH Pensacola FL

SKIN NEOPLASM GROIN (239.2)

Encounter Date	Clinic	Clinician	Facility
29 Sep 2015	Dermatology Clinic Bethesda	MARQUART, JASON DANIEL	WRNMMC

SKIN NEOPLASM UNCERTAIN BEHAVIOR (238.2)

Encounter Date	Clinic	Clinician	Facility
24 Nov 2010	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL

Sleep disturbances (780.50)

Encounter Date	Clinic	Clinician	Facility
23 Sep 2015	Integrative Hlth & Well BE	JARRETT, ERICA M	WRNMMC

Sprain of other ligament of left ankle, subsequent encounter (S93.492D)

Encounter Date	Clinic	Clinician	Facility
16 Feb 2016	Int Med CL C Medical Home BE	WILSON, BRYAN J	WRNMMC

SUPERFICIAL INJURY - ABRASION OF CORNEA (918.1)

Encounter Date	Clinic	Clinician	Facility
04 May 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL

Unspecified disturbances of smell and taste (R43.9)

Encounter Date	Clinic	Clinician	Facility
07 Jun 2016	Otolaryngology Clinic Bethesda	XYDAKIS, MICHAEL S	WRNMMC
11 Apr 2016	Otolaryngology Clinic Bethesda	THOMPSON, DAVID HERRON	WRNMMC

Vaccines Prophylactic Need Against Bacterial Diseases (V03.9)

Encounter Date	Clinic	Clinician	Facility
05 Aug 2013	Immunization Kimbrough	WRAY, KIM D	WRNMMC
09 Mar 2010	Corry Prime Care	THOMAS, JOSHUA L	NH Pensacola FL

Vaccines Prophylactic Need Against Influenza (V04.81)

Encounter Date	Clinic	Clinician	Facility
22 Oct 2014	SRP CI Ki	JORDAN, TIMOTHY W	WRNMMC
24 Oct 2012	SRP CI Ki	AHLTA SYSTEM ADMINISTRATOR	WRNMMC
02 Nov 2011	Corry MHP	GRIMM, CHRISTOPHER T	NH Pensacola FL
15 Nov 2010	Corry Prime Care	WILLIAMS, TREVOR MICHAEL	NH Pensacola FL
23 Sep 2009	Corry Prime Care	GUNTER, ROGER WILLIAM	NH Pensacola FL

VIRAL SYNDROME (079.99)

Encounter Date	Clinic	Clinician	Facility
14 May 2012	Corry MHP	BRADLEY, RACHAEL NAOMI	NH Pensacola FL
10 May 2012	Corry MHP	GUNTER, ROGER WILLIAM	NH Pensacola FL

Visit for: administrative purpose (V68.9)

Encounter Date	Clinic	Clinician	Facility
30 Sep 2015	Dermatology Clinic Bethesda	CUNNINGHAM, RACHEL E	WRNMMC
08 Jul 2015	Dermatology Clinic Bethesda	TAYLOR, BRADLEY MICHAEL	WRNMMC
07 Oct 2014	Int Med CL C Medical Home	RINIS, DONNA L	WRNMMC

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

	BE		
30 Dec 2013	GI Clinic Bethesda	COPSEY, HELEN C	WRNMMC
07 May 2009	Corry Health Promotion And Wel	LINVILLE, TREVOR S	NH Pensacola FL

Visit for: ears / hearing exam (V72.19)

Encounter Date	Clinic	Clinician	Facility
19 Mar 2013	Hearing Conservation Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC

Visit for: exam following treatment (V67.59)

Encounter Date	Clinic	Clinician	Facility
06 May 2014	AMH M01A Red Ki	UDE, ASSUMPTA O	WRNMMC

Visit for: follow-up exam (V67.9)

Encounter Date	Clinic	Clinician	Facility
21 Mar 2013	Immunization Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC

Visit for: issue medical certificate fitness (V68.0)

Encounter Date	Clinic	Clinician	Facility
06 Mar 2006	NATTC MHP	MAYNARD, PENELOPE A	NH Pensacola FL

Visit for: military services physical (V70.5)

Encounter Date	Clinic	Clinician	Facility
28 Apr 2015	Medical Readiness Clinic Bethesda	PARSON, MARSHEA S	WRNMMC
19 May 2014	AMH M01A Red Ki	UDE, ASSUMPTA O	WRNMMC
07 Aug 2013	AMH M01A Red Ki	SLOAN, DAWN M	WRNMMC
10 Apr 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC
16 Sep 2009	Corry Phys Exams	GUNTER, ROGER WILLIAM	NH Pensacola FL

Visit for: occupational health / fitness exam (V70.5)

Encounter Date	Clinic	Clinician	Facility
19 Mar 2013	Hearing Conservation Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC
06 Mar 2012	Readiness Center	TREVEN, LAUREN A	NH Pensacola FL
08 Feb 2011	Readiness Center	BROWN, TRAVIS S	NH Pensacola FL
17 Mar 2010	Readiness Center	BROWN, TRAVIS S	NH Pensacola FL

Visit for: preoperative exam (V72.84)

Encounter Date	Clinic	Clinician	Facility
29 Mar 2011	Ophthalmology Clinic	ROPP, CORBY D	NH Pensacola FL

Visit for: screening exam alcoholism (V79.1)

Encounter Date	Clinic	Clinician	Facility
17 Mar 2015	Substance Abuse NY	REGIS, JAMES	WRNMMC

Visit for: screening exam malignant neoplasm skin (V76.43)

Encounter Date	Clinic	Clinician	Facility
24 Nov 2010	Dermatology Clinic	BRUMWELL, ERIC P	NH Pensacola FL

Visit for: screening exam pulmonary tuberculosis (V74.1)

Encounter Date	Clinic	Clinician	Facility
19 Mar 2013	Immunization Kimbrough	AHLTA SYSTEM ADMINISTRATOR	WRNMMC

Visit for: screening exam STD (V74.5)

Encounter Date	Clinic	Clinician	Facility
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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

28 Jan 2013	AMH M01B Blue Ki	UDE, ASSUMPTA O	WRNMMC
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***** End of Diagnosis History *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medications*Active Medications*

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
JP7479252	Naltrexone Hcl, 50 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Active	30	09 Aug 2017	1 of 1
JP7479249	Venlafaxine Hcl, 150 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Day	Active	30	09 Aug 2017	1 of 1
JP7479839	Chlorhexidine Gluconate 0.12%, Solution, Oral Rinse By Mouth One Time Per Day For 14 Days.	Active	1	09 Aug 2017	NR
JP7441901	Probiotic (Vsl#3) Ds--Po Pack Take One Packet By Mouth Every Day	Active	3	06 Jun 2017	1 of 1
BC7174607	Omega-3/Dha/Epa/Fish Oil, 1000 Mg, Capsule, Oral Take 2 By Mouth Every Day	Active	180	06 Jun 2017	3 of 3
JP7441911	Simethicone, 80 Mg, Tab Chew, Oral Chew 1 Tablet By Mouth Four Times A Day As Needed For Gas	Active	100	18 May 2017	2 of 2
BC7155209	Hyoscyamine Sulfate, 0.125 Mg, Tab Subl, Sublingual Dissolve 1 Tablet Under Tongue Every Eight Hours As Needed For Abdominal Pain	Active	30	10 May 2017	3 of 3
BC7155207	Psyllium Seed 3.4 G/Scoop + Sucrose Granules, Oral Take One Scoop Every Day Mixed In Liquid. After Two Weeks Increase To Twice Every Day	Active	2	10 May 2017	3 of 3
NB10627135	Pseudoephedrine Hydrochloride 6Mg/ML, Liquid, Oral, 5ML Drink 10ML Every 6 Hours For Congestion	Active	1	28 Apr 2017	3 of 3
NB10627121	Ibuprofen, 100 Mg/5ML, Oral Susp, Oral Drink 20ML (400Mg) Every Four Hours For Baseline Pain Control	Active	7	28 Apr 2017	1 of 1
680015	Fluarix Quad 2016-2017 (Flu Vacc Qs2016-17 36Mos Up/Pf), 60Mcg/.5ML, Syringe, Intramusc, Glaxosmithkline, 0.5 ML Syringe	Active	0.5	14 Oct 2016	NR

Merwin, Daniel Dennis

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Medical Record

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Created: 16 Aug 2017

551867	Afluria 2015-2016 (Flu Vacc Ts 2015-16(5Yr,Up)/Pf), 45Mcg/.5Ml, Syringe, Intramusc, Csl Biotherapie, 0.5 Ml Syringe	Active	0.5	05 Oct 2015	NR
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Cancelled Medications

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
	Hydromorphone 1Mg/ML, Syringe, Intravenous Prnq2h	Cancelled		UNK	NR
	Ondansetron 2Mg/ML, Syringe, Intravenous Prnq4h	Cancelled		UNK	NR
	Enoxaparin Sodium 40Mg, Solution, Injection Q Day	Cancelled		UNK	NR
	Acetaminophen 10Mg/ML Solution, Intravenous Prnq6h	Cancelled		UNK	NR
	Benzocaine + Menthol Lozenge, Oral Prntid	Cancelled		UNK	NR
	Folic Acid, 1 Mg, Tablet, Oral Q Day	Cancelled		UNK	NR
	Lorazepam 2Mg/ML, Solution, Injection Prnq4h	Cancelled		UNK	NR
	Lorazepam, 1 Mg, Tablet, Oral Prnq4h	Cancelled		UNK	NR
	Ibuprofen, 400 Mg, Tablet, Oral Prnq8h	Cancelled		UNK	NR
	Acetaminophen, 500 Mg, Tablet, Oral Prnq6h	Cancelled		UNK	NR
	Docusate Sodium, 100 Mg, Capsule, Oral Prnbid	Cancelled		UNK	NR
	Promethazine Hcl, 25 Mg, Tablet, Oral Prnq6h	Cancelled		UNK	NR
	Mag Hydrox/Al Hydrox/Simeth, Oral Susp, Oral Prnq6h	Cancelled		UNK	NR

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Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Thiamine Hcl, 50 Mg, Tablet, Oral Q Day	Cancelled	UNK	NR
Sertraline Hcl, 50 Mg, Tablet, Oral Hs	Cancelled	UNK	NR
Nicotine 21Mg/24Hr, Transdermal System, Transdermal Prnq Day	Cancelled	UNK	NR
Diphenhydramine Hydrochloride 50Mg/MI Solution For Injection Prnq4h	Cancelled	UNK	NR
Diphenhydramine Hcl, 50 Mg, Capsule, Oral Prnhs	Cancelled	UNK	NR
Nicotine Polacrilex, 2 Mg, Gum, Buccal Prnq2h	Cancelled	UNK	NR
Multivitamins, (Daily-Vite), Tablet, Oral Q Day	Cancelled	UNK	NR
Haloperidol Lactate 5Mg/MI Solution For Injection Prnq4h	Cancelled	UNK	NR
Diphenhydramine Hcl, 50 Mg, Capsule, Oral Prnhs	Cancelled	UNK	NR
Acetaminophen, 500 Mg, Tablet, Oral Prnq6h	Cancelled	UNK	NR
Diphenhydramine Hcl, 50 Mg, Capsule, Oral Prnhs	Cancelled	UNK	NR
Melatonin, 3 Mg, Tablet, Oral Hs	Cancelled	UNK	NR

Discontinued Medications

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
JP7473902	Venlafaxine Hcl, 150 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Day	Discontinued	14	27 Jul 2017	1 of 1
JP7465544	Naltrexone Hcl, 50 Mg, Tablet, Oral Take 1/2 Tablet By Mouth Every Day For 3 Days, Then Increase To One Tablet By Mouth Every Day	Discontinued	30	27 Jul 2017	0 of 1

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Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

JP7469597	Venlafaxine Hcl, 75 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Morning	Discontinued	30	18 Jul 2017	1 of 1
JP7465548	Venlafaxine Hcl, 37.5 Mg, Cap Er 24H, Oral Take One Capsule By Mouth Every Morning	Discontinued	14	10 Jul 2017	1 of 1
NB10626510	Ibuprofen, 800 Mg, Tablet, Oral Take One Tablet Three Times Every Day	Discontinued	50	27 Apr 2017	NR
NB2340643	Oxycodone Hcl/Acetaminophen, 5 Mg-325Mg, Tablet, Oral Take 1 To 2 Tablets Every 6 Hours As Needed For Post Surgical Pain	Discontinued	30	27 Apr 2017	NR
NB10626505	Pseudoephedrine Hydrochloride 6Mg/ML, Liquid, Oral, 5ML 5 ML By Mouth Every Six Hours	Discontinued	1	27 Apr 2017	NR
NB10626507	Amoxicillin Tri/Potassium Clav, 875-125 Mg, Tablet, Oral Take 1 Tablet Twice A Day Until Gone	Discontinued	14	27 Apr 2017	NR
JP7372725	Naltrexone Hcl, 50 Mg, Tablet, Oral Take 1/2 Tablet By Mouth Every Day X 1 Week, Then Increase To One Tablet By Mouth Every Day If Tolerated	Discontinued	30	01 Mar 2017	1 of 3
JP7401962	Escitalopram Oxalate, 20 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Discontinued	70	01 Mar 2017	3 of 3
JP7337239	Escitalopram Oxalate, 20 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Discontinued	30	01 Feb 2017	0 of 3
JP3063504	Eszopiclone, 1 Mg, Tablet, Oral Take 1 To 2 Tablets By Mouth Every Night As Needed For Sleep	Discontinued	30	04 Jan 2017	1 of 1
JP7359043	Bupropion Hcl, 150 Mg, Tab Er 24H, Oral Take One Tablet By Mouth Every Morning For 1 Week, Then Increase To Two Tablets By Mouth Every Morning If Tolerated	Discontinued	60	05 Dec 2016	1 of 1
JP7323675	Escitalopram Oxalate, 5 Mg, Tablet, Oral Take One Tablet By Mouth Every Day For 1 Week, Then Increase To Two Tablets By Mouth Every Day If Tolerated	Discontinued	60	24 Oct 2016	0 of 1
JP7121731	Imiquimod 5%, Cream, Topical Apply To Warts At Bedtime, Three Times Every Day For 5 Consecutive Days Per Week . For 4 Weeks	Discontinued	1	28 Sep 2015	3 of 3
JP7059879	Sertraline Hcl, 100 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Discontinued	30	08 Sep 2015	0 of 2

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Medical Record

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1985

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Created: 16 Aug 2017

JP7093523	Imiquimod 5%, Cream, Topical Apply To Warts At Bedtime Three Times A Week	Discontinued	1	11 Aug 2015	1 of 1
JP7093524	Sertraline Hcl, 100 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Discontinued	30	11 Aug 2015	2 of 2
BC6916714	Sertraline Hcl, 50 Mg, Tablet, Oral Take 1.5 Tablets (75Mg) By Mouth Every Day	Discontinued	45	19 May 2015	1 of 1
PI6290684	Sertraline Hcl, 50 Mg, Tablet, Oral Take One And 1/2 Tablet By Mouth Every Night	Discontinued	30	22 Apr 2015	NR
H1112787	Oxycodone Hcl/Acetaminophen, 5 Mg-325Mg, Tablet, Oral T 1-2 Tabs Q4h Pp #30	Discontinued	30	14 Apr 2011	NR
H2317349	Diazepam, 5 Mg, Tablet, Oral T1 Tab 30 Min Prior To The Procedure Time #1 Rf0	Discontinued	1	14 Apr 2011	NR
R2424173	Ibuprofen (Motrin Eq.) Tablet 800Mg Oral Take One Tablet By Mouth Three Times A Day As Needed For Pain #10 Rf2	Discontinued	10	14 Nov 2005	2 of 2
R2422214	Ibuprofen (Motrin Eq.) Tablet 800Mg Oral Take One Tablet By Mouth Three Times A Day As Needed For Pain #12 Rf0	Discontinued	12	10 Nov 2005	NR
	Sodium Chloride + Polyethylene Glycol 3350 + Sodium Bicarbonate + Sodium Sulfate + Potassium Chloride, (Moviprep), Reconstituted Solution, Oral	Discontinued		UNK	NR
	Acetaminophen 10Mg/ML Solution, Intravenous	Discontinued		UNK	NR
	Sulbactam Sodium 1G + Ampicillin Sodium 2G, Reconstituted Solution, Intravenous	Discontinued		UNK	NR
	Dexamethasone Sodium Phosphate 4Mg/ML Solution, Intravenous	Discontinued		UNK	NR

Expired Medications

Rx #	Drug	Status	Quantity	Fill Date	Refills Left
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Merwin, Daniel Dennis

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1985

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Medical Record

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Created: 16 Aug 2017

BC7174608	Rifaximin, 550 Mg, Tablet, Oral Take One Tablet By Mouth Three Times A Day For 14 Days	Expired	42	06 Jun 2017	NR
JP7441897	Cetirizine Hcl, 10 Mg, Tablet, Oral Take One Tablet By Mouth Every Day	Expired	30	18 May 2017	NR
JP7441899	Albuterol Sulfate 0.09 Mg/Actuation, Aerosol, Inhalation Inhale 2 Puffs By Mouth Every Four Hours As Needed For Cough, Wheeze, Or Shortness Of Breath	Expired	1	18 May 2017	NR
JP7437988	Chlorhexidine Gluconate 0.12%, Solution, Oral Rinse And Spit With 15 ML By Mouth Once Every 12 Hours Until Gone	Expired	1	10 May 2017	NR
BC2110660	Oxycodone Hcl/Acetaminophen, 5 Mg-325Mg, Tablet, Oral Take One Tablet By Mouth Once Every 6 Hours As Needed For Pain	Expired	20	03 May 2017	NR
NB10626508	Ondansetron 4Mg, (Zofran Odt), Tablet, Oral Dissolve 1 Tablet Under Tongue Every 12 Hours As Needed For Nausea	Expired	8	28 Apr 2017	NR
NB2340707	Oxycodone Hcl, 5 Mg/5 ML, Solution, Oral Drink 5-10ML Every Four Hours As Needed For Breakthrough Post-Surgical Pain.	Expired	240	28 Apr 2017	NR
NB10627134	Amoxicillin Tri/Potassium Clav, 400-57Mg/5, Susp Recon, Oral Take 10ML Twice A Day For 5 Days, Until Finished	Expired	1	28 Apr 2017	NR
NB10626504	Oxymetazoline Hcl, 0.05 %, Spray, Nasal 2 Puffs Each Nostril 2 Times A Day Every Day For 3 Days	Expired	1	27 Apr 2017	NR
NB10626509	Chlorhexidine Gluconate 0.12%, Solution, Oral Rinse (50% Peridex/50% Water) 2 Times A Day Every Day Starting On The Day After Surgery	Expired	1	27 Apr 2017	NR
NB10626506	Petrolatum, White, Ointment, Topical Apply To Lips As Needed To Keep Moist	Expired	1	27 Apr 2017	NR
NB10626511	Sodium Chloride, 0.65 %, Spray, Nasal 2 Puffs Each Nostril 4 Times A Day Every Day To Keep Nose Moist	Expired	1	27 Apr 2017	NR
DE6004028	Ibuprofen, 800 Mg, Tablet, Oral Take One Tablet By Mouth Three Times A	Expired	30	22 Jun 2016	NR

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Medical Record

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Created: 16 Aug 2017

Day As Needed For Pain					
JP7249798	Amoxicillin Trihydrate, 500 Mg, Capsule, Oral Take Two Capsules By Mouth Twice A Day For Two Weeks	Expired	56	11 May 2016	NR
JP7249797	Clarithromycin, 500 Mg, Tablet, Oral Take One Tablet By Mouth Twice A Day For Fourteen Days	Expired	28	11 May 2016	NR
JP7249795	Pantoprazole Sodium 40Mg, Delayed Release Enteric Coated Tablet, Oral Take One Tablet By Mouth Twice A Day For Two Weeks	Expired	28	11 May 2016	NR
JP7197759	Ibuprofen, 800 Mg, Tablet, Oral Take One Tablet By Mouth Three Times A Day As Needed For Pain	Expired	60	24 Feb 2016	NR
JP7203231	Podofilox, 0.5 %, Solution, Topical Apply Twice A Day For 3 Days Then Stop For 4 Days, Repeat Weekly As Needed	Expired	1	24 Feb 2016	2 of 2
CX6015674	Sertraline Hcl, 25 Mg, Tablet, Oral Take One Tablet By Mouth Every Day For 7 Days Then Decrease To One Half Tablet (12.5Mg) By Mouth Every Day	Expired	30	04 Nov 2015	NR
JP7122424	Fluocinolone Acetonide, 0.01 %, Solution, Topical Apply To Scalp Every Day As Needed	Expired	1	29 Sep 2015	3 of 3
JP7121748	Fluticasone Propionate 220Mcg, Aerosol Powder, Inhalation, Hfa Inhale 2 Puffs By Mouth Twice A Day Then Rinse Mouth With Water	Expired	1	28 Sep 2015	3 of 3
JP7121749	Benzonatate, 100 Mg, Capsule, Oral Take One Capsule By Mouth Every Eight Hours As Needed For Cough	Expired	60	28 Sep 2015	NR
JP7121751	Guaifenesin, 600 Mg, Tablet Er, Oral Take One Tablet By Mouth Twice A Day	Expired	90	28 Sep 2015	NR
JP7109231	Valacyclovir Hcl, 500 Mg, Tablet, Oral Take 1 Tablet Twice Every Day For 10 Days	Expired	20	08 Sep 2015	NR
NB10053781	Ibuprofen, 800 Mg, Tablet, Oral Take One Tablet Three Times A Day As Needed For Pain	Expired	30	18 Sep 2014	NR
NB10053782	Chlorhexidine Gluconate 0.12%, Solution, Oral Swish And Spit 15 Ml Twice A Day For 2	Expired	1	18 Sep 2014	NR

Merwin, Daniel Dennis

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1985

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

Weeks Starting Tomorrow

NB2277055	Oxycodone Hcl/Acetaminophen, 5 Mg-325Mg, Tablet, Oral Take One Tablet Every 4-6 Hours As Needed For Pain	Expired	20	18 Sep 2014	NR
JP6830628	Doxycycline Hyclate, 100 Mg, Tablet, Oral Take One Tablet By Mouth Twice A Day For 30 Days	Expired	60	16 Jun 2014	1 of 1
BC6585316	Clindamycin Phosphate, 1 %, Gel (Gram), Topical Apply To Rash Area Along The Beard Twice A Day For Seven Days	Expired	1	30 Nov 2012	NR
BC6585319	Sulfamethoxazole/Trimethoprim, 800-160 Mg, Tablet, Oral 1 Tablet By Mouth Twice A Day	Expired	20	30 Nov 2012	NR
BC6585329	Skin Cleansing (Cetaphil) Lotion Topical Use Instead Of Soap As Directed	Expired	1	30 Nov 2012	NR
H8299054	Albuterol Sulfate 90Mcg, Aerosol Powder, Inhalation, Hfa Inhale 2 Puffs By Mouth Every Four Hours For Wheezing	Expired	2	27 Jul 2011	5 of 5
H8299603	Ammonium Lactate, 12%, Lotion, Topical Apply To Affected Areas Trunk And Neck Every Day	Expired	2	27 Jul 2011	4 of 4
H8299605	Clindamycin Phosphate, 1 %, Solution, Topical Apply To Upper Trunk And Neck Daily-- This Is The Antibiotic	Expired	2	27 Jul 2011	3 of 3
H8227551	Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic Instill 1 Drop In Each Eye Every 5 To 10 Minutes As Needed X 5 Days, Then As Needed	Expired	120	04 May 2011	5 of 6
H8240982	Ibuprofen, 800 Mg, Tablet, Oral Take One Tablet By Mouth Every Eight Hours As Needed For Pain	Expired	20	04 May 2011	NR
H8240981	Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic Instill 1 Drop In Left Eye Four Times A Day For 5 Days	Expired	1	04 May 2011	NR
H8227553	Cyclosporine 0.05%, Emulsion, Ophthalmic Ins 1 Gtt Ou Bid Ud #2 Rf3	Expired	2	14 Apr 2011	3 of 3

Merwin, Daniel Dennis

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Medical Record

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

H8227554	Ibuprofen, 800 Mg, Tablet, Oral T1 Tab Po Q8h Pp #30 Rf0	Expired	30	14 Apr 2011	NR
H8227549	Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic Ins 1 G Ou Qid X 7 Days #1 Rf1	Expired	1	14 Apr 2011	1 of 1
H8227550	Fluorometholone 0.1%, Suspension, Ophthalmic Instill 1 Drop Ou Qid X 1 Week, Then Tid X 1 Week, Then Bid X 2 Weeks, Then Daily X 2 Weeks And Stop #2 Rf0	Expired	2	14 Apr 2011	NR
H8227552	Nepafenac 0.1%, Suspension, Ophthalmic Ins 1 G Ou Tid - Qid Prn Severe Pain #1 Rf0	Expired	1	14 Apr 2011	NR
H8061857	Salmeterol Xinafoate 50Mcg + Fluticasone Propionate 250Mcg, Device, Inhalation Inhale 1 Puff Orally Bid #1 Rf1	Expired	1	24 Jan 2011	0 of 1
H8162826	Cetirizine Hcl, 10 Mg, Tablet, Oral T1 Tab Po Hs #30 Rf5	Expired	30	24 Jan 2011	5 of 5
H8162824	Fluticasone Propionate 0.05%, Spray, Nasal Inhale 2 Sprays In Each Nostril Once A Day #1 Rf3	Expired	1	24 Jan 2011	3 of 3
H8090733	Non-Formulary Drug Request (Nfdr) Device Not Specified Miscellaneous Ketoconazole 2% Shampoo-- Use On Trunk And Scalp Twice Daily As Directed #2 Rf4	Expired	2	13 Oct 2010	4 of 4
H8090761	Ketoconazole, 2 %, Shampoo, Topical Use On Trunk And Scalp Bid As Directed	Expired	2	13 Oct 2010	4 of 4
H8061856	Albuterol Sulfate 90Mcg, Aerosol Powder, Inhalation, Hfa Inh 2 Pf Po Q4h For Wheezing #1 Rf1	Expired	1	01 Sep 2010	1 of 1
H8056814	Fexofenadine Hcl, 180 Mg, Tablet, Oral T1 Tab Po Qd F Allergies Ud #30 Rf2	Expired	30	25 Aug 2010	2 of 2
H8056815	Triamcinolone Acetonide 0.025%, Cream, Topical Aaa Bid To Tid For 2-3 Days At Onset Of Rash Ud #1 Rf0	Expired	1	25 Aug 2010	NR
H8033753	Cetaphil/Aquanil Cleanser Lotion Topical Instead Of Soap Ud (But The Best Soap Is No Soap) #2 Rf6	Expired	2	20 Jul 2010	6 of 6
H7949343	Guaifenesin 600Mg + Pseudoephedrine Hydrochloride 60Mg, Extended Release Tablet, Oral Take One Tablet Twice Daily **Max 50 Tabs	Expired	40	17 Mar 2010	NR

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Per Fill** #40 Rf0

H7949342	Loratadine, 10 Mg, Tablet, Oral T 1 Tablet Po Qd Prn For Allergies #100 Rf0	Expired	100	17 Mar 2010	NR
C4200630	Sodium Fluoride, Cream, Dental Brush For 5 Minutes Before Bedtime. Do Not Rinse. #2 Rf3	Expired	2	18 Sep 2009	3 of 3
S4279109	Acetaminophen, 325 Mg, Tablet, Oral Take 2 Tabs Po Q4-6H Prn	Expired	50	24 Jan 2006	NR
S4279110	Dextromethorphan Hydrobromide + Guaifenesin Syrup, Oral T1 Tsp Po Q4h Prn	Expired	120	24 Jan 2006	NR
B231582	Acetaminophen, 325 Mg, Tablet, Oral 1-2 Tabs Q4-6H Prn For Pain/Fever #24 Rf0	Expired	24	29 Dec 2005	NR
B231583	Benzocaine/Menthol/Cetylpyridinium Chloride (Cepacol Eq.) Loz Mth Dizolve 1 Tab In Mouth Prn For Sore Throat #27 Rf0	Expired	27	29 Dec 2005	NR
B231581	Pseudoephedrine Hcl (Sudogest Eq.) Tablet 30Mg Oral 1-2 Tab2 Q4-6H Prn For Congestion #24 Rf0	Expired	24	29 Dec 2005	NR
H1856669	Psyllium Seed, Powder, Oral Use As Directed On Bottle #1 Rf0	Expired	595	19 Nov 2005	NR
H1856670	Acetaminophen, 500 Mg, Tablet, Oral T1-2 Tabs Po Q6 Pp #12 Rf0	Expired	12	19 Nov 2005	NR
H1856671	Dicyclomine Hcl, 20 Mg, Tablet, Oral T 1 Tab Po Q6 Prn F Spasm	Expired	12	19 Nov 2005	NR
D60093920	Ibuprofen (Motrin Eq.) Tablet 800Mg Oral 1 Tab Q6h #12 Rf1	Expired	12	16 Nov 2005	1 of 1
D30100153	Hydrocodone Bit/Acetaminophen, 5 Mg- 500Mg, Tablet, Oral 1-2 Tabs Q6h Prn #6 Rf0	Expired	6	16 Nov 2005	NR
R2424142	Omeprazole 20Mg, Extended Release Capsule, Oral T 1 Tab Daily #14 Rf0	Expired	14	14 Nov 2005	NR
R2422213	Dicloxacillin Sodium, 250 Mg, Capsule, Oral Take 2 Capsule Four Times A Day For 10 Days #60 Rf0	Expired	60	10 Nov 2005	NR
R2422285	Docusate Calcium, 240 Mg, Capsule, Oral T1 Cap Po Once A Day F Constipation #14 Rf0	Expired	14	10 Nov 2005	NR

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

R2422286	Phospho Soda (Oral Fleets) @\$.01/ML Po Take 45 ML This Evening #1 Rf0	Expired	1	10 Nov 2005	NR
R2420749	Penicillin V Potassium, 250 Mg, Tablet, Oral T1 Tab Po Bid Tat #60	Expired	60	07 Nov 2005	NR

***** End of Medications *****

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Procedures**Postoperative Visit, Without Charge on 06 Jun 2011**

Date Performed:	06 Jun 2011	Date Reported:	06 Jun 2011
Verified:	Yes	CPT:	99024
Source:	Unknown Source of Info	Status:	Active
Comment:			

Postoperative Visit, Without Charge on 06 Jun 2011

Date Performed:	06 Jun 2011	Date Reported:	06 Jun 2011
Verified:	Yes	CPT:	99024
Source:	Unknown Source of Info	Status:	Active
Comment:			

Ophthalmological Prior Patient Start Comprehensive Care on 04 May 2011

Date Performed:	04 May 2011	Date Reported:	04 May 2011
Verified:	Yes	CPT:	92014
Source:	Unknown Source of Info	Status:	Active
Comment:			

Postoperative Visit, Without Charge on 26 Apr 2011

Date Performed:	26 Apr 2011	Date Reported:	26 Apr 2011
Verified:	Yes	CPT:	99024
Source:	Unknown Source of Info	Status:	Active
Comment:			

Postoperative Visit, Without Charge on 22 Apr 2011

Date Performed:	22 Apr 2011	Date Reported:	22 Apr 2011
Verified:	Yes	CPT:	99024
Source:	Unknown Source of Info	Status:	Active
Comment:			

HCPCS code Error on 21 Apr 2011

Date Performed:	21 Apr 2011	Date Reported:	21 Apr 2011
Verified:	Yes	CPT:	S0810
Source:	Unknown Source of Info	Status:	Active
Comment:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ophthalmological New Patient Start Comprehensive Care on 29 Mar 2011

Date Performed:	29 Mar 2011	Date Reported:	29 Mar 2011
Verified:	Yes	CPT:	92004
Source:	Unknown Source of Info	Status:	Active
Comment:			

Determination Of Refractive State on 29 Mar 2011

Date Performed:	29 Mar 2011	Date Reported:	29 Mar 2011
Verified:	Yes	CPT:	92015
Source:	Unknown Source of Info	Status:	Active
Comment:			

Corneal Pachymetry Both Eyes on 29 Mar 2011

Date Performed:	29 Mar 2011	Date Reported:	29 Mar 2011
Verified:	Yes	CPT:	76514
Source:	Unknown Source of Info	Status:	Active
Comment:			

Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral on 29 Mar 2011

Date Performed:	29 Mar 2011	Date Reported:	29 Mar 2011
Verified:	Yes	CPT:	92132
Source:	Unknown Source of Info	Status:	Active
Comment: Wavescan, low RMS, okay for Allegretto PentaCam - nl A/P floats and Belin-Ambrosio scans ou - Hard copy on file on system - no printer ink			

Computerized Corneal Topography on 29 Mar 2011

Date Performed:	29 Mar 2011	Date Reported:	29 Mar 2011
Verified:	Yes	CPT:	92025
Source:	Unknown Source of Info	Status:	Active
Comment:			

Special Dr. Services Analysis Of Computerized Data on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	99090
Source:	Unknown Source of Info	Status:	Active
Comment:			

Pulse Oximetry on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94760

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Source:	Unknown Source of Info	Status:	Active
Comment:			

Pulmonary Function MVV on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94200
Source:	Unknown Source of Info	Status:	Active
Comment:			

Pulmonary Function FRC (% Predicted Normal) on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	
Source:	Unknown Source of Info	Status:	Active
Comment:			

Pulmonary Function Carbon Monoxide Diffusion % (DLCO) on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94729
Source:	Unknown Source of Info	Status:	Active
Comment:			

Bronchial Challenge With Methacholine on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94070
Source:	Unknown Source of Info	Status:	Active
Comment:			

Spirometry Pre-bronchodilator on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94010
Source:	Unknown Source of Info	Status:	Active
Comment:			

Spirometry Post-bronchodilator on 24 Mar 2011

Date Performed:	24 Mar 2011	Date Reported:	24 Mar 2011
Verified:	Yes	CPT:	94060
Source:	Unknown Source of Info	Status:	Active
Comment:			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Ophthalmological Prior Patient Start Intermediate Level Care on 16 Mar 2011

Date Performed:	16 Mar 2011	Date Reported:	16 Mar 2011
Verified:	Yes	CPT:	92012
Source:	Unknown Source of Info	Status:	Active
Comment:			

Determination Of Refractive State on 16 Mar 2011

Date Performed:	16 Mar 2011	Date Reported:	16 Mar 2011
Verified:	Yes	CPT:	92015
Source:	Unknown Source of Info	Status:	Active
Comment:			

Ophthalmological Prior Patient Start Comprehensive Care on 17 Feb 2011

Date Performed:	17 Feb 2011	Date Reported:	17 Feb 2011
Verified:	Yes	CPT:	92014
Source:	Unknown Source of Info	Status:	Active
Comment:			

Corneal Pachymetry Both Eyes on 17 Feb 2011

Date Performed:	17 Feb 2011	Date Reported:	17 Feb 2011
Verified:	Yes	CPT:	76514
Source:	Unknown Source of Info	Status:	Active
Comment:			

Biopsy Skin on 24 Nov 2010

Date Performed:	24 Nov 2010	Date Reported:	24 Nov 2010
Verified:	Yes	CPT:	11100
Source:	Unknown Source of Info	Status:	Active
Comment:			

Immunization Administration One Vaccine on 15 Nov 2010

Date Performed:	15 Nov 2010	Date Reported:	15 Nov 2010
Verified:	Yes	CPT:	90471
Source:	Unknown Source of Info	Status:	Active
Comment:			

Influenza Virus Vaccine Live Intranasal on 15 Nov 2010

Date Performed:	15 Nov 2010	Date Reported:	15 Nov 2010
Verified:	Yes	CPT:	90660
Source:	Unknown Source of Info	Status:	Active
Comment:			

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Biopsy Skin on 28 Sep 2010

Date Performed:	28 Sep 2010	Date Reported:	28 Sep 2010
Verified:	Yes	CPT:	11100
Source:	Unknown Source of Info	Status:	Active
Comment:			

Biopsy Skin Each Additional Lesion on 28 Sep 2010

Date Performed:	28 Sep 2010	Date Reported:	28 Sep 2010
Verified:	Yes	CPT:	11101
Source:	Unknown Source of Info	Status:	Active
Comment:			

Ophthalmological New Patient Start Comprehensive Care on 23 Apr 2010

Date Performed:	23 Apr 2010	Date Reported:	23 Apr 2010
Verified:	Yes	CPT:	92004
Source:	Unknown Source of Info	Status:	Active
Comment:			

Spectacles Services Fitting Monofocals (Not For Aphakia) on 23 Apr 2010

Date Performed:	23 Apr 2010	Date Reported:	23 Apr 2010
Verified:	Yes	CPT:	92340
Source:	Unknown Source of Info	Status:	Active
Comment:			

Determination Of Refractive State on 23 Apr 2010

Date Performed:	23 Apr 2010	Date Reported:	23 Apr 2010
Verified:	Yes	CPT:	92015
Source:	Unknown Source of Info	Status:	Active
Comment:			

Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia on 23 Apr 2010)

Date Performed:	23 Apr 2010	Date Reported:	23 Apr 2010
Verified:	Yes	CPT:	92310
Source:	Unknown Source of Info	Status:	Active
Comment:			

Anthrax Vaccine, For Subcutaneous Use on 09 Mar 2010

Date Performed:	09 Mar 2010	Date Reported:	09 Mar 2010
Verified:	Yes	CPT:	90581
Source:	Unknown Source of Info	Status:	Active

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Comment:

Immunization Administration One Vaccine on 22 Dec 2009

Date Performed:	22 Dec 2009	Date Reported:	22 Dec 2009
Verified:	Yes	CPT:	90471
Source:	Unknown Source of Info	Status:	Active
Comment:			

Influenza Virus Vaccine Pandemic Formulation on 22 Dec 2009

Date Performed:	22 Dec 2009	Date Reported:	22 Dec 2009
Verified:	Yes	CPT:	90471
Source:	Unknown Source of Info	Status:	Active
Comment:			

Immunization Administration One Vaccine on 23 Sep 2009

Date Performed:	23 Sep 2009	Date Reported:	23 Sep 2009
Verified:	Yes	CPT:	90471
Source:	Unknown Source of Info	Status:	Active
Comment:			

Influenza Virus Vaccine Live Intranasal on 23 Sep 2009

Date Performed:	23 Sep 2009	Date Reported:	23 Sep 2009
Verified:	Yes	CPT:	90660
Source:	Unknown Source of Info	Status:	Active
Comment:			

***** End of Procedures *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Family History**Family medical history on 07 Aug 2017**

Date Onset:	07 Aug 2017	Date Reported:	07 Aug 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~M -- Well~F -- DM. MI / stent at age 40. Melanoma.~		

Family history of supplemental HPI [use for free text] on 13 Jul 2017

Date Onset:	14 Jul 2017	Date Reported:	13 Jul 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	Patient has received other care since their last visit with this clinic		

No family history of malignant melanoma of the skin on 21 Jun 2017

Date Onset:	21 Jun 2017	Date Reported:	21 Jun 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

Family history of cancer on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	Dad- melanoma;		

Family history of heart disease on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	dad/PGF- CAD; dad- stent 2v (alcohol); Dad/PGM/PGF/sister- DM,~ Dad- AMI (s/p heart surgery); no CVA		

Family history of father is alive on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	not in contact		

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Family history of mother is alive on 05 Apr 2017

Date Onset:	07 Apr 2017	Date Reported:	05 Apr 2017
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	No DM, No CAD. healthy		

No family history of malignant neoplasm of the gastrointestinal tract on 04 Oct 2016

Date Onset:	04 Oct 2016	Date Reported:	04 Oct 2016
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

No family history of malignant neoplasm of large intestine on 04 Oct 2016

Date Onset:	04 Oct 2016	Date Reported:	04 Oct 2016
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

Paternal grandmother's history of HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandmother
Status:	Active		
Comment:	<p><<Note accomplished in TSWF-IBHC Anxiety tab>>~ ~Description of Symptoms: Extreme mood swings with depression and anxiety, irritability, concentration problems, poor sleep, fatigue, racing heart and thoughts, trouble relaxing, and worrying. PT reported dry heaving episodes for the past 2 years and pulling the hair off a spot on his scalp since 2008. Several times a week he has a "tingling sensation" with a mood change where he will suddenly smile or frown. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16.~ ~PT reported having passive SI since he was a child. He reported 2 prior suicide attempts when he was in high school: one by overdosing on OTC medicine and one by overdosing on alcohol. His last plan was to overdose on helium before self-referring to substance abuse treatment last year. He last had passive SI("why even bother") 3 weeks ago, with no plans or intent. PT denied any current SI, plans, or intent. ~ ~Duration of Problem: PT has experienced symptoms since his first ship tour in 2006. Symptoms have worsened since he re-enlisted last October.~ ~Factors correlated with onset: Anxiety started after PT joined the Navy in 2006. He regrets re-enlisting last October, and because he waited so long to re-enlist he had last pick for orders. Subsequently he was stationed in the same same environment with the same work stress.~ ~Frequency of symptoms: Symptoms occur every day.~ ~Severity of symptoms: Depression symptoms from PHQ-9 are in the mild range. Anxiety symptoms from GAD-7 are in the moderate range.~ ~Psychosocial factors: Occupational stress and minimal social support.~ ~Aggravating/alleviating factors: Aggravating factors include occupational stress and feeling disconnected from others. Alleviating factors include cooking and programming.~ ~Current tx: None~ ~Past tx: PT began behavioral health treatment in 2012. ~ ~Functional impact: Symptoms negatively impact PT's functioning at home and work.~.....</p>		

Merwin, Daniel Dennis

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1985

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Paternal history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Father
Status:	Active		
Comment:	- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model~of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and~short-term intervention focused approach~- Pt indicated understanding		

Paternal grandfather's history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandfather
Status:	Active		
Comment:	Patient was seen for 30 minute IBHC appointment		

Paternal grandmother's history of preliminary background HPI [use for free text] on 25 Aug 2016

Date Onset:	25 Aug 2016	Date Reported:	25 Aug 2016
Source:	Clinical Evidence	Relationship:	Paternal Grandmother
Status:	Active		
Comment:	Patient was seen by a trainee under the supervision of a licensed mental health professional. Patient indicated an understanding of this.~.....		

Family history of test conclusions [Use for free text] on 11 Aug 2015

Date Onset:	18 Aug 2015	Date Reported:	11 Aug 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	A written list of medications was given to the patient		

Family history of the options include referral on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~[] Physical Activity~[] Safety~[] Diabetes Counseling~[] Cholesterol~[X] Nutrition~[X] Sexuality~[] Other:		

Family history of diabetes mellitus on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	PATERNAL GF and Father		

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Family history of patient counseling on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	~[] Tobacco Use~[] Alcohol Use~[] Weight Management ~[] Dental Care~[] Mental Health~[] Hypertension ~[X] Other:STRESS MANAGEMENT, SLEEP		

Family history of mental illness (not retardation) on 28 Apr 2015

Date Onset:	28 Apr 2015	Date Reported:	28 Apr 2015
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:	MATERNAL		

Fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] on 23 Apr 2015

Date Onset:	23 Apr 2015	Date Reported:	23 Apr 2015
Source:	Clinical Evidence	Relationship:	Brother
Status:	Active		
Comment:	Depression Screening:~ ~[1] 1. Little Interest or pleasure in doing things~[1] 2. Feeling down depressed or hopeless~[0] 3. Trouble sleeping or sleeping too much~[1] 4. Feeling tired or little energy~[0] 5. Poor appetite or overeating~[0] 6. Feeling bad about self~[0] 7. Trouble concentrating on things~[1] 8. Moving or speaking slowly or being restless~[0] 9. Thoughts that you would be better off dead~Add point values from each response. Total (PHQ-9) Score = 4~ ~Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely		

No family history of chronic liver disease on 24 Oct 2012

Date Onset:	24 Oct 2012	Date Reported:	24 Oct 2012
Source:	Clinical Evidence	Relationship:	General FHx
Status:	Active		
Comment:			

***** End of Family History *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Resulted Labs**Drug Abuse Screen on 15 Aug 2017**

Collection Date: 15 Aug 2017
 Ordering Clinician: LANDE, RAYMOND G.
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	
Interpretation: >300 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Amphetamines	NEGATIVE		(Negative)	
Interpretation: >1000 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Barbiturates	NEGATIVE		(Negative)	
Interpretation: > 200 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Benzodiazepines	NEGATIVE		(Negative)	
Interpretation: >200 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				
Opiates	NEGATIVE		(Negative)	
Interpretation: >300 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.				

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Phencyclidine, UA	NEGATIVE	(Negative)
-------------------	----------	------------

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Negative)
-----------	----------	------------

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
-----------	----------	-------	------------

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

ETG/ETS, UA (250 Cut-Off) on 08 Aug 2017

Collection Date: 08 Aug 2017

Site/Specimen: URINE

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Drug Abuse Screen on 08 Aug 2017

Collection Date: 08 Aug 2017

Site/Specimen: URINE

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines	NEGATIVE	(Negative)
-----------------	----------	------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine	NEGATIVE	(Negative)
---------	----------	------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA	NEGATIVE	(Negative)
-------------------	----------	------------

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Cannabinoids NEGATIVE (Negative)

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Methadone NEGATIVE (Negative)

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.**

Oxycodone NEGATIVE ng/mL (Negative)

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 01 Aug 2017**

Collection Date: 01 Aug 2017

Site/Specimen: URINE

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.****Drug Abuse Screen on 01 Aug 2017**

Collection Date: 01 Aug 2017

Site/Specimen: URINE

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:**>300 ng/mL reported as positive**

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines **NEGATIVE** (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates **NEGATIVE** (Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines **NEGATIVE** (Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine **NEGATIVE** (Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA **NEGATIVE** (Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids **NEGATIVE** (Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Methadone	NEGATIVE	(Negative)
------------------	----------	------------

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
------------------	----------	-------	------------

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Vitamin B12 (Cyanocobalamin)+Folate Panel on 27 Jul 2017

Collection Date:	27 Jul 2017	Site/Specimen:	SERUM
Ordering Clinician:	TOBAR, EDEN T		
Comment:			
Chem			

Name	Value	Units	Range	Abnormal
Vitamin B12 (Cobalamins)	549	pg/mL	(211-946)	

Interpretation:

Laboratory testing performed at:

WRNMMC
Dept of Pathology
8901 Wisconsin Ave BLDG 9
Bethesda, MD 20889

Folate	16.54	ng/mL	(4.6-34.8)
---------------	-------	-------	------------

Interpretation:

Laboratory testing performed at:

WRNMMC
Dept of Pathology
8901 Wisconsin Ave BLDG 9
Bethesda, MD 20889

Comment on 25 Jul 2017

Collection Date:	25 Jul 2017	Site/Specimen:	SERUM
Ordering Clinician:	LANDE, RAYMOND G.		
Comment:			
Chem			

Name	Value	Units	Range	Abnormal
Comment 15	COMMENT			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:

A Carbohydrate Deficient Transferrin (CDT) result <1.4% is considered to be normal and is consistent with low or no alcohol use during the previous two weeks.

Transferrin Carbohydrate Deficient on 25 Jul 2017

Collection Date: 25 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Transferrin Carbohydrate Deficient/Transferrin Total	0.5	%	0.0-1.3	

Interpretation:

Normal <1.4
Inconclusive 1.4 - 1.6
Elevated >1.6

Clinical use only. Not specific for medico-legal purposes.

This test is not suitable for the evaluation of patients suspected of having congenital glycosylation disorders.

Gamma Glutamyl Transferase on 25 Jul 2017

Collection Date: 25 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: LANDE, RAYMOND G.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Gamma-Glutamyl Transferase	34	U/L	(10.0-71.0)	

Drug Abuse Screen on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: URINE

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Amphetamines	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines	NEGATIVE	(Negative)
------------------------	-----------------	-------------------

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA	NEGATIVE	(Negative)
--------------------------	-----------------	-------------------

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Not-Detected)
------------------	-----------------	-----------------------

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

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Created: 16 Aug 2017

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone NEGATIVE ng/mL (Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Urinalysis Panel on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: URINE

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Color	Yellow		(Yellow)	
Ketones	NEGATIVE	mg/dL	(Negative)	
Hemoglobin	NEGATIVE		(Negative)	
Nitrite	NEGATIVE		(Negative)	
pH	7.0		(5.0-8.0)	
RBC	<1	/HPF	(0-2)	
Protein	NEGATIVE	mg/dL	(NEGATIVE)	
Appearance	CLEAR		(Clear)	
Leukocyte Esterase	NEGATIVE		(Negative)	
Specific Gravity	1.006		(1.001-1.026)	
Bilirubin	NEGATIVE		(Negative)	
Urobilinogen	<2.0	mg/mL	(0.0-1.9)	
WBC	<1	/HPF	(0-2)	
Glucose	NEGATIVE	mg/dL	(Negative)	
Bacteria	TRACE	/HPF	(None)	

Urine Culture on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: Urine

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Order #	170706-22962
Filler #	170706 NBA 33616
Ordering Provider	FITZGERALD, MICHAEL F.
Priority	ROUTINE
DATE_ORDERED	20170706150900
DATE_RESULTED	20170708101946
COLLECT_SAMPLE	URINE/CLEAN CATCH
BACTERIOLOGY RESULT	07/07/17 LESS THAN 24 HOURS, FURTHER INCUBATION REQUIRED

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

7/8/17 URINE CULTURE NEGATIVE

Results

Final report

Rapid Plasma Reagin on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Reagin Ab	NONREACTIVE		(Non-Reactive)	

Interpretation:**REACTIVE:** Reactive - may indicate past or current syphilis infection.

Reactive results will be quantified and will be reflexed to the Treponema pallidum AB test. The diagnosis of syphilis should not be made on the basis of a single reactive serologic test without taking history, clinical, and other information into consideration.

NON REACTIVE : Nonreactive - current or past infection is unlikely, cannot exclude incubating or early syphilis.

METHODOLOGY:

This test is a macroscopic, non-treponemal flocculation procedure for the serologic screening for syphilis in serum.

CBC W/Diff on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: BLOOD

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
RDW CV	12.3	%	(11.6-14.7)	
WBC	6.6	x10(3)/mcL	(4.2-9.2)	
RBC	4.53	x10(6)/mcL	(4.3-5.6)	
Hemoglobin	14.4	g/dL	(13.2-16.5)	
Hematocrit	41.9	%	(39.7-50.3)	
MCV	92.5	fL	(82.9-99.9)	
MCH	31.8	pg	(27.5-32.7)	
MCHC	34.4	g/dL	(31.3-35.0)	
Platelets	284	x10(3)/mcL	(166-407)	
MPV	10.5	fL	(9.0-12.4)	
Neutrophils	63.3	%	(43.0-68.8)	
Lymphocytes	26.9	%	(20.2-45.5)	
Monocytes	8.3	%	(5.2-11.9)	
Eosinophils	0.5	%	(0.4-5.5)	
Basophils	0.5	%	(0.2-1.2)	
ABS Neutrophils	4.2	x10(3)/mcL	(1.9-5.9)	
ABS Lymphocytes	1.8	x10(3)/mcL	(1.0-2.9)	

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Created: 16 Aug 2017

ABS Monocytes	0.6	x10(3)/mcL	(0.3-0.8)
ABS Eosinophils	0.0	x10(3)/mcL	(0.0-0.4)
ABS Basophils	0.0	x10(3)/mcL	(0.0-0.1)
Nucleated RBC/100 WBC	0.0	/100 WBCs	(1)
Differential Review	MANUAL DIFF NOT PERFORMED		
Granulocytes Immature	0.5	%	(0.0-1.1)
Absolute Immature Granulocytes	0.03	x10(3)/mcL	(0.0-0.1)

Thyroid Stimulating Hormone on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Thyrotropin	1.250	mIU/mL	(0.27-4.2)	
Interpretation:				
Methodology: Chemiluminescence (3rd Generation)				
Laboratory testing performed at:				
WRNMMC				
Dept of Pathology				
8901 Wisconsin Ave BLDG 9				
Bethesda, MD 20889				

Acetaminophen on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Acetaminophen	<2.4	mcg/mL	(10.0-30.0)	Lower Than Normal

Salicylates on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Salicylates	<0.3	mg/dL	(3.0-30.0)	Lower Than Normal

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Comprehensive Metabolic Panel on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: SERUM

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Alanine Aminotransferase	39	U/L	(0-41)	
Albumin	5.0	g/dL	(3.5-5.2)	
Alkaline Phosphatase	61	U/L	(40-129)	
Bilirubin	0.5	mg/dL	(0.15-1.2)	
Urea Nitrogen	9.0	mg/dL	(6-20)	
Calcium	10.5	mg/dL	(8.6-10.2)	Higher Than Normal
Carbon Dioxide	28	mmol/L	(22-29)	
Chloride	99	mmol/L	(98-107)	
Creatinine	0.96	mg/dL	(0.7-1.2)	
Glucose	87	mg/dL	(74-106)	
Anion Gap	14	mmol/L	(7-16)	
Potassium	4.3	mmol/L	(3.5-5.1)	
Protein	7.8	g/dL	(6.6-8.7)	
Sodium	141	mmol/L	(136-145)	
GFR Calculated Non-Black	104.2	mL/min	(60->=60)	
GFR Calculated Black	120.4	mL/min	(60->=60)	

Interpretation:**Reference values:**

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

Aspartate Aminotransferase	26	U/L	(0-40)
----------------------------	----	-----	--------

Ethanol on 06 Jul 2017

Collection Date: 06 Jul 2017

Site/Specimen: PLASMA

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ordering Clinician: FITZGERALD, MICHAEL F.

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethanol	<10	mg/dL		
Interpretation: A value of <10: None Detected				

TISSUE EXAM on 21 Jun 2017

Collection Date: 21 Jun 2017

Site/Specimen: TISSUE

Ordering Clinician: DIBLASI, DANIEL ROBERT

Comment:

Order #	170627-29853
Ordered Date	20170627225500
Priority	ROUTINE
Resulted Date	20170627225530.1-0400
Col	21Jun17@1539 TISSUE(TISSUE)
Hcp	DIBLASI,DANIEL ROBERT Req Loc: DERMATOL
Performing Lab	NNMC AP LAB, BETHESDA,MD 170622 NSP 12523
TISSUE E	C AWC27Jun17@2255 CoPath Report
Patient	MERWIN,DANIEL DENNIS Specimen #: NS17-12523
Accessioned	06/22/17
===== ===== -== awc/06/27/17 ** Report Electronically Signed Out ** Major Arthur W. Clarkson, MC, USAF ===== ===== -== DTW/AWC DTW/baw	

FINAL DIAGNOSIS**SKIN, SCROTUM, EXCISION**

- CALCINOSIS CUTIS.

CLINICAL DIAGNOSIS AND HISTORY

32 year old male with several subcutaneous cysts on the scrotum.
Three
lesions excised. One was performed using punch biopsy.

PRE-OPERATIVE DIAGNOSIS

EIC.

OPERATIVE FINDINGS

SAA.

POST-OPERATIVE DIAGNOSIS

SAA.

GROSS DESCRIPTION

The specimen is received in formalin, labeled with the patient's

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

name
 Merwin, Daniel, and designated "Excision, Scrotum". The specimen consists of multiple pieces of tan-brown soft tissue ranging in size from 0.3 to 0.4 cm in greatest dimension. Specimen submitted entirely in one cassette.
 3/1/NG

CPT Codes

; 88305 ; 88305 (LEVEL 4)

Hemoglobin A1c on 18 May 2017

Collection Date: 18 May 2017
 Ordering Clinician: RODAK, COLLEEN M
 Comment:
 Chem

Site/Specimen: BLOOD

Name	Value	Units	Range	Abnormal
Hemoglobin A1c	5.2	%	(6.4)	

Interpretation:

Normal: 4.8 - 5.6% HbA1c

Pre Diabetes: 5.7 - 6.4% HbA1c

The American Diabetes Association has determined that individuals with HbA1c between 5.7 and 6.4% are at increased risk of developing diabetes and should be counseled on their increased risk.

For Diagnosis of Diabetes: \geq 6.5% HbA1c

Hemoglobin A1c levels greater than or equal to 6.5% may be diagnostic of diabetes and should be correlated with repeat testing of HbA1c, fasting plasma glucose, and/or 2 hour oral glucose tolerance test.

Note: Hemoglobin A1c levels vary with race and ethnicity. There is no well-established reference range for HbA1c in individuals younger than 18 years of age. HbA1c levels must be interpreted with caution in the context of HbF concentrations $>10\%$ or in medical conditions that increase red cell turnover to avoid falsely low values; diagnosis of diabetes is best done through measurement of blood glucose levels in these patients. Patients with hemoglobinopathies should have HbA1c levels measured by an alternative method such as HPLC.

Reference: "Classification and Diagnosis of Diabetes." Diabetes Care, January 2015; 38(Suppl 1):S8-S16.

Test Performed at:

Walter Reed National Military Medical Center
 8901 Wisconsin Avenue
 Bethesda, MD 20889

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Lipid Panel on 18 May 2017

Collection Date: 18 May 2017

Site/Specimen: SERUM

Ordering Clinician: RODAK, COLLEEN M

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cholesterol/HDL	4.6	ratio		
Cholesterol				
Cholesterol	224	mg/dL		

Interpretation:**Adults: ages 18 and up****Desirable: <200 mg/dL****Borderline High: 200-239 mg/dL****High: > or = 240 mg/dL****Pediatric: ages 2-17****Acceptable: <170 mg/dL****Borderline High: 170-199 mg/dL****High > or = 200 mg/dL**

Triglyceride 262 mg/dL

Interpretation:**Adults: ages 18 and up****Desirable: <150 mg/dL****Borderline High: 150-199 mg/dL****High: 200-499 mg/dL****Very High: > or = 500 mg/dL****Pediatric: ages 2-9****Acceptable: <75 mg/dL****Borderline High: 75-99 mg/dL****High: > or = 100 mg/dL****Pediatric: ages 10-17****Acceptable: <90 mg/dL****Borderline High: 90-129 mg/dL****High: > or = 130 mg/dL**

HDL Cholesterol 49 mg/dL

Interpretation:**Adults: ages 18 and up****Desirable: > or = 60 mg/dL****Low: <40 mg/dL**

An HDL cholesterol less than 40 mg/dL is low and constitutes a coronary heart disease risk factor. An HDL cholesterol greater than 60 mg/dL is a negative risk factor for coronary heart disease.

Pediatric: ages 2-17**Acceptable: >45 mg/dL**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Borderline Low: 40-45 mg/dL**Low: <40 mg/dL****LDL Cholesterol Direct** 140 mg/dL**Interpretation:****Adults: ages 18 and up****Optimal: <100 mg/dL****Near Optimal: 100-129 mg/dL****Borderline High: 130-159 mg/dL****High: 160-189 mg/dL****Very High: > or = 190 mg/dL****Pediatric: ages 2-17****Acceptable: <110 mg/dL****Borderline High: 110-129 mg/dL****High: > or = 130 mg/dL****Cholesterol Non-HDL** 175 mg/dL**Interpretation:****Adults: ages 18 and up****Desirable: <130 mg/dL****Above Desirable: 130-159 mg/dL****Borderline High: 160-189 mg/dL****High: 190-219****Very High: > or = 220 mg/dL**

Non-HDL cholesterol is a secondary target of therapy in persons with high serum triglycerides (greater than 199 mg/dL). The goal for non-HDL cholesterol in persons with high triglycerides is 30 mg/dL higher than their LDL cholesterol goal.

Pediatric: ages 2-17**Acceptable: <120 mg/dL****Borderline High: 120-144 mg/dL****High: > or = 145 mg/dL****Source:**

-Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report. Circulation 2002 Dec 17;106(25):3143-421.

-National Lipid Association Recommendations for Patient-Centered Management of Dyslipidemia: Part 1-Full Report. Journal of Clinical Lipidology 2015; In Press.

-Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents; National Heart, Lung, and Blood Institute. Pediatrics. 2011 Dec;128 Suppl 5:S213-56.

-NCEP Expert Panel of Blood Cholesterol Levels in Children and Adolescents. National Cholesterol Education Program (NCEP): Highlights of the Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents. Pediatrics 1992;89:495-501.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Created: 16 Aug 2017

-Srinivasan SR, Myers L, Berenson GS. Distribution and correlates of non-high-density lipoprotein cholesterol in children: the Bogalusa Heart Study. *Pediatrics* 2002;110(3):e29.

ABO Group+Rh Type Confirmation on 27 Apr 2017

Collection Date: 27 Apr 2017

Site/Specimen: BLOOD

Ordering Clinician: HARKINS, CHARLES KARL

Comment:

Chem

Name	Value	Units	Range	Abnormal
ABO Group+Rh Type Confirm	O POSITIVE			

Type & Screen (with SF518) on 27 Apr 2017

Collection Date: 27 Apr 2017

Site/Specimen: BLOOD

Ordering Clinician: HARKINS, CHARLES KARL

Comment:

Chem

Name	Value	Units	Range	Abnormal
ABO Group+Rh Type	O POS			
Antibody Screen	NEGATIVE			

Basic Metabolic Panel on 12 Apr 2017

Collection Date: 12 Apr 2017

Site/Specimen: SERUM

Ordering Clinician: JENSEN, DAMON TY

Comment:

Chem

Name	Value	Units	Range	Abnormal
Urea Nitrogen	16.0	mg/dL	(6-20)	
Carbon Dioxide	28	mmol/L	(22-29)	
Chloride	99	mmol/L	(98-107)	
Creatinine	0.88	mg/dL	(0.7-1.2)	
Glucose	112	mg/dL	(74-106)	Higher Than Normal
Potassium	4.9	mmol/L	(3.5-5.1)	
Sodium	140	mmol/L	(136-145)	
Calcium	9.9	mg/dL	(8.6-10.2)	
Anion Gap	13	mmol/L	(7-16)	
GFR Calculated Non-Black	113.7	mL/min	(60->=60)	
GFR Calculated Black	131.4	mL/min	(60->=60)	

Interpretation:**Reference values:**

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

CBC W/o Diff on 12 Apr 2017

Collection Date: 12 Apr 2017
 Ordering Clinician: JENSEN, DAMON TY
 Comment:
 Chem

Site/Specimen: BLOOD

Name	Value	Units	Range	Abnormal
Hematocrit	42.3	%	(37.5-50.9)	
WBC	6.0	x10(3)/mcL	(3.6-10.6)	
RBC	4.58	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	14.4	g/dL	(12.8-17.7)	
MCV	92.4	fL	(79.5-96.8)	
MCH	31.5	pg	(26.2-33.1)	
MCHC	34.1	g/dL	(32.6-35.0)	
Platelets	262	x10(3)/mcL	(162-427)	
RDW CV	13.1	%	(12.0-16.2)	
MPV	8.7	fL	(7.0-10.9)	

Gamma Glutamyl Transferase on 04 Jan 2017

Collection Date: 04 Jan 2017
 Ordering Clinician: TOBAR, EDEN T
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Gamma-Glutamyl Transferase	49	U/L	(10.0-71.0)	

Hepatic Function Panel on 04 Jan 2017

Collection Date: 04 Jan 2017
 Ordering Clinician: TOBAR, EDEN T
 Comment:
 Chem

Site/Specimen: SERUM

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Name	Value	Units	Range	Abnormal
Albumin	4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	58	U/L	(40-129)	
Alanine Aminotransferase	34	U/L	(0-41)	
Aspartate Aminotransferase	24	U/L	(0-40)	
Bilirubin	0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	<0.2	mg/dL	(0.0-0.3)	
Protein	7.6	g/dL	(6.6-8.7)	

Tissue Transglutaminase Ab IgA+IgG Panel on 06 Oct 2016

Collection Date: 06 Oct 2016
Ordering Clinician: COPSEY, HELEN C.
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Tissue Transglutaminase Ab IgA	<2	U/mL	0-3	
Interpretation: Negative 0 - 3 Weak Positive 4 - 10 Positive >10 Tissue Transglutaminase (tTG) has been identified as the endomysial antigen. Studies have demonstrated that endomysial IgA antibodies have over 99% specificity for gluten sensitive enteropathy.				
Tissue Transglutaminase Ab IgG	<2	U/mL	0-5	

Interpretation:
Negative 0 - 5
Weak Positive 6 - 9
Positive >9

IgA on 06 Oct 2016

Collection Date: 06 Oct 2016
Ordering Clinician: COPSEY, HELEN C.
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
IgA	256	mg/dL	(70-400)	

Thyroid Stimulating Hormone on 06 Sep 2016

Collection Date: 06 Sep 2016
Ordering Clinician: TOBAR, EDEN T

Site/Specimen: SERUM

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Comment:

Chem

Name	Value	Units	Range	Abnormal
Thyrotropin	2.500	mcIU/mL	(0.27-4.2)	

Interpretation:**Methodology:** Chemiluminescence (3rd Generation)**Laboratory testing performed at:**

WRNMMC

Dept of Pathology

8901 Wisconsin Ave BLDG 9

Bethesda, MD 20889

Thyroxine Free on 06 Sep 2016

Collection Date:

06 Sep 2016

Site/Specimen:

SERUM

Ordering Clinician:

TOBAR, EDEN T

Comment:

Chem

Name	Value	Units	Range	Abnormal
Thyroxine Free	1.28	ng/dL	(0.93-1.7)	

Interpretation:**Laboratory testing performed at:**

WRNMMC

Dept of Pathology

8901 Wisconsin Ave BLDG 9

Bethesda, MD 20889

Troponin T Cardiac on 22 Jun 2016

Collection Date:

22 Jun 2016

Site/Specimen:

SERUM

Ordering Clinician:

WEATHERS, BRUCE KENT

Comment:

Chem

Name	Value	Units	Range	Abnormal
Troponin T Cardiac	<0.01	ng/mL	(0.00-0.03)	

Interpretation:

***** For cTnT results between 0.04 and 0.09 ng/mL (inclusively) : Results between the 99th percentile or 10% CV and the AMI cutoff may indicate increased risk for a cardiac event. Serial draws are recommended per ACC/AHA guidelines.**

For cTnT results >or = 0.1ng/mL: The AMI cutoff based on historical WHO criteria is 0.1ng/mL. Any condition resulting in myocardial cell damage can increase cardiac troponin levels such as angina, CHF, myocarditis, cardiac surgery, or invasive testing and non-specific cardiac related

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causes such as PE, renal failure, and sepsis.

Basic Metabolic Panel on 22 Jun 2016

Collection Date: 22 Jun 2016

Site/Specimen: SERUM

Ordering Clinician: WEATHERS, BRUCE KENT

Comment:

Chem

Name	Value	Units	Range	Abnormal
Urea Nitrogen	14.8	mg/dL	(6-20)	
Carbon Dioxide	28	mmol/L	(22-29)	
Chloride	98	mmol/L	(98-107)	
Creatinine	1.00	mg/dL	(0.7-1.2)	
Glucose	89	mg/dL	(74-106)	
Potassium	4.5	mmol/L	(3.5-5.1)	
Sodium	139	mmol/L	(136-145)	
Calcium	10.1	mg/dL	(8.6-10.2)	
Anion Gap	13	mmol/L	(7-16)	
GFR Calculated Non-Black	99.8	mL/min	(60->=60)	
GFR Calculated Black	115.4	mL/min	(60->=60)	

Interpretation:**Reference values:**

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

Fibrin D-Dimer on 22 Jun 2016

Collection Date: 22 Jun 2016

Site/Specimen: PLASMA

Ordering Clinician: WEATHERS, BRUCE KENT

Comment:

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Created: 16 Aug 2017

Chem

Name	Value	Units	Range	Abnormal
Fibrin D-Dimer FEU	<0.27	mcg/mL FEU	(<0.5)	
Interpretation: Lowest measureable value is 0.27 mcg/mL FEU Any medical condition which activates the coagulation system may elevate D-Dimer values. This includes but is not limited to trauma, post-operative states, hemorrhage, cancer and sepsis. In multiple studies a cut-off value of 0.50 mcg/mL FEU had a 93-99% negative predictive value for the exclusion of venous thrombosis. This test must not be used to exclude deep vein thrombosis and/or pulmonary embolism with pretest probability alone.				

CBC W/Diff on 22 Jun 2016

Collection Date:

22 Jun 2016

Site/Specimen:

BLOOD

Ordering Clinician:

WEATHERS, BRUCE KENT

Comment:

Chem

Name	Value	Units	Range	Abnormal
MCV	91.4	fL	(79.5-96.8)	
WBC	5.6	x10(3)/mcL	(3.6-10.6)	
RBC	4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	15.1	g/dL	(12.8-17.7)	
Hematocrit	44.4	%	(37.5-50.9)	
MCH	31.1	pg	(26.2-33.1)	
MCHC	34.1	g/dL	(32.6-35.0)	
RDW CV	12.9	%	(12.0-16.2)	
Platelets	272	x10(3)/mcL	(162-427)	
MPV	9.0	fL	(7.0-10.9)	
Neutrophils	59.4	%	(40.7-76.4)	
Lymphocytes	29.8	%	(15.9-47.8)	
Monocytes	8.9	%	(4.5-11.8)	
Eosinophils	1.5	%	(0.3-7.1)	
Basophils	0.4	%	(0.2-1.2)	
ABS Neutrophils	3.3	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	MANUAL DIFF NOT PERFORMED			

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Created: 16 Aug 2017

Helicobacter Pylori Antigen EIA on 06 Jun 2016

Collection Date: 06 Jun 2016
 Ordering Clinician: SHAH, NISHA AMISH
 Comment:

Site/Specimen: Stool

Order #	160511-04658
Filler #	160606 NBL 374
Ordering Provider	SHAH, NISHA AMISH
Priority	ROUTINE
DATE ORDERED	20160511084300
DATE RESULTED	20160610085729
COLLECT_SAMPLE	STOOL
Order Comment	to be done two weeks after stopping protonix
BACTERIOLOGY RESULT	OBSERVATION
Results	Final report

Zinc on 11 Apr 2016

Collection Date: 11 Apr 2016
 Ordering Clinician: THOMPSON, DAVID HERRON
 Comment:
 Chem

Site/Specimen: PLASMA

Name	Value	Units	Range	Abnormal
Zinc	117	mcg/dL	56-134	
Interpretation:				
Detection Limit = 5				

Lyme Disease Ab Total Screen on 11 Apr 2016

Collection Date: 11 Apr 2016
 Ordering Clinician: THOMPSON, DAVID HERRON
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Borrelia burgdorferi Ab	Negative		(See-Below)	
Interpretation:				
INTERPRETATION OF RESULTS:				
Negative - Absence of detectable Borrelia burgdorferi antibodies. A negative result does not exclude the possibility of Borrelia burgdorferi infection. If Lyme disease is suspected, a second sample should be collected and tested two to four weeks later.				
Equivocal -The imprecision inherent in this method does not allow definitive categorization of samples that read close to the cutoff. Sample will be confirmed by Western Blot.				
Positive - Presence of detectable Borrelia burgdorferi antibodies. Sample will be confirmed by Western Blot.				

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

METHODOLOGY:

This assay uses chemiluminescent immunoassay (CLIA) technology for the qualitative presumptive detection of IgG and IgM antibodies to VlsE (variable major protein-like sequence expressed) protein antigen of *Borrelia burgdorferi*. The assay should only be used on patients with signs and symptoms consistent with Lyme disease. Positive and equivocal results should be supplemented by testing with a standardized Western Blot.

Treponema pallidum Ab on 11 Apr 2016

Collection Date: 11 Apr 2016

Site/Specimen: SERUM

Ordering Clinician: THOMPSON, DAVID HERRON

Comment:

Chem

Name	Value	Units	Range	Abnormal
Treponema pallidum Ab	Negative		(Negative)	

Interpretation:

Negative If non-treponemal result was nonreactive, there is no serological evidence of infection with *T. pallidum* (incubating or early primary syphilis cannot be excluded).

If non-treponemal result was reactive, current infection is unlikely. There may be a biological false positive secondary to other medical conditions. Recommended repeat testing (non-treponemal and treponemal by other test methods).

If non-treponemal assay was not performed, current or past infection is unlikely, cannot exclude incubating or early syphilis.

Equivocal If the result is equivocal please send a new sample to the laboratory for testing within one week.

Positive If non-treponemal result was nonreactive, this is probably past infection or potential cross-reactivity with other spirochetes/related antigens; additional testing is recommended. There is a possibility of a false negative non-treponemal assay due to prozone and late syphilis or neurosyphilis, clinical correlation is advised.

If non-treponemal result was reactive, this may indicate evidence of past or current infection. Could also represent a biological false-positive and thus clinical correlation is advised.

METHODOLOGY:

This assay uses chemiluminescent immunoassay (CLIA) technology for the qualitative determination of total antibodies directed against *Treponema pallidum*. The presence of antibodies to *Treponema pallidum* specific antigen, in conjunction with non-treponemal laboratory tests and clinical findings may aid in the diagnosis of syphilis infection.

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Helicobacter pylori Ab IgG on 11 Apr 2016

Collection Date: 11 Apr 2016

Site/Specimen: SERUM

Ordering Clinician: THOMPSON, DAVID HERRON

Comment:

Chem

Name	Value	Units	Range	Abnormal
Helicobacter pylori Ab IgG	7.1	U/mL	0.0-0.8	Higher Than Normal
Interpretation:				
	Negative	<0.9		
	Indeterminate	0.9 - 1.0		
	Positive	>1.0		

ESR on 11 Apr 2016

Collection Date: 11 Apr 2016

Site/Specimen: BLOOD

Ordering Clinician: THOMPSON, DAVID HERRON

Comment:

Chem

Name	Value	Units	Range	Abnormal
ESR	5	mm/hr	(1-19)	

Basic Metabolic Panel on 11 Apr 2016

Collection Date: 11 Apr 2016

Site/Specimen: SERUM

Ordering Clinician: THOMPSON, DAVID HERRON

Comment:

Chem

Name	Value	Units	Range	Abnormal
Urea Nitrogen	9.7	mg/dL	(6-20)	
Carbon Dioxide	28	mmol/L	(22-29)	
Chloride	97	mmol/L	(98-107)	Lower Than Normal
Creatinine	0.87	mg/dL	(0.7-1.2)	
Glucose	92	mg/dL	(74-106)	
Potassium	4.4	mmol/L	(3.5-5.1)	
Sodium	139	mmol/L	(136-145)	
Calcium	10.2	mg/dL	(8.6-10.2)	
Anion Gap	15	mmol/L	(7-16)	
GFR Calculated Non-Black	115.0	mL/min	(60->=60)	
GFR Calculated Black	132.9	mL/min	(60->=60)	
Interpretation:				
Reference values:				
>= 60 = Normal or mildly decreased GFR				

Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

30-59 = Moderately decreased GFR**15-29 = Severely decreased GFR****<15 = Kidney failure**

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

CBC W/o Diff on 11 Apr 2016

Collection Date:

11 Apr 2016

Site/Specimen:

BLOOD

Ordering Clinician:

THOMPSON, DAVID HERRON

Comment:

Chem

Name	Value	Units	Range	Abnormal
MCH	31.5	pg	(26.2-33.1)	
WBC	4.7	x10(3)/mcL	(3.6-10.6)	
RBC	4.88	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	15.4	g/dL	(12.8-17.7)	
Hematocrit	45.0	%	(37.5-50.9)	
MCV	92.3	fL	(79.5-96.8)	
MCHC	34.1	g/dL	(32.6-35.0)	
Platelets	293	x10(3)/mcL	(162-427)	
RDW CV	13.3	%	(12.0-16.2)	
MPV	8.6	fL	(7.0-10.9)	

Methylmalonic Acid on 16 Feb 2016

Collection Date:

16 Feb 2016

Site/Specimen:

SERUM

Ordering Clinician:

WILSON, BRYAN JAMES

Comment:

Chem

Name	Value	Units	Range	Abnormal
Methylmalonate	170	nmol/L	0-378	

HIV-1/O/2 Ab on 16 Feb 2016

Collection Date:

16 Feb 2016

Site/Specimen:

SERUM

Ordering Clinician:

WILSON, BRYAN JAMES

Comment:

Merwin, Daniel Dennis

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Chem

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Homocysteine on 16 Feb 2016

Collection Date:

16 Feb 2016

Site/Specimen:

SERUM

Ordering Clinician:

WILSON, BRYAN JAMES

Comment:

Chem

Name	Value	Units	Range	Abnormal
Homocysteine	8.9	mcmol/L	(4.0-15.4)	

Interpretation:

Test performed by: WRNMMC
 Dept of Pathology
 Wisconsin Ave BLDG 9
 8901 Bethesda, MD 20889

Comprehensive Metabolic Panel on 16 Feb 2016

Collection Date:

16 Feb 2016

Site/Specimen:

SERUM

Ordering Clinician:

WILSON, BRYAN JAMES

Comment:

Chem

Name	Value	Units	Range	Abnormal
Urea Nitrogen	13.8	mg/dL	(6-20)	
Albumin	4.7	g/dL	(3.5-5.2)	
Alkaline Phosphatase	53	U/L	(40-129)	
Alanine Aminotransferase	17	U/L	(0-41)	
Bilirubin	0.4	mg/dL	(0.15-1.2)	
Calcium	9.7	mg/dL	(8.6-10.2)	
Carbon Dioxide	29	mmol/L	(22-29)	
Chloride	98	mmol/L	(98-107)	
Creatinine	0.96	mg/dL	(0.7-1.2)	
Glucose	89	mg/dL	(74-106)	
Anion Gap	14	mmol/L	(7-16)	
Potassium	4.4	mmol/L	(3.5-5.1)	
Protein	7.6	g/dL	(6.6-8.7)	
Sodium	141	mmol/L	(136-145)	
GFR Calculated Non-Black	105.6	mL/min	(60->=60)	
GFR Calculated Black	122.1	mL/min	(60->=60)	

Interpretation:**Reference values:**

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

Aspartate Aminotransferase	20	U/L	(0-40)
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Vitamin B12 (Cyanocobalamin) on 16 Feb 2016

Collection Date: 16 Feb 2016 Site/Specimen: SERUM
 Ordering Clinician: WILSON, BRYAN JAMES
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Vitamin B12 (Cobalamins)	293	pg/mL	(211-946)	
Interpretation: Laboratory testing performed at: WRNMMC Dept of Pathology 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889				

ETG/ETS, UA (250 Cut-Off) on 02 Feb 2016

Collection Date: 02 Feb 2016 Site/Specimen: URINE
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	
Interpretation: This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.				

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Drug Abuse Screen on 02 Feb 2016

Collection Date:

02 Feb 2016

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA

NEGATIVE

(Negative)

Interpretation:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

>25 ng/mL reported as positive**For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Cannabinoids**

NEGATIVE

(Negative)

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Methadone**

NEGATIVE

(Not-Detected)

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.****Oxycodone**

NEGATIVE

ng/mL

(Negative)

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 05 Jan 2016**

Collection Date:

05 Jan 2016

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Interpretation:**This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.****Drug Abuse Screen on 05 Jan 2016**

Collection Date:

05 Jan 2016

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:**>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Amphetamines****NEGATIVE****(Negative)****Interpretation:****>1000 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Barbiturates****NEGATIVE****(Negative)****Interpretation:****> 200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Benzodiazepines****NEGATIVE****(Negative)****Interpretation:****>200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Opiates****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone **NEGATIVE** (Not-Detected)

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone **NEGATIVE** **ng/mL** (Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Reference Testing Miscellaneous on 04 Jan 2016

Collection Date:

04 Jan 2016

Site/Specimen:

OTHER

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Miscellaneous Mailout	SEE REPORT		(SEE-BELOW)	

Drug Abuse Screen on 29 Dec 2015

Collection Date:

29 Dec 2015

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Methadone	NEGATIVE		(Not-Detected)	

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines **NEGATIVE** (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates **NEGATIVE** (Negative)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA

NEGATIVE

(Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids

NEGATIVE

(Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone

NEGATIVE

ng/mL

(Negative)

Interpretation:

Reporting limit 100 ng/mL

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

ETG/ETS, UA (250 Cut-Off) on 08 Dec 2015

Collection Date: 08 Dec 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 08 Dec 2015

Collection Date: 08 Dec 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines NEGATIVE (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates NEGATIVE (Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines NEGATIVE (Negative)

Interpretation:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

>200 ng/mL reported as positive**For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Opiates****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**
-----**Methadone****NEGATIVE****(Not-Detected)****Interpretation:****>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.****Oxycodone****NEGATIVE****ng/mL****(Negative)****Interpretation:****Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****ETG/ETS, UA (250 Cut-Off) on 01 Dec 2015**

Collection Date:

01 Dec 2015

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Ethyl Glucuronide	Negative	ng/mL	Cutoff=250
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Drug Abuse Screen on 01 Dec 2015

Collection Date:

01 Dec 2015

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines

NEGATIVE

(Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates

NEGATIVE

(Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Phencyclidine, UA	NEGATIVE	(Negative)
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Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids	NEGATIVE	(Negative)
--------------	----------	------------

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone	NEGATIVE	(Not-Detected)
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Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
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Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay**ETG/ETS, UA (250 Cut-Off) on 17 Nov 2015**

Collection Date: 17 Nov 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 17 Nov 2015

Collection Date: 17 Nov 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines **NEGATIVE** (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates **NEGATIVE** (Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines **NEGATIVE** (Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates **NEGATIVE** (Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA **NEGATIVE** (Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids **NEGATIVE** (Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Methadone	NEGATIVE	(Not-Detected)
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Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone	NEGATIVE	ng/mL	(Negative)
------------------	-----------------	--------------	-------------------

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Varicella Zoster Virus DFA on 29 Sep 2015

Collection Date: 29 Sep 2015

Site/Specimen: SKIN

Ordering Clinician: CUNNINGHAM, RACHEL ELIZABETH

Comment:

Chem

Name	Value	Units	Range	Abnormal
Varicella Zoster Virus Ag	NO VZ ANTIGEN DETECTED			

Interpretation:**METHODOLOGY:**

This test utilizes a direct immunofluorescence technique for identifying Varicella Zoster Virus (VZV) in direct specimens.

LIMITATIONS:

The monoclonal antibodies used in this kit were prepared using a prototype strain and may not detect all antigenic variants or new strains of VZV.

Performance characteristics for direct specimens from patients undergoing antiviral therapy have not been established.

A negative result does not rule out infection with VZV and should be interpreted cautiously. Patient history, clinical status and other tests and findings should be considered. Correlation of this information may dictate additional specimen testing.

Herpes DFA on 29 Sep 2015

Collection Date: 29 Sep 2015

Site/Specimen: Wound

Ordering Clinician: CUNNINGHAM, RACHEL ELIZABETH

Comment:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Order #	150929-09137
Filler #	150929 NVI 2333
Ordering Provider	CUNNINGHAM, RACHEL ELIZABETH
Priority	ROUTINE
DATE ORDERED	20150929103200
DATE RESULTED	20150930095455
COLLECT SAMPLE	LESION/WOUND
VIROLOGY RESULT	NEGATIVE DIRECT FLUORESCENT ANTIBODY FOR
Results	Final report

ETG/ETS, UA (500 Cut-Off) on 15 Sep 2015

Collection Date: 15 Sep 2015
Ordering Clinician: AILOR, LYNNE P
Comment:
Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=500	

Drug Abuse Screen on 15 Sep 2015

Collection Date: 15 Sep 2015
Ordering Clinician: AILOR, LYNNE P
Comment:
Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	
Interpretation: >300 ng/mL reported as positive For medical screening only. Unconfirmed screening results must not be used for non-medical purposes. -----				

Amphetamines NEGATIVE (Negative)

Interpretation:
>1000 ng/mL reported as positive
For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates NEGATIVE (Negative)

Interpretation:
> 200 ng/mL reported as positive
For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Benzodiazepines	NEGATIVE	(Negative)
------------------------	-----------------	-------------------

Interpretation:**>200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Cocaine	NEGATIVE	(Negative)
----------------	-----------------	-------------------

Interpretation:**>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Phencyclidine, UA	NEGATIVE	(Negative)
--------------------------	-----------------	-------------------

Interpretation:**>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Cannabinoids	NEGATIVE	(Negative)
---------------------	-----------------	-------------------

Interpretation:**>50 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.**

Methadone	NEGATIVE	(Not-Detected)
------------------	-----------------	-----------------------

Interpretation:**>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.**

Oxycodone	NEGATIVE	ng/mL	(Negative)
------------------	-----------------	--------------	-------------------

Interpretation:**Reporting limit 100 ng/mL****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Methodology: Immunoassay****Herpes Virus Culture on 08 Sep 2015**

Collection Date: 08 Sep 2015

Site/Specimen: Groin, Left

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Order #	150909-02160
Filler #	150909 NVI 2193
Ordering Provider	FIACCO, NICHOLAS RYAN
Priority	ROUTINE
DATE_ORDERED	20150909074800
DATE_RESULTED	20150914121050
COLLECT_SAMPLE	OTHER SOURCE
Order Comment	for specimen already in lab
VIROLOGY RESULT	NO HERPES SIMPLEX VIRUS ISOLATED.
Results	Final report

HSV 1 & 2 Abs Indirect Panel on 08 Sep 2015

Collection Date: 08 Sep 2015

Site/Specimen: SERUM

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Herpes Simplex Virus 1 Ab IgM	<1:10	Titer units	<1:10	
Herpes Simplex Virus 2 Ab IgM	<1:10	Titer units	<1:10	

Interpretation:

HSV 1 and HSV 2 share many cross-reacting antigens. Elevated titers to both HSV 1 and HSV 2 may represent crossreactive HSV antibodies rather than exposure to both HSV 1 and HSV 2.

Results for this test are for research purposes only by the assay's manufacturer. The performance characteristics of this product have not been established. Results should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.

Chlamydia+Gonococcus DNA Panel NAAT on 08 Sep 2015

Collection Date: 08 Sep 2015

Site/Specimen: URINE

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Neisseria gonorrhoeae DNA	NEGATIVE FOR N.GONORRHOEAE			

Interpretation:

Laboratory testing performed at:

WRNMMC

Dept of Pathology

8901 Wisconsin Ave BLDG 9

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Bethesda, MD 20889**Method: Ribosomal RNA Amplification**

The APTIMA Combo 2 Assay detects the presence or absence of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* ribosomal RNA in female cervical and vaginal swabs, male urethral swabs, and female/male urine specimens. The assay uses a target amplification nucleic acid probe technology and is run on the TIGRIS DTS Automated Analyzer.

Data on the performance of nucleic acid testing (NAATs) for *Chlamydia trachomatis* and *Neisseria gonorrhea* in patients under 16 is limited. This assay has not specifically been evaluated for patients under 16. Consultation with an expert is recommended before the performance and interpretation of NAAT in this context, to minimize the possibility of false positive and false negative results. This assay is not intended for the evaluation of suspected sexual abuse or for other medico-legal indications.

Chlamydia trachomatis	NEGATIVE FOR	(Negative)
DNA	C.TRACHOMAT	
	IS	

Interpretation:

Laboratory testing performed at:

WRNMMC
Dept of Pathology
Wisconsin Ave BLDG 9
Bethesda, MD 20889

Herpes Simplex Virus 1+2 Ab IgG on 08 Sep 2015

Collection Date: 08 Sep 2015

Site/Specimen: SERUM

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Herpes Simplex Virus 1 Ab IgG	<0.91	Index	0.00-0.90	

Interpretation:

Negative <0.91
Equivocal 0.91 - 1.09
Positive >1.09

Note: Negative indicates no antibodies detected to HSV-1. Equivocal may suggest early infection. If clinically appropriate, retest at later date. Positive indicates antibodies detected to HSV-1.

Herpes Simplex Virus 2 Ab IgG	<0.91	Index	0.00-0.90
--------------------------------------	-------	-------	-----------

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1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:

Negative <0.91
 Equivocal 0.91 - 1.09
 Positive >1.09

Note: Negative indicates no antibodies detected to HSV-2. Equivocal may suggest early infection. If clinically appropriate, retest at later date. Positive indicates antibodies detected to HSV-2.

Rapid Plasma Reagin on 08 Sep 2015

Collection Date: 08 Sep 2015

Site/Specimen: SERUM

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Reagin Ab	NONREACTIVE		(Non-Reactive)	
Interpretation: REACTIVE: Reactive - may indicate past or current syphilis infection. Reactive results will be quantified and will be reflexed to the Treponema pallidum AB test The diagnosis of syphilis should not be made on the basis of a single reactive serologic test without taking history, clinical, and other information into consideration NON REACTIVE : Nonreactive - current or past infection is unlikely, cannot exclude incubating or early syphilis. METHODOLOGY: This test is a macroscopic, non-treponemal flocculation procedure for the serologic screening for syphilis in serum.				

HIV Rapid on 08 Sep 2015

Collection Date: 08 Sep 2015

Site/Specimen: BLOOD

Ordering Clinician: FIACCO, NICHOLAS RYAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
HIV-1 Ab Rapid	NEGATIVE-ONBOARD QC ACCEPTED		(Negative)	
Interpretation: ----- POST-EXPOSURE RAPID HIV-1/2 AB SCREEN: A preliminary positive screen may not be indicative of an individual's HIV status. A confirmatory HIV-1/O/2 test				

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

must be performed as soon as possible on ALL preliminary positive results on initial screens. One (1) additional sample must be collected (HIV SST tube) from the patient and sent to the laboratory, along with an order for an HIV-1/O/2 AB placed in CHCS (source of test "I"-clinically indicated).

***NOTE: This test is NOT to be used to meet the annual requirements for HIV testing.

ETG/ETS, UA (250 Cut-Off) on 23 Jun 2015

Collection Date: 23 Jun 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 23 Jun 2015

Collection Date: 23 Jun 2015
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cocaine	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines NEGATIVE (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Barbiturates NEGATIVE (Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Benzodiazepines

NEGATIVE

(Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Opiates

NEGATIVE

(Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA

NEGATIVE

(Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids

NEGATIVE

(Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone

NEGATIVE

(Not-Detected)

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone

NEGATIVE

ng/mL

(Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

TISSUE EXAM on 23 Jun 2015

Collection Date:

23 Jun 2015

Site/Specimen:

Ordering Clinician:

TAYLOR, BRADLEY MICHAEL

Comment:

Order #	150702-23826
Ordered Date	20150702192500
Priority	ROUTINE
Resulted Date	20150702192525.1-0400
Col	23Jun15@1131 TISSUE(TISSUE)
Hcp	TAYLOR, BRADLEY MICHAEL Req Loc: DERMATOL
Performing Lab	NNMC AP LAB, BETHESDA, MD 150626 NSP 11753
TISSUE E	C LRS02Jul15@1925 CoPath Report
Patient	MERWIN, DANIEL DENNIS Specimen #: NS15-11753
Accessioned	06/26/15
A	Skin, Scalp, Punch B: Skin, Left scalp, Punch

lrs/07/02/15 ** Report Electronically Signed Out **
Laurel R. Stearns, MAJ, MC, USA

B. The specimen is received in formalin, labeled with the patient's name Merwin, Daniel, and designated "Punch, Left Scalp". It consists of a tan, hair-bearing punch of skin measuring 4.0 cm in diameter that is previously horizontally sectioned and excised to a maximum depth of 0.6 cm. The specimen is submitted in its entirety in one cassette. 3/1/NG (Sponge)
CLP/PDP/LRS
CLP/mrg

FINAL DIAGNOSIS**A. SKIN, SCALP, PUNCH BIOPSY**

- MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA.
(SEE COMMENT)

B. SKIN, LEFT SCALP, PUNCH BIOPSY

- NORMAL SCALP.

COMMENT

The sections were difficult to interpret due to processing and orientation. In part A, the sections show a normal number of terminal hair follicles with a slightly increased number of vellus hairs. Mild superficial perifollicular lymphocytic inflammation is present. Evidence of scarring alopecia is not present in multiple additional step sections.
If clinically indicated additional biopsies may be helpful.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CLINICAL DIAGNOSIS AND HISTORY

30 y/o M, tufted, scarring alopecia on scalp after reported infection about six years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well. Wound care discussed. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v LPP v other scarring etiologies.

PRE-OPERATIVE DIAGNOSIS

A) Mature scar w/overlying seb derm v folliculitis decalvans v LPP v other scarring etiology. B) Normal scalp.

POST-OPERATIVE DIAGNOSIS**Operative Findings**

SAA

Post-operative Diagnosis

SAA

GROSS DESCRIPTION

A. The specimen is received in formalin, labeled with the patient's name Merwin, Daniel, and designated "Punch, Scalp". It consists of a tan, hair-bearing punch of skin that is previously horizontally sectioned measuring 0.4 cm in diameter and excised to a maximum depth of 0.6 cm.

CPT Codes

; 88305 ; 88305 (LEVEL 4)
; 88305 ; 88305 (LEVEL 4)

ETG/ETS, UA (250 Cut-Off) on 18 May 2015

Collection Date:

18 May 2015

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 18 May 2015

Collection Date:

18 May 2015

Site/Specimen:

URINE

Ordering Clinician:

AILOR, LYNNE P

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:**>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Amphetamines****NEGATIVE****(Negative)****Interpretation:****>1000 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Barbiturates****NEGATIVE****(Negative)****Interpretation:****> 200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Benzodiazepines****NEGATIVE****(Negative)****Interpretation:****>200 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cocaine****NEGATIVE****(Negative)****Interpretation:****>300 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Phencyclidine, UA****NEGATIVE****(Negative)****Interpretation:****>25 ng/mL reported as positive****For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.****Cannabinoids****NEGATIVE****(Negative)****Interpretation:****>50 ng/mL reported as positive**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone **NEGATIVE** (Not-Detected)

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone **NEGATIVE** **ng/mL** (Negative)

Interpretation:

Reporting limit 100 ng/mL

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

ETG/ETS, UA (250 Cut-Off) on 04 May 2015

Collection Date: 04 May 2015 Site/Specimen: URINE
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 04 May 2015

Collection Date: 04 May 2015 Site/Specimen: URINE
 Ordering Clinician: AILOR, LYNNE P
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Opiates	NEGATIVE		(Negative)	

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Amphetamines **NEGATIVE** (Negative)

Interpretation:

>1000 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Barbiturates NEGATIVE (Negative)

Interpretation:

> 200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Benzodiazepines NEGATIVE (Negative)

Interpretation:

>200 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cocaine NEGATIVE (Negative)

Interpretation:

>300 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Phencyclidine, UA NEGATIVE (Negative)

Interpretation:

>25 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Cannabinoids NEGATIVE (Negative)

Interpretation:

>50 ng/mL reported as positive

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methadone NEGATIVE (Not-Detected)

Interpretation:

>300 ng/mL reported as positive. Unconfirmed screening results must not be used for non-medical purposes.

Oxycodone NEGATIVE ng/mL (Negative)

Interpretation:**Reporting limit 100 ng/mL**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

For medical screening only. Unconfirmed screening results must not be used for non-medical purposes.

Methodology: Immunoassay

Comprehensive Metabolic Panel on 28 Apr 2015

Collection Date: 28 Apr 2015
 Ordering Clinician: AUSTIN, MARIE
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Glucose	90	mg/dL	(74-106)	
Albumin	5.1	g/dL	(3.5-5.2)	
Alkaline Phosphatase	70	U/L	(40-129)	
Alanine Aminotransferase	33	U/L	(0-41)	
Bilirubin	0.3	mg/dL	(0-1.2)	
Urea Nitrogen	13.4	mg/dL	(6-20)	
Calcium	9.9	mg/dL	(8.6-10.2)	
Carbon Dioxide	29	mmol/L	(22-29)	
Chloride	101	mmol/L	(98-107)	
Creatinine	0.97	mg/dL	(0.7-1.2)	
Potassium	4.6	mmol/L	(3.5-5.1)	
Protein	7.7	g/dL	(6.6-8.7)	
Sodium	143	mmol/L	(136-145)	
Anion Gap	13	mmol/L	(7-16)	
GFR Calculated Non-Black	104.3	mL/min	(60->=60)	
GFR Calculated Black	120.6	mL/min	(60->=60)	

Interpretation:**Reference values:**

>= 60 = Normal or mildly decreased GFR
 30-59 = Moderately decreased GFR
 15-29 = Severely decreased GFR
 <15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

Aspartate	26	U/L	(0-40)
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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Aminotransferase**ETG/ETS, UA (500 Cut-Off) on 20 Apr 2015**

Collection Date: 20 Apr 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment: NONE
 Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=500	

Drug Abuse Screen on 20 Apr 2015

Collection Date: 20 Apr 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment: NONE
 Chem

Name	Value	Units	Range	Abnormal
Cocaine	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 300 ng/mL				

Amphetamines Not detected (Not-detected)

Interpretation:
 Assay cutoff: 500 ng/mL

Barbiturates	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 200 ng/mL				

Benzodiazepines Not detected (Not-detected)

Interpretation:
 Assay cutoff: 100 ng/mL

Opiates	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 300 ng/mL				

Phencyclidine, UA Not detected (Not-detected)

Interpretation:
 Assay cutoff: 25 ng/mL

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Note: (For Medical Purpose only). Performed by enzyme immunoassay (EIA) and all positive results will be confirmed by appropriate methods. The confirmation will be on a separate report.

Cannabinoids Not detected (Not-detected)

Interpretation:
Assay cutoff: 50 ng/mL

Methadone Not detected (Not-detected)

Interpretation:
Assay cutoff: 300 ng/mL

Oxycodone Not detected (Not-detected)

Interpretation:
Assay cutoff: 100 ng/mL

ETG/ETS, UA (500 Cut-Off) on 13 Apr 2015

Collection Date:

13 Apr 2015

Site/Specimen:

URINE

Ordering Clinician:

CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=500	

Drug Abuse Screen on 13 Apr 2015

Collection Date:

13 Apr 2015

Site/Specimen:

URINE

Ordering Clinician:

CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Opiates	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 300 ng/mL				

Amphetamines Not detected (Not-detected)

Interpretation:
Assay cutoff: 500 ng/mL

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Barbiturates	Not detected	(Not-detected)
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Interpretation:
Assay cutoff: 200 ng/mL

Benzodiazepines	Not detected	(Not-detected)
------------------------	--------------	----------------

Interpretation:
Assay cutoff: 100 ng/mL

Cocaine	Not detected	(Not-detected)
----------------	--------------	----------------

Interpretation:
Assay cutoff: 300 ng/mL

Phencyclidine, UA	Not detected	(Not-detected)
--------------------------	--------------	----------------

Interpretation:
Assay cutoff: 25 ng/mL

Note: (For Medical Purpose only). Performed by enzyme immunoassay (EIA) and all positive results will be confirmed by appropriate methods. The confirmation will be on a separate report.

Cannabinoids	Not detected	(Not-detected)
---------------------	--------------	----------------

Interpretation:
Assay cutoff: 50 ng/mL

Methadone	Not detected	(Not-detected)
------------------	--------------	----------------

Interpretation:
Assay cutoff: 300 ng/mL

Oxycodone	Not detected	(Not-detected)
------------------	--------------	----------------

Interpretation:
Assay cutoff: 100 ng/mL

ETG/ETS, UA (500 Cut-Off) on 06 Apr 2015

Collection Date: 06 Apr 2015
Ordering Clinician: DUDA, ROGER H
Comment:
Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
------	-------	-------	-------	----------

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ethyl Glucuronide	Negative	ng/mL	Cutoff=500
--------------------------	----------	-------	------------

Drug Abuse Screen on 06 Apr 2015

Collection Date:

06 Apr 2015

Site/Specimen:

URINE

Ordering Clinician:

DUDA, ROGER H

Comment:

Chem

Name	Value	Units	Range	Abnormal
Cocaine	Not detected		(Not-detected)	

Interpretation:

Assay cutoff: 300 ng/mL

Amphetamines

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 500 ng/mL

Barbiturates

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 200 ng/mL

Benzodiazepines

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 100 ng/mL

Opiates

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 300 ng/mL

Phencyclidine, UA

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 25 ng/mL

Note: (For Medical Purpose only). Performed by enzyme immunoassay (EIA) and all positive results will be confirmed by appropriate methods. The confirmation will be on a separate report.

Cannabinoids

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 50 ng/mL

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Methadone	Not detected	(Not-detected)
------------------	--------------	----------------

Interpretation:

Assay cutoff: 300 ng/mL

Oxycodone	Not detected	(Not-detected)
------------------	--------------	----------------

Interpretation:

Assay cutoff: 100 ng/mL

Chlamydia+Gonococcus DNA Panel NAAT on 31 Mar 2015

Collection Date:

31 Mar 2015

Site/Specimen:

URINE

Ordering Clinician:

CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Neisseria gonorrhoeae DNA	NEGATIVE FOR N.GONORRHOE AE			
Interpretation: Laboratory testing performed at: <div style="display: flex; justify-content: space-between;"> <div> WRNMMC 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889 </div> <div> Dept of Pathology </div> </div> Method: Ribosomal RNA Amplification The APTIMA Combo 2 Assay detects the presence or absence of Neisseria gonorrhoeae and Chlamydia trachomatis ribosomal RNA in female cervical and vaginal swabs, male urethral swabs, and female/male urine specimens. The assay uses a target amplification nucleic acid probe technology and is run on the TIGRIS DTS Automated Analyzer. Data on the performance of nucleic acid testing (NAATs) for Chlamydia trachomatis and Neisseria gonorrhea in patients under 16 is limited. This assay has not specifically been evaluated for patients under 16. Consultation with an expert is recommended before the performance and interpretation of NAAT in this context, to minimize the possibility of false positive and false negative results. This assay is not intended for the evaluation of suspected sexual abuse or for other medico-legal indications.				
Chlamydia trachomatis DNA	NEGATIVE FOR C.TRACHOMAT IS			(Negative)

Interpretation:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Laboratory testing performed at:

WRNMMC
 Dept of Pathology
 Wisconsin Ave BLDG 9
 Bethesda, MD 20889

ETG/ETS, UA (500 Cut-Off) on 30 Mar 2015

Collection Date: 30 Mar 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=500	

Drug Abuse Screen on 30 Mar 2015

Collection Date: 30 Mar 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Cocaine	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 300 ng/mL				

Amphetamines Not detected (Not-detected)

Interpretation:
 Assay cutoff: 500 ng/mL

Barbiturates	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 200 ng/mL				

Benzodiazepines Not detected (Not-detected)

Interpretation:
 Assay cutoff: 100 ng/mL

Opiates	Not detected		(Not-detected)	
Interpretation: Assay cutoff: 300 ng/mL				

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Phencyclidine, UA Not detected (Not-detected)

Interpretation:

Assay cutoff: 25 ng/mL

Note: (For Medical Purpose only). Performed by enzyme immunoassay (EIA) and all positive results will be confirmed by appropriate methods. The confirmation will be on a separate report.

Cannabinoids Not detected (Not-detected)

Interpretation:

Assay cutoff: 50 ng/mL

Methadone Not detected (Not-detected)

Interpretation:

Assay cutoff: 300 ng/mL

Oxycodone Not detected (Not-detected)

Interpretation:

Assay cutoff: 100 ng/mL

Urinalysis Panel on 28 Mar 2015

Collection Date: 28 Mar 2015

Site/Specimen: URINE

Ordering Clinician: BROCKINGTON, RHANDA J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Specific Gravity	1.006		(1.000-1.035)	
Color	Straw		(Yellow)	
Ketones	neg	mg/dL	(neg)	
Hemoglobin	neg		(neg)	
Nitrite	neg		(neg)	
pH	7.0		(5.0-9.0)	
Protein	neg	mg/dL	(neg)	
Appearance	Clear		(Clear)	
Leukocyte Esterase	neg		(neg)	
Urobilinogen	normal	mg/dL	(norm 0.2-1)	
Glucose	neg	mg/dL	(neg)	
Bilirubin	neg		(neg)	

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Mephedrone, MDPV, Methylone on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Mephedrone	Negative		NEGATIVE	
Methylenedioxypyrovalerone	Negative		NEGATIVE	
Methylone	Negative		NEGATIVE	

Cannabinoids (THC), Synthetic on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Cannabinoids, Synthetic	Negative			

Chlamydia+Gonococcus DNA Panel NAAT on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Neisseria gonorrhoeae DNA	NEGATIVE FOR N.GONORRHOEAE			
Interpretation: Laboratory testing performed at: WRNMMC Dept of Pathology 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889 Method: Ribosomal RNA Amplification The APTIMA Combo 2 Assay detects the presence or absence of Neisseria gonorrhoeae and Chlamydia trachomatis ribosomal RNA in female cervical and vaginal swabs, male urethral swabs, and female/male urine specimens. The assay uses a target amplification nucleic acid probe technology and is run on the TIGRIS DTS Automated Analyzer. Data on the performance of nucleic acid testing (NAATs) for Chlamydia trachomatis and Neisseria gonorrhea in patients under 16 is limited. This assay has not specifically been evaluated for patients under 16. Consultation with an expert is recommended before the performance and interpretation of NAAT in this context, to minimize the possibility of				

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

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false positive and false negative results. This assay is not intended for the evaluation of suspected sexual abuse or for other medico-legal indications.

Chlamydia trachomatis NEGATIVE FOR (Negative)
DNA C.TRACHOMAT
 IS

Interpretation:

Laboratory testing performed at:

WRNMMC
 Dept of Pathology
 Wisconsin Ave BLDG 9
 Bethesda, MD 20889

ETG/ETS, UA (250 Cut-Off) on 27 Mar 2015

Collection Date: 27 Mar 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Ethyl Glucuronide	Negative	ng/mL	Cutoff=250	

Drug Abuse Screen on 27 Mar 2015

Collection Date: 27 Mar 2015 Site/Specimen: URINE
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Opiates	Not detected		(Not-detected)	

Interpretation:

Assay cutoff: 300 ng/mL

Amphetamines Not detected (Not-detected)

Interpretation:

Assay cutoff: 500 ng/mL

Barbiturates Not detected (Not-detected)

Interpretation:

Assay cutoff: 200 ng/mL

Benzodiazepines Not detected (Not-detected)

Medical Record

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Interpretation:

Assay cutoff: 100 ng/mL

Cocaine

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 300 ng/mL

Phencyclidine, UA

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 25 ng/mL

Note: (For Medical Purpose only). Performed by enzyme immunoassay (EIA) and all positive results will be confirmed by appropriate methods. The confirmation will be on a separate report.

Cannabinoids

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 50 ng/mL

Methadone

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 300 ng/mL

Oxycodone

Not detected

(Not-detected)

Interpretation:

Assay cutoff: 100 ng/mL

Urinalysis Panel on 27 Mar 2015

Collection Date:

27 Mar 2015

Site/Specimen:

URINE

Ordering Clinician:

CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Nitrite	neg		(neg)	
Color	Straw		(Yellow)	
Ketones	neg	mg/dL	(neg)	
Hemoglobin	neg		(neg)	
pH	7.0		(5.0-9.0)	
RBC	< 1	/HPF	(0-3)	
Protein	neg	mg/dL	(neg)	

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Created: 16 Aug 2017

Appearance	Clear	(Clear)	
Leukocyte Esterase	MOD	(neg)	Higher Than Normal
Specific Gravity	1.008	(1.000-1.035)	
Urobilinogen	normal	mg/dL	(norm 0.2-1)
WBC	3	/HPF	(0-2) Higher Than Normal
Glucose	neg	mg/dL	(neg)
Bilirubin	neg	(neg)	

Urine Culture on 27 Mar 2015

Collection Date: 27 Mar 2015

Site/Specimen: Urine

Ordering Clinician: CEREMUGA, GEORGE J

Comment:

Order #	150327-24502
Filler #	150327 DWB 64394
Ordering Provider	CEREMUGA, GEORGE J
Priority	ROUTINE
DATE_ORDERED	20150327155700
DATE_RESULTED	20150329065106
COLLECT_SAMPLE	URINE/CLEAN CATCH
BACTERIOLOGY RESULT	03/28/15 03/29/15 URINE CULTURE NEGATIVE
Results	Final report

Vitamin D, 1,25-Dihydroxy (Calcitriol) Panel on 27 Mar 2015

Collection Date: 27 Mar 2015

Site/Specimen: SERUM

Ordering Clinician: CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Vitamin D, 1,25-Dihydroxy	78	pg/mL		
Vitamin D2, 1,25-Dihydroxy	<10	pg/mL		
Vitamin D3, 1,25-Dihydroxy	76	pg/mL		

Vitamin B1 (Thiamine) on 27 Mar 2015

Collection Date: 27 Mar 2015

Site/Specimen: BLOOD

Ordering Clinician: CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Vitamin B1 (Thiamine)	193.4	nmol/L	66.5-200.0	

Medical Record

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Created: 16 Aug 2017

HIV-1/O/2 Ab on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Rapid Plasma Reagin on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Reagin Ab	NONREACTIVE		(Non-Reactive)	

Interpretation:**REACTIVE:** Reactive - may indicate past or current syphilis infection.

Reactive results will be quantified and will be reflexed to the Treponema pallidum AB test The diagnosis of syphilis should not be made on the basis of a single reactive serologic test without taking history, clinical, and other information into consideration

NON REACTIVE : Nonreactive - current or past infection is unlikely, cannot exclude incubating or early syphilis.

METHODOLOGY:

This test is a macroscopic, non-treponemal flocculation procedure for the serologic screening for syphilis in serum.

Vitamin B12 (Cyanocobalamin)+Folate Panel on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Vitamin B12 (Cobalamins)	329	pg/mL	(211-946)	

Interpretation:**Laboratory testing performed at:**

WRNMMC
 Dept of Pathology
 8901 Wisconsin Ave BLDG 9
 Bethesda, MD 20889

Folate >20.00 ng/mL (4.6-34.8)

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Created: 16 Aug 2017

Interpretation:**Laboratory testing performed at:**

WRNMMC

Dept of Pathology

8901 Wisconsin Ave BLDG 9

Bethesda, MD 20889

Homocysteine on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Homocysteine	9.1	mcmmol/L	(4.0-15.4)	
Interpretation: Test performed by: WRNMMC Dept of Pathology Wisconsin Ave BLDG 9 8901 Bethesda, MD 20889				

Thyroid Stimulating Hormone on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Thyrotropin	0.757	mIU/mL	(0.27-4.20)	
Interpretation: Free T4 will be automatically performed when TSH <0.27 or >4.20				

Magnesium on 27 Mar 2015

Collection Date: 27 Mar 2015
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Magnesium	2.2	mg/dL	(1.7-2.6)	

Gamma Glutamyl Transferase on 27 Mar 2015

Collection Date: 27 Mar 2015

Site/Specimen: SERUM

Medical Record

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ordering Clinician: CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Gamma-Glutamyl Transferase	40	U/L	(10-71)	

Comprehensive Metabolic Panel on 27 Mar 2015

Collection Date: 27 Mar 2015

Site/Specimen: SERUM

Ordering Clinician: CEREMUGA, GEORGE J

Comment:

Chem

Name	Value	Units	Range	Abnormal
Albumin	4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	71	U/L	(40-130)	
Alanine Aminotransferase	29	U/L	(0-41)	

Interpretation:

Any abnormality in a patient's ALT could be a marker of serious liver disease, including chronic viral hepatitis. If the ALT is repeatedly elevated consider testing for Hepatitis C AB.

Bilirubin	0.3	mg/dL	(0-1.0)	
Urea Nitrogen	14	mg/dL	(6-20)	
Calcium	10.0	mg/dL	(8.6-10.2)	
Carbon Dioxide	29	mmol/L	(22-31)	
Chloride	98	mmol/L	(98-107)	
Creatinine	0.9	mg/dL	(0.7-1.4)	
Glucose	82	mg/dL	(74-106)	
Potassium	4.7	mmol/L	(3.5-5.1)	
Protein	7.9	g/dL	(6.4-8.3)	
Sodium	139	mmol/L	(135-145)	
Anion Gap	13	mmol/L	(8-18)	
GFR Calculated Non-Black	114.7	mL/min	(>=90)	
GFR Calculated Black	132.6	mL/min	(>=90)	

Interpretation:**Reference values:**

>=90 = Normal

60-89 = Mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American (AA) patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain

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Medical Record

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sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. Results will not be reported on patients under 18 years of age.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

Aspartate Aminotransferase	<5	U/L	(0-40)
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CBC W/Diff on 27 Mar 2015

Collection Date: 27 Mar 2015 Site/Specimen: BLOOD
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Hematocrit	43.1	%	(37.5-50.9)	
WBC	6.8	x10(3)/mcL	(3.6-10.6)	
RBC	4.65	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	14.5	g/dL	(12.8-17.7)	
MCV	92.6	fL	(79.5-96.8)	
MCH	31.1	pg	(26.2-33.1)	
MCHC	33.6	g/dL	(32.6-35.0)	
RDW CV	12.0	%	(12.0-16.2)	
Platelets	296	x10(3)/mcL	(162-427)	
MPV	8.5	fL	(7.0-10.9)	
Neutrophils	67.0	%	(40.7-76.4)	
Lymphocytes	25.1	%	(15.9-47.8)	
Monocytes	6.7	%	(4.5-11.8)	
Eosinophils	0.9	%	(0.3-7.1)	
Basophils	0.3	%	(0.2-1.2)	
ABS Neutrophils	4.5	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	MANUAL DIFF NOT PERFORMED			

Coagulation Panel 1 (PT+APTT) on 27 Mar 2015

Collection Date: 27 Mar 2015 Site/Specimen: PLASMA
 Ordering Clinician: CEREMUGA, GEORGE J
 Comment:
 Chem

Name	Value	Units	Range	Abnormal
Prottime	12.5	Sec	(12.4-14.4)	
INR	1.0			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:

The recommended therapeutic range for INR is 2.0 - 3.0 for most clinical indications such as prophylaxis/treatment of DVT/PE, prevention of embolism (valvular heart disease, tissue heart valves, atrial fibrillation), and bi-leaflet mechanical aortic valves. Exceptions include mechanical prosthetic valves for which an INR of 2.5 - 3.5 is recommended. These are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

APTT 32.9 Sec (23.4-36.2)

Interpretation:

APTT may be used to monitor Heparin, LMW Heparin and Lepirudin therapy. Therapeutic range: 69-107 sec. is based on laboratory's heparin study.

HIV-1/O/2 Ab on 10 Apr 2014

Collection Date: 10 Apr 2014
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Lipid Panel on 10 Apr 2014

Collection Date: 10 Apr 2014
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
LDL Cholesterol	112	mg/dL	(0-129)	

Interpretation:

Ref: Desirable: <130 / Borderline: 130-159 / High: =>160

Cholesterol 208 mg/dL (50-200) Higher Than Normal

Interpretation:

Ref: Desirable: 50-200 / Borderline: 200-239 / High: => 240

Triglyceride 158 mg/dL (40-150) Higher Than Normal

Interpretation:

Normal <150, Borderline High 150-199, High 200-499, Very High >500.

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Created: 16 Aug 2017

HDL Cholesterol	64.0	mg/dL	(40-60)	Higher Than Normal
VLDL Cholesterol	32	mg/dL	(2-49)	
Cholesterol/HDL Cholesterol	3.25			

Hemoglobin A1c on 04 Jun 2013

Collection Date: 04 Jun 2013
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: BLOOD

Name	Value	Units	Range	Abnormal
Hemoglobin A1c	5.4	%	(4.5-6.2)	
Interpretation: The American Diabetes Association recommends that a primary goal of therapy should be HbA1C of 7% and that physicians should evaluate the treatment regimen in patients with HbA1C values consistently >8%. Laboratory Testing Performed at: Kimbrough Ambulatory Care Center 2480 Llewellyn Ave Fort Meade, MD 20755				

Basic Metabolic Panel on 04 Jun 2013

Collection Date: 04 Jun 2013
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Urea Nitrogen	12	mg/dL	(7-18)	
Carbon Dioxide	30	mmol/L	(21-32)	
Chloride	102	mmol/L	(98-107)	
Creatinine	1.0	mg/dL	(0.6-1.3)	
Glucose	94	mg/dL	(70-99)	
Interpretation: Normal fasting reference range is based on the clinical practice recommendations of the American Diabetes Association				
Potassium	4.3	mmol/L	(3.5-5.1)	
Sodium	140	mmol/L	(136-145)	
Calcium	9.7	mg/dL	(8.5-10.1)	
Anion Gap	8	mmol/L	(8-16)	
GFR Calculated Non-Black	102.0	mL/min	(>=60)	
GFR Calculated Black	117.9	mL/min	(>=60)	
Interpretation:				

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Reference values:

>= 60 = Normal or mildly decreased GFR
 30-59 = Moderately decreased GFR
 15-29 = Severely decreased GFR
 <15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the Chronic Kidney Disease - Epidemiology (CKD-Epi) Collaboration Equation. The calculation automatically takes patient sex into account, but CHCS cannot automatically adjust the formula for African American patients, therefore two GFR results are reported -- GFR-NON AA and GFR-AA. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus.

Some pharmacological therapeutics are dosed based on older versions of the eGFR. Where deemed necessary, refer to Pharmacy for assistance or more information.

HIV-1/O/2 Ab on 19 Mar 2013

Collection Date: 19 Mar 2013
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Lipid Panel on 19 Mar 2013

Collection Date: 19 Mar 2013
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
LDL Cholesterol	93	mg/dL	(0-129)	

Interpretation:

Ref: Desirable: <130 / Borderline: 130-159 / High: =>160

Cholesterol	209	mg/dL	(50-200)	Higher Than Normal
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Interpretation:

Ref: Desirable: 50-200 / Borderline: 200-239 / High: => 240

Triglyceride	265	mg/dL	(40-150)	Higher Than Normal
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Interpretation:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Normal <150, Borderline High 150-199, High 200-499, Very High >500.

HDL Cholesterol	63.0	mg/dL	(40-60)	Higher Than Normal
VLDL Cholesterol	53	mg/dL	(2-49)	Higher Than Normal
Cholesterol/HDL Cholesterol	3.32			

Chlamydia+Gonococcus DNA Panel NAAT on 28 Jan 2013

Collection Date: 28 Jan 2013
 Ordering Clinician: UDE, ASSUMPTA O
 Comment:
 Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Neisseria gonorrhoeae DNA	NEGATIVE FOR N.GONORRHOEAE			
Interpretation: Laboratory testing performed at: WRNMMC Dept of Pathology 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889 Method: Ribosomal RNA Amplification The APTIMA Combo 2 Assay detects the presence or absence of Neisseria gonorrhoeae and Chlamydia trachomatis ribosomal RNA in female cervical and vaginal swabs, male urethral swabs, and female/male urine specimens. The assay uses a target amplification nucleic acid probe technology and is run on the TIGRIS DTS Automated Analyzer. Data on the performance of nucleic acid testing (NAATs) for Chlamydia trachomatis and Neisseria gonorrhea in patients under 16 is limited. This assay has not specifically been evaluated for patients under 16. Consultation with an expert is recommended before the performance and interpretation of NAAT in this context, to minimize the possibility of false positive and false negative results. This assay is not intended for the evaluation of suspected sexual abuse or for other medico-legal indications.				
Chlamydia trachomatis DNA	NEGATIVE FOR C.TRACHOMATIS		(Negative)	

Interpretation:
 Laboratory testing performed at:

WRNMMC
 Dept of Pathology

Medical Record

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Wisconsin Ave BLDG 9
Bethesda, MD 20889

Urinalysis Panel on 28 Jan 2013

Collection Date: 28 Jan 2013
Ordering Clinician: UDE, ASSUMPTA O
Comment:
Chem

Site/Specimen: URINE

Name	Value	Units	Range	Abnormal
Specific Gravity	1.013		(1.000-1.035)	
Color	Yellow			
Ketones	NEGATIVE	mg/dL	(NEG)	
Blood	NEGATIVE	mg/dL	(NEG)	
Mucus	RARE	/LPF	(FEW)	
Nitrite	NEGATIVE		(NEG)	
pH	6.5		(5.0-9.0)	
RBC	< 1	/HPF	(0-2)	
Protein	NEGATIVE	mg/dL	(NEG)	
Appearance	CLEAR			
Leukocyte Esterase	NEGATIVE	WBC/mcL	(NEG)	
Urobilinogen	NORMAL	mg/dL		
WBC	1	/HPF	(0-2)	
Glucose	NEGATIVE	mg/dL	(NEG)	
Bilirubin	NEGATIVE	mg/dL	(NEG)	

Herpes Simplex Virus 1+2 Ab IgG on 28 Jan 2013

Collection Date: 28 Jan 2013
Ordering Clinician: UDE, ASSUMPTA O
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Herpes Simplex Virus 1 Ab IgG	Negative	AI	(see comm-ent)	
Interpretation: Reference Ranges: < 0.9 AI: Negative - No HSV-1 IgG antibodies detected. Patient is presumed not to have had a previous HSV-1 infection. 0.9-1.0 AI: Equivocal - Obtain an additional sample for re-testing. >= 1.1 AI: Positive - IgG antibody to HSV-1 detected.				
----- Test performed by: WRNMMC Dept of Pathology 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889				
Herpes Simplex Virus 2 Ab	Negative	AI	(0.0-0.8)	

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Created: 16 Aug 2017

IgG**Interpretation:****Reference Ranges:**

< 0.9 AI: Negative - No HSV-2 IgG antibodies detected.

Patient is presumed not to have had a previous HSV-2 infection.

0.9-1.0 AI: Equivocal - Obtain an additional sample for re-testing.

>= 1.1 AI: Positive - IgG antibody to HSV-2 detected.

Mathodology: Multiplex Flow Immunoassay**Laboratory testing performed at:****WRNMMC****Dept of Pathology****8901 Wisconsin Ave BLDG 9****Bethesda, MD 20889****Rapid Plasma Reagin on 28 Jan 2013**

Collection Date:

28 Jan 2013

Site/Specimen:

SERUM

Ordering Clinician:

UDE, ASSUMPTA O

Comment:

Chem

Name	Value	Units	Range	Abnormal
Reagin Ab	NONREACTIVE		(NON-REACTIVE)	

ESR on 12 Oct 2012

Collection Date:

12 Oct 2012

Site/Specimen:

BLOOD

Ordering Clinician:

SALTER, CAROLYN A

Comment:

Chem

Name	Value	Units	Range	Abnormal
ESR	10	mm/hr	(1-19)	

C-Reactive Protein on 12 Oct 2012

Collection Date:

12 Oct 2012

Site/Specimen:

SERUM

Ordering Clinician:

SALTER, CAROLYN A

Comment:

Chem

Name	Value	Units	Range	Abnormal
C-Reactive Protein	1.206	mg/dL	(0.000-0.500)	Higher Than Normal

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Created: 16 Aug 2017

Phosphorus on 12 Oct 2012

Collection Date: 12 Oct 2012
 Ordering Clinician: O'DONNELL, MARY T
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Phosphate	3.5	mg/dL	(2.5-4.5)	

Magnesium on 12 Oct 2012

Collection Date: 12 Oct 2012
 Ordering Clinician: O'DONNELL, MARY T
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Magnesium	2.1	mg/dL	(1.6-2.6)	

Basic Metabolic Panel on 12 Oct 2012

Collection Date: 12 Oct 2012
 Ordering Clinician: O'DONNELL, MARY T
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Urea Nitrogen	5	mg/dL	(6-20)	Lower Than Normal
Carbon Dioxide	27	mmol/L	(22-29)	
Chloride	107	mmol/L	(98-107)	
Creatinine	0.80	mg/dL	(0.7-1.2)	
Glucose	113	mg/dL	(74-106)	Higher Than Normal
Potassium	4.0	mEq/L	(3.5-5.1)	
Sodium	141	mmol/L	(136-145)	
Calcium	9.2	mg/dL	(8.6-10.2)	
Anion Gap	8	mmol/L	(8-16)	
GFR	>60	mL/min	(>=60)	

Interpretation:

Units: mL/min/1.73m2

GFR: ** A result of "0" (zero) for ages 17 and under is the same as not performed. Reference Values:

>= 60 = Normal or mildly decreased GFR
 30-59 = Moderately decreased GFR
 15-29 = Severely decreased GFR
 <15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the modified MDRD

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

(Modification of Diet in Renal Disease) equation:
 $GFR = 175 \times \text{serum creatinine}^{-1.154} \times \text{age}^{-0.203} \times 0.742$ (if female). Values for African Americans should be adjusted by multiplying by 1.212. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. This equation does not accurately estimate GFR in patients with a relatively normal GFR (i.e. ≥ 60 ml/min/1.73m²). If a more accurate estimation is required, consider obtaining a Nuclear Medicine GFR determination or Nephrology consultation.

Laboratory testing performed at:

WRNMMC
 Dept of Pathology
 8901 Wisconsin Ave BLDG 9
 Bethesda, MD 20889

CBC W/o Diff on 12 Oct 2012

Collection Date:

12 Oct 2012

Site/Specimen:

BLOOD

Ordering Clinician:

O'DONNELL, MARY T

Comment:

Chem

Name	Value	Units	Range	Abnormal
WBC	5.5	x10(3)/mcL	(3.6-10.6)	
RBC	4.02	x10(6)/mcL	(4.21-5.92)	Lower Than Normal
MCH	32.6	pg	(26.2-33.1)	
Hemoglobin	13.1	g/dL	(12.8-17.7)	
Hematocrit	38.1	%	(37.5-50.9)	
MCV	94.9	fL	(79.5-96.8)	
MCHC	34.3	%	(32.6-35.0)	
Platelets	264	x10(3)/mcL	(162-427)	
RDW CV	13.1	%	(12.0-16.2)	
MPV	7.8	fL	(7.0-10.9)	

TISSUE EXAM on 12 Oct 2012

Collection Date:

12 Oct 2012

Site/Specimen:

Ordering Clinician:

COX, TIFFANY CANDACE

Comment:

Order #	121028-01374
Ordered Date	20121028103800
Priority	ROUTINE
Resulted Date	20121028103846.1-0500
121018 NSP 23631	Col 12Oct12 TISSUE(TISSUE)
Hcp	COX, TIFFANY CANDACE Req Loc: 5 EAST
TISSUE E	C RB28Oct12@1038

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CoPath Report	
Patient	MERWIN,DANIEL DENNIS Specimen #: NS12-23631
Accessioned	10/18/12
A	<p>ascending colon B: sigmoid colon</p> <p>The specimen is received in formalin, labeled with the patient's name</p> <p>Merwin, Daniel designated, "Ascending Colon" consists of two tan-white irregular soft tissue fragments measuring 0.4 and 0.6 cm in greatest dimension. Submitted entirely. 2/1/ng</p> <p>=====</p> <p>=====</p> <p>=====</p> <p>rxb/10/19/12 ** Report Electronically Signed Out **</p> <p>Ross Barner, COL MC USA</p> <p>=====</p> <p>=====</p> <p>=====</p>
FINAL DIAGNOSIS	
A. ASCENDING COLON, BIOPSY	- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATE.
B. SIGMOID COLON, BIOPSY	- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATES.
Comment	There is no evidence of acute cryptitis, architectural distortion, or dysplasia.
CLINICAL DIAGNOSIS AND HISTORY	thickening of ascending colon on ct with no stranding, presented with obstructive symptoms, rule out mass vs. inflamm.
PRE-OPERATIVE DIAGNOSIS	ascending colon thickening
POST-OPERATIVE DIAGNOSIS	
Operative Findings	sigmoid thickening
Post-operative Diagnosis	sigmoid thickening
GROSS DESCRIPTION	
B	<p>The specimen is received in formalin, labeled with the patient's name</p> <p>Merwin, Daniel designated, "Sigmoid" consists of four tan-white irregular soft tissue fragments measuring 0.2 to 0.5 cm in greatest dimension. Submitted entirely. 4/1/ng NW/JAP/DVC</p> <p>HLS/meh</p>

Neutrophil Cytoplasmic Ab (ANCA) on 11 Oct 2012

Collection Date:

11 Oct 2012

Site/Specimen:

SERUM

Ordering Clinician:

KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
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Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Myeloperoxidase Ab <0.2 AI (see-below)

Interpretation:

< 1.0 AI: Negative

>= 1.0 AI: Positive

Methodology: Multiplex Flow Immunoassay**Test performed by: WRNMMC****Dept of Pathology****8901 Wisconsin Ave BLDG 9****Bethesda, MD 20889**

Proteinase 3 Ab <0.2 AI (see-below)

Interpretation:

< 1.0 AI: Negative

>= 1.0 AI: Positive

Methodology: Multiplex Flow Immunoassay**Neutrophil Cytoplasmic Ab (ANCA) Screen W/Reflex Titer on 11 Oct 2012**

Collection Date:

11 Oct 2012

Site/Specimen:

SERUM

Ordering Clinician:

KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Neutrophil Cytoplasmic Ab C-ANCA	Titer not indicated-ANCA screen Negative	Titer units	(<1:20)	
Neutrophil Cytoplasmic Ab Perinuclear	Titer not indicated-ANCA screen Negative	Titer units	(<1:20)	
Neutrophil Cytoplasmic Ab	Negative		(Negative)	
Neutrophil Cytoplasmic Ab Perinuclear Atypical	Titer not indicated-ANCA screen Negative	Titer units	(<1:20)	

Interpretation:

*"ANCA Screen includes evaluation for p-ANCA, c-ANCA, and atypical p-ANCA."

Methodolgy: Immunoassay**Test performed: Quest Diagnostics Nichols Institute****14225 Newbrook Dr****Chantilly, VA 20151**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Carcinoembryonic Ag on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Carcinoembryonic Ag	0.9	ng/mL	(0.2-4.7)	
Interpretation: Laboratory testing performed at: WRNMMC Dept of Pathology 8901 Wisconsin Ave BLDG 9 Bethesda, MD 20889				

Amylase on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Amylase	49	U/L	(28-100)	

Phosphorus on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Phosphate	3.5	mg/dL	(2.5-4.5)	

Magnesium on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Magnesium	2.3	mg/dL	(1.6-2.6)	

Lipase on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Comment:

Chem

Name	Value	Units	Range	Abnormal
Triacylglycerol Lipase	19	U/L	(13-60)	

Comprehensive Metabolic Panel on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: SERUM

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
Albumin	4.7	g/dL	(3.5-5.2)	
Alkaline Phosphatase	56	U/L	(40-129)	
Alanine Aminotransferase	33	U/L	(0-41)	
Aspartate Aminotransferase	29	U/L	(0-40)	
Bilirubin	0.5	mg/dL	(0-1.0)	
Urea Nitrogen	9	mg/dL	(6-20)	
Calcium	9.5	mg/dL	(8.6-10.2)	
Carbon Dioxide	29	mmol/L	(22-29)	
Chloride	101	mmol/L	(98-107)	
Creatinine	0.85	mg/dL	(0.7-1.2)	
Glucose	82	mg/dL	(74-106)	
Potassium	4.0	mEq/L	(3.5-5.1)	
Protein	7.3	g/dL	(6.4-8.3)	
Sodium	139	mmol/L	(136-145)	
Anion Gap	9	mmol/L	(8-16)	
GFR	>60	mL/min	(>=60)	

Interpretation:Units: mL/min/1.73m²

GFR: ** A result of "0" (zero) for ages 17 and under is the same as not performed. Reference Values:

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the modified MDRD (Modification of Diet in Renal Disease) equation:

$$\text{GFR} = 175 \times \text{serum creatinine}^{-1.154} \times \text{age}^{-0.203} \times 0.742 \text{ (if female).}$$
 Values for African Americans should be adjusted by multiplying by 1.212. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. This equation does not accurately estimate GFR in patients with a relatively

Merwin, Daniel Dennis

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Created: 16 Aug 2017

normal GFR (i.e. ≥ 60 ml/min/1.73m²). If a more accurate estimation is required, consider obtaining a Nuclear Medicine GFR determination or Nephrology consultation.

Laboratory testing performed at:

WRNMMC

Dept of Pathology

8901 Wisconsin Ave BLDG 9

Bethesda, MD 20889

CBC W/Diff on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: BLOOD

Ordering Clinician: KINDELAN, TAMARA JEAN

Comment:

Chem

Name	Value	Units	Range	Abnormal
MCHC	34.2	%	(32.6-35.0)	
WBC	6.4	x10(3)/mcL	(3.6-10.6)	
RBC	4.30	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	14.1	g/dL	(12.8-17.7)	
Hematocrit	41.0	%	(37.5-50.9)	
MCV	95.4	fL	(79.5-96.8)	
MCH	32.6	pg	(26.2-33.1)	
RDW CV	13.1	%	(12.0-16.2)	
Platelets	268	x10(3)/mcL	(162-427)	
MPV	8.3	fL	(7.0-10.9)	
Neutrophils	72.7	%	(40.7-76.4)	
Lymphocytes	18.1	%	(15.9-47.8)	
Monocytes	7.1	%	(4.5-11.8)	
Eosinophils	1.8	%	(0.3-7.1)	
Basophils	0.3	%	(0.2-1.2)	
ABS Neutrophils	4.6	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	1.2	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	MANUAL DIFF NOT PERFORMED			

MRSA PCR on 11 Oct 2012

Collection Date: 11 Oct 2012

Site/Specimen: NASAL MUCUS

Ordering Clinician: O'DONNELL, MARY T

Comment:

Chem

Name	Value	Units	Range	Abnormal
MRSA DNA	Negative for MRSA by Real-Time PCR		(Negative)	

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Interpretation:

The Cepheid Xpert MRSA Assay is an FDA approved qualitative test designed for rapid detection of MRSA from nasal swabs only utilizing real-time PCR to detect MRSA DNA. This assay is to be used for infection control surveillance purposes only. Concomitant cultures are necessary only to recover organisms for further susceptibility testing.

Laboratory testing performed at:

WRNMMC
Dept of Pathology
8901 Wisconsin Ave BLDG 9
Bethesda, MD 20889

Amylase on 11 Oct 2012

Collection Date: 11 Oct 2012
Ordering Clinician: PUTKO, ROBERT M
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Amylase	50	U/L	(28-100)	

Lipase on 11 Oct 2012

Collection Date: 11 Oct 2012
Ordering Clinician: PUTKO, ROBERT M
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Triacylglycerol Lipase	22	U/L	(13-60)	

Comprehensive Metabolic Panel on 11 Oct 2012

Collection Date: 11 Oct 2012
Ordering Clinician: PUTKO, ROBERT M
Comment:
Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Albumin	4.6	g/dL	(3.5-5.2)	
Alkaline Phosphatase	59	U/L	(40-129)	
Alanine Aminotransferase	19	U/L	(0-41)	
Aspartate Aminotransferase	22	U/L	(0-40)	
Bilirubin	0.2	mg/dL	(0-1.0)	
Urea Nitrogen	14	mg/dL	(6-20)	
Calcium	9.8	mg/dL	(8.6-10.2)	
Carbon Dioxide	32	mmol/L	(22-29)	Higher Than Normal

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Chloride	105	mmol/L	(98-107)	
Creatinine	0.88	mg/dL	(0.7-1.2)	
Glucose	106	mg/dL	(74-106)	
Potassium	4.3	mEq/L	(3.5-5.1)	
Protein	7.5	g/dL	(6.4-8.3)	
Sodium	143	mmol/L	(136-145)	
Anion Gap	6	mmol/L	(8-16)	Lower Than Normal
GFR	>60	mL/min	(>=60)	

Interpretation:Units: mL/min/1.73m²

GFR: ** A result of "0" (zero) for ages 17 and under is the same as not performed. Reference Values:

>= 60 = Normal or mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney failure

This is an estimated GFR (Glomerular Filtration Rate) only. The value has been derived from the modified MDRD (Modification of Diet in Renal Disease) equation: $GFR = 175 \times \text{serum creatinine}^{-1.154} \times \text{age}^{-0.203} \times 0.742$ (if female). Values for African Americans should be adjusted by multiplying by 1.212. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. This equation does not accurately estimate GFR in patients with a relatively normal GFR (i.e. ≥ 60 mL/min/1.73m²). If a more accurate estimation is required, consider obtaining a Nuclear Medicine GFR determination or Nephrology consultation.

Laboratory testing performed at:

WRNMMC
Dept of Pathology
8901 Wisconsin Ave BLDG 9
Bethesda, MD 20889

CBC W/Diff on 11 Oct 2012

Collection Date: 11 Oct 2012
Ordering Clinician: PUTKO, ROBERT M
Comment:
Chem

Site/Specimen: BLOOD

Name	Value	Units	Range	Abnormal
Hematocrit	40.9	%	(37.5-50.9)	
WBC	10.1	x10(3)/mcL	(3.6-10.6)	
RBC	4.37	x10(6)/mcL	(4.21-5.92)	

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Hemoglobin	14.2	g/dL	(12.8-17.7)	
MCV	93.6	fL	(79.5-96.8)	
MCH	32.4	pg	(26.2-33.1)	
MCHC	34.7	%	(32.6-35.0)	
RDW CV	12.9	%	(12.0-16.2)	
Platelets	246	x10(3)/mcL	(162-427)	
MPV	8.0	fL	(7.0-10.9)	
Neutrophils	84.9	%	(40.7-76.4)	Higher Than Normal
Lymphocytes	10.4	%	(15.9-47.8)	Lower Than Normal
Monocytes	3.4	%	(4.5-11.8)	Lower Than Normal
Eosinophils	1.0	%	(0.3-7.1)	
Basophils	0.3	%	(0.2-1.2)	
ABS Neutrophils	8.6	x10(3)/mcL	(1.8-7.5)	Higher Than Normal
ABS Lymphocytes	1.1	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	0.3	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	MANUAL DIFF NOT PERFORMED			

Infectious Mononucleosis Screen on 10 May 2012

Collection Date:

10 May 2012

Site/Specimen:

SERUM

Ordering Clinician:

GUNTER, ROGER WILLIAM

Comment:

Chem

Name	Value	Units	Range	Abnormal
Heterophile Ab	NEGATIVE, INTERNAL CONTROL ACCEPTABLE			

CBC on 10 May 2012

Collection Date:

10 May 2012

Site/Specimen:

BLOOD

Ordering Clinician:

GUNTER, ROGER WILLIAM

Comment:

Chem

Name	Value	Units	Range	Abnormal
ABS Lymphocytes	1.5	x10(3)	(1.0-4.8)	
WBC	6.3	x10(3)	(4-11)	
RBC	4.73	x10(6)	(3.9-5.9)	
Hemoglobin	14.8	g/dL	(13.0-17.4)	
Hematocrit	43.0	%	(39.8-52.2)	
MCV	90.9	fL	(80.0-100.0)	
MCH	31.3	pg	(26.0-35.0)	
MCHC	34.4	g/dL	(31.0-37.0)	

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

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Created: 16 Aug 2017

RDW CV	12.5	%	(11.0-18.0)
Platelets	315	x10(3)	(150-450)
MPV	10.6	fL	(6.5-11.6)
Neutrophils	63.9	%	(40-73)
Lymphocytes	23.9	%	(16-51)
Monocytes	10.5	%	(0-12)
Eosinophils	1.4	%	(0-6)
Basophils	0.3	%	(0-2)
ABS Neutrophils	4.0	x10(3)	(1.8-7.8)
ABS Monocytes	0.7	x10(3)	(0.0-0.8)
ABS Eosinophils	0.1	x10(3)	(0.0-0.45)
ABS Basophils	0.0	x10(3)	(0.0-0.2)

Streptococcus Group A Ag Rapid on 10 May 2012

Collection Date: 10 May 2012

Site/Specimen: PHARYNX

Ordering Clinician: GUNTER, ROGER WILLIAM

Comment:

Chem

Name	Value	Units	Range	Abnormal
Streptococcus pyogenes Ag Rapid Strep	NEGATIVE, INTERNAL CONTROL ACCEPTABLE			

Throat Culture on 10 May 2012

Collection Date: 10 May 2012

Site/Specimen: Pharynx

Ordering Clinician: GUNTER, ROGER WILLIAM

Comment:

Order #	120510-04943
Filler #	120510 MI 3241
Ordering Provider	GUNTER, ROGER WILLIAM
Priority	ASAP
DATE_ORDERED	20120510165200
DATE_RESULTED	20120511084514
COLLECT_SAMPLE	PHARYNX
BACTERIOLOGY RESULT	FINAL REPORT RESULTS
Results	Final report

HIV-1/O/2 Ab on 22 Feb 2012

Collection Date: 22 Feb 2012

Site/Specimen: SERUM

Ordering Clinician: LINNVILLE, VAUNZELL W

Comment: awa

Chem

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Glucose Fasting on 22 Feb 2012

Collection Date: 22 Feb 2012

Site/Specimen: PLASMA

Ordering Clinician: LINNVILLE, VAUNZELL W

Comment: awa

Chem

Name	Value	Units	Range	Abnormal
Glucose Fasting	93	mg/dL	(60-99)	

Interpretation:

Fasting Glucose Interpretation

< 100 mg/dl Normal

100-125 mg/dl Impaired Fasting Glucose

>= 126 mg/dl Diabetes if the same or higher on two or more occasions

Lipid Profile on 22 Feb 2012

Collection Date: 22 Feb 2012

Site/Specimen: PLASMA

Ordering Clinician: LINNVILLE, VAUNZELL W

Comment: awa

Chem

Name	Value	Units	Range	Abnormal
Cholesterol	207	mg/dL	(25-199)	Higher Than Normal

Interpretation:

DESIRABLE: <200 MG/DL

BORDERLINE: 200-239 MG/DL

HIGH: =>240 MG/DL

HDL Cholesterol 60 mg/dL

Interpretation:

A level LESS THAN 40 MG/DL is LOW and is considered a MAJOR RISK FACTOR because it INCREASES YOUR RISK for developing HEART DISEASE. HDL levels of 60 MG/DL OR MORE help to LOWER YOUR RISK FOR HEART DISEASE.

Triglyceride	183	mg/dL	(20-150)	Higher Than Normal
--------------	-----	-------	----------	--------------------

Interpretation:

DESIRABLE: < 150 MG/DL

BORDERLINE HIGH: 150-199 MG/DL

+ HIGH: =>200 MG/DL

PANCREATITIS RISK: >1000 MG/DL

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

LDL Cholesterol	110	mg/dL	(25-100)	Higher Than Normal
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Interpretation:

A level **GREATER THAN 100 MG/DL** is **HIGH** and is considered a **MAJOR RISK FACTOR** because it **INCREASES YOUR RISK** for developing **HEART DISEASE**.

Further Interpretation information is available in Patient Instructions Inquiry.

Lipid Profile on 02 Feb 2011

Collection Date: 02 Feb 2011

Site/Specimen: PLASMA

Ordering Clinician: RUEFF, JAMES LOUIS

Comment: JRT

Chem

Name	Value	Units	Range	Abnormal
Triglyceride	196	mg/dL	(20-150)	Higher Than Normal

Interpretation:

DESIRABLE: < 150 MG/DL

BORDERLINE HIGH: 150-199 MG/DL

+ HIGH: =>200 MG/DL

PANCREATITIS RISK: >1000 MG/DL

Cholesterol	194	mg/dL	(25-199)
--------------------	-----	-------	----------

Interpretation:

DESIRABLE: <200 MG/DL

BORDERLINE: 200-239 MG/DL

HIGH: =>240 MG/DL

HDL Cholesterol	56	mg/dL
------------------------	----	-------

Interpretation:

A level **LESS THAN 40 MG/DL** is **LOW** and is considered a **MAJOR RISK FACTOR** because it **INCREASES YOUR RISK** for developing **HEART DISEASE**. HDL levels of **60 MG/DL OR MORE** help to **LOWER YOUR RISK FOR HEART DISEASE**.

LDL Cholesterol	99	mg/dL	(25-100)
------------------------	----	-------	----------

Interpretation:

A level **GREATER THAN 100 MG/DL** is **HIGH** and is considered a **MAJOR RISK FACTOR** because it **INCREASES YOUR RISK** for developing **HEART DISEASE**.

Further Interpretation information is available in Patient Instructions Inquiry.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

TISSUE EXAM on 24 Nov 2010

Collection Date:

24 Nov 2010

Site/Specimen:

Ordering Clinician:

BRUMWELL, ERIC

Comment:

Order #		101129-02781	
Ordered Date		20101129122000	
Priority		ROUTINE	
Resulted Date		20101129122054.1-0600	
101125 SP 3213	Col	24Nov10@0837	TISSUE(TISSUE)
Hcp		BRUMWELL,ERIC	Req Loc: DERMATOL
TISSUE E	C	RDB29Nov10@1220	
		CoPath Report	
Patient		MERWIN,DANIEL DENNIS	Specimen #: S10-3213
Accessioned		11/25/10	
Pathologist		RODNEY D BOYUM, CDR MC USN	
		SKIN, LOWER MUCOSAL LIP, SHAVE BX	
		bac/11/29/10 ** Report Electronically Signed **	
		RODNEY D BOYUM, CDR MC USN	
		SNOMED CODES	
		1. P1147; T02150	
		2. M57250	

CLINICAL DIAGNOSIS AND HISTORY

3MOS NEW IRREGULAR DARK BROWN MACULE ON LOWER MUCOSAL LIP OF VERY SUN DAMAGED RED-HEAD 25 Y/O MALE WHO HAS MANY OTHER EPILIDES AND SOLAR LENTIGO ON BODY

PRE-OPERATIVE DIAGNOSIS

SOLAR LENTIGO, EPILIDE VS MELANOMA

POST-OPERATIVE DIAGNOSIS**Operative Findings**

SAA

Post-operative Diagnosis

SAA

GROSS DESCRIPTION

Received in Formalin, labeled with the patient's name "Merwin," and designated "Lip" is a 0.4 x 0.2cm shave biopsy of tan skin. The skin surface is remarkable for a 0.3cm tan-brown papule. Bisected. 2/1/NG dd

FINAL DIAGNOSIS**SKIN, "LIP," SHAVE BIOPSY****CPT Codes**

; 88305 ; TISSUE LEVEL IV

Wound Culture and Gram Stain on 28 Sep 2010

Collection Date:

28 Sep 2010

Site/Specimen:

Skin

Ordering Clinician:

BRUMWELL, ERIC

Comment:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Filler #	100928 MI 3904
Ordering Provider	BRUMWELL, ERIC
Priority	ROUTINE
DATE ORDERED	20100928085400
DATE RESULTED	20100928113448
COLLECT SAMPLE	SKIN LESION
Order Comment	FROM PUSTULE OF BACK
GRAM STAIN (GRAM STAIN -- Final)	NO WBCs OR ORGANISMS NOTED
BACTERIOLOGY RESULT (CULT AEROBIC WOUND -- Final)	NO GROWTH IN 24 HOURS FINAL REPORT RESULTS
Results	Final report

Acid Fast Bacilli Culture on 28 Sep 2010

Collection Date: 28 Sep 2010 Site/Specimen: Tissue
Ordering Clinician: BRUMWELL, ERIC
Comment:

Order #	100928-00798
Filler #	100928 STB 48
Ordering Provider	BRUMWELL, ERIC
Priority	ROUTINE
DATE ORDERED	20100928084700
DATE RESULTED	20101206103848
COLLECT SAMPLE	TISSUE
Order Comment	left back
MYCOBACTERIUM	Negative for M. tuberculosis complex rRNA Performed by Fl. Dept. of Health Lab. Jacksonville No Acid Fast Bacilli cultured. Performed by Fl. Dept. of Health Lab Jacksonville.
ACID FAST STAIN	No Acid Fast Bacilli seen on smear. Performed by Fl. Dept. of Health Lab. Jacksonville
Results	Final report

Tissue Culture and Stain on 28 Sep 2010

Collection Date: 28 Sep 2010 Site/Specimen: Tissue
Ordering Clinician: BRUMWELL, ERIC
Comment:

Order #	100928-00627
Filler #	100928 MI 3893
Ordering Provider	BRUMWELL, ERIC
Priority	ROUTINE
DATE ORDERED	20100928082700
DATE RESULTED	20101001091816
COLLECT SAMPLE	TISSUE
Order Comment	PLEASE DO FUNGAL, AFB AND BACTERIAL
BACTERIOLOGY RESULT (CULT TISSUE -- Final)	NO GROWTH IN 24 HOURS NO GROWTH IN 48 HOURS FINAL REPORT RESULTS
GRAM STAIN (GRAM STAIN -- Final)	NO WBCs OR ORGANISMS NOTED

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Results

Final report

Fungus Culture on 28 Sep 2010

Collection Date: 28 Sep 2010 Site/Specimen: Body (Whole)
 Ordering Clinician: BRUMWELL, ERIC
 Comment:

Order #	100928-00825
Filler #	100928 MY 153
Ordering Provider	BRUMWELL, ERIC
Priority	ROUTINE
DATE ORDERED	20100928085000
DATE RESULTED	20101105145833
COLLECT_SAMPLE	GENERAL CATEGORY(SEE COMMENTS)
MYCOLOGY RESULT	No fungus seen on microscopic examination.

No fungus isolated after 4 weeks.

Results

Final report

TISSUE EXAM on 28 Sep 2010

Collection Date: 28 Sep 2010 Site/Specimen:
 Ordering Clinician: BRUMWELL, ERIC
 Comment:

Order #		101005-04215	
Ordered Date		20101005142100	
Priority		ROUTINE	
Resulted Date		20101005142132.1-0500	
100929 SP 2595	Col	28Sep10@0821	TISSUE(TISSUE)
Hcp		BRUMWELL,ERIC	Req Loc: DERMATOL
TISSUE E	C	DMR05Oct10@1421	
		CoPath Report	
Patient		MERWIN,DANIEL DENNIS	Specimen #: S10-2595
Accessioned		09/29/10	
Pathologist		DAVID M ROGERS, LT MC USN	
A		SKIN, CHEST, PUNCH BX B: SKIN, BACK, PUNCH BX	

CLINICAL DIAGNOSIS AND HISTORY

A/B- PUSTULES ON A-CHEST AND B-BACK THAT DEVELOP AFTER EXPOSURE TO WATER AND SUN AT BEACH--PT HAS THESE LESIONS ON UPPER TRUNK AND FACE--HAS HISTORY OF SEVERE SUNBURN AS A CHILD IN THESE AREAS

PRE-OPERATIVE DIAGNOSIS

MILIARIA PUSTULOSA VS FOLLICULITIS--PLEASE DO FUNGAL STAINS AS WELL

POST-OPERATIVE DIAGNOSIS

Operative Findings SAA

Post-operative Diagnosis SAA

GROSS DESCRIPTION

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

A) Received in Formalin, labeled with the patient's name "Merwin," and designated "Chest" is a 0.4cm punch biopsy of tan skin excised to a depth of 0.5cm. The skin surface is remarkable for a 0.3cm creamy-white lesion.

Bisected. 2/1/NG hh

B) Received in Formalin, labeled with the patient's name "Merwin," and designated "Right Back" is a 0.5cm punch biopsy of tan skin excised to a depth of 0.6cm. The skin surface is remarkable for a 0.3cm white-tan area.

Bisected. 2/1/NG hh

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES, CONSISTENT WITH ACUTE FOLLICULITIS.

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES, CONSISTENT WITH ACUTE FOLLICULITIS.

dmr/10/05/10

** Report Electronically Signed **

DAVID M ROGERS, LT MC USN

SNOMED CODES

1. P1148; T02424

2. M41780; M47401; T01000

3. E4000

4. P1148; T02450

5. M41780; M47401; T01000

6. E4000

FINAL DIAGNOSIS**A) SKIN, "CHEST," PUNCH BIOPSY****Comment**

A mixture of acute inflammatory cells and Langerhans' cells with associated necroinflammatory debris forming microabscess cavities is present within the infundibulum of follicles in biopsies from both the chest and back, extending into the sebaceous units. These findings are consistent with an acute folliculitis. Fungal stains are non-contributory.

CPT Codes

; 88305 ; TISSUE LEVEL IV
; 88305 ; TISSUE LEVEL IV
; 88313 ; SPECIAL STAINS OTHER
; 88313 ; SPECIAL STAINS OTHER

HIV-1/O/2 Ab on 09 Mar 2010

Collection Date:

09 Mar 2010

Site/Specimen:

SERUM

Ordering Clinician:

HEDARIA, ELIZABETH A

Comment:

lwc

Chem

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Name	Value	Units	Range	Abnormal
HIV-1/O/2 Ab	Negative			

Rapid Plasma Reagin on 09 Mar 2010

Collection Date: 09 Mar 2010 Site/Specimen: SERUM
Ordering Clinician: HEDARIA, ELIZABETH A
Comment: lwc
Chem

Name	Value	Units	Range	Abnormal
Reagin Ab	NON-REACTIVE			

Lipid Profile on 09 Mar 2010

Collection Date: 09 Mar 2010 Site/Specimen: PLASMA
Ordering Clinician: HEDARIA, ELIZABETH A
Comment: lwc
Chem

Name	Value	Units	Range	Abnormal
Cholesterol	170	mg/dL	(25-199)	
Interpretation: DESIRABLE: <200 MG/DL BORDERLINE: 200-239 MG/DL HIGH: =>240 MG/DL -----				

HDL Cholesterol 50 mg/dL

Interpretation:

A level LESS THAN 40 MG/DL is LOW and is considered a MAJOR RISK FACTOR because it INCREASES YOUR RISK for developing HEART DISEASE. HDL levels of 60 MG/DL OR MORE help to LOWER YOUR RISK FOR HEART DISEASE.

Triglyceride 192 mg/dL (20-150) Higher Than Normal

Interpretation:

DESIRABLE: < 150 MG/DL
BORDERLINE HIGH: 150-199 MG/DL
+ HIGH: =>200 MG/DL
PANCREATITIS RISK: >1000 MG/DL

LDL Cholesterol 82 mg/dL (25-100)

Interpretation:

A level GREATER THAN 100 MG/DL is HIGH and is considered a MAJOR RISK FACTOR because it INCREASES YOUR RISK for developing HEART DISEASE.

Further Interpretation information is available in Patient Instructions

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Inquiry.**Lipid Profile on 15 Sep 2009**

Collection Date: 15 Sep 2009

Site/Specimen: PLASMA

Ordering Clinician: GUNTER, ROGER WILLIAM

Comment: tmw

Chem

Name	Value	Units	Range	Abnormal
Cholesterol	190	mg/dL	(25-199)	
Interpretation: DESIRABLE: <200 MG/DL BORDERLINE: 200-239 MG/DL HIGH: =>240 MG/DL				

HDL Cholesterol	56	mg/dL
------------------------	----	-------

Interpretation:

A level LESS THAN 40 MG/DL is LOW and is considered a MAJOR RISK FACTOR because it INCREASES YOUR RISK for developing HEART DISEASE. HDL levels of 60 MG/DL OR MORE help to LOWER YOUR RISK FOR HEART DISEASE.

Triglyceride	221	mg/dL	(20-150)	Higher Than Normal
Interpretation: DESIRABLE: < 150 MG/DL BORDERLINE HIGH: 150-199 MG/DL + HIGH: =>200 MG/DL PANCREATITIS RISK: >1000 MG/DL				

LDL Cholesterol	90	mg/dL	(25-100)
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Interpretation:

A level GREATER THAN 100 MG/DL is HIGH and is considered a MAJOR RISK FACTOR because it INCREASES YOUR RISK for developing HEART DISEASE. Further Interpretation information is available in Patient Instructions Inquiry.

Chlamydia+Gonococcus DNA Panel NAAT on 20 Aug 2009

Collection Date: 20 Aug 2009

Site/Specimen: URETHRA

Ordering Clinician: HEDARIA, ELIZABETH A

Comment:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Chem

Name	Value	Units	Range	Abnormal
Neisseria gonorrhoeae DNA	NEGATIVE		NEGATIVE	
Interpretation: INTERPRETATION(S): NAAT : Nucleic acid amplification test ****POSITIVE RESULT INTERPRETATION**** <p>The 2006 CDC guidelines recommend that all positive Chlamydia and GC tests be confirmed using a different nucleic acid target. A positive result will only be reported if both the screening test and the confirmatory test are positive. A positive screen that confirms negative will be reported as negative.</p> <p>This test is not approved for treatment of cure confirmation. As is true for all non-culture methods, a positive specimen obtained from a patient after therapeutic treatment cannot be interpreted as indicating the presence of viable C. trachomatis or N. gonorrhoeae.</p> <p>****NEGATIVE RESULT INTERPRETATION**** A negative result does not preclude presence of C. trachomatis or N. gonorrhoeae infection because results are dependent on adequate specimen collection, absence of inhibitors, and sufficient rRNA to be detected. Test results may be affected by improper specimen storage.</p> <p>Notifiable result/condition for Local/State PH department, notify your local military public health immediately for proper notification.</p>				
Chlamydia trachomatis DNA	NEGATIVE		NEGATIVE	

Rapid Plasma Reagin on 20 Aug 2009

Collection Date:

20 Aug 2009

Site/Specimen:

SERUM

Ordering Clinician:

HEDARIA, ELIZABETH A

Comment:

Chem

Name	Value	Units	Range	Abnormal
Reagin Ab	NON-REACTIVE			

Methicillin Resistant Staphylococcus aureus Culture on 01 Feb 2007

Collection Date:

01 Feb 2007

Site/Specimen:

Nasal Cavity

Ordering Clinician:

SORTOR, BRETT V

Comment:

Order #	070201-01796
Filler #	070201 BA 3312
Ordering Provider	SORTOR, BRETT V

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Priority	ROUTINE
DATE ORDERED	20070201113600
DATE RESULTED	20070203143607
COLLECT_SAMPLE	SWAB
Order Comment	recurrent abscesses
BACTERIOLOGY RESULT	NO METHICILLIN RESISTANT STAPH AUREUS ISOLATED.
Results	Final report

CBC W/Diff on 29 Nov 2005

Collection Date: 29 Nov 2005

Site/Specimen: BLOOD

Ordering Clinician: FRANKLIN, MALCOM B

Comment:

Chem

Name	Value	Units	Range	Abnormal
Hemoglobin	13.1	g/dL	13.2-17.0	Lower Than Normal
WBC	12.90	x10(9)/L	3.4-10.8	Higher Than Normal
RBC	4.42	x10(12)/L	4.2-5.6	
Hematocrit	38.0	%	38.1-49.3	Lower Than Normal
RDW CV	10.3	%	9.8-12.8	
MCV	86.1	fL	80-100	
MCH	29.7	pg	27-31	
MCHC	34.5	g/dL	31-36	
MPV	7.8	fL	7.4-10.4	
Platelets	358	x10(9)/L	130-400	
Lymphocytes	7.2	%	12.4-46	Lower Than Normal
Monocytes	6.6	%	4-14.6	
Neutrophils	85.1	%	43.3-74.3	Higher Than Normal
Basophils	0.361	%	0-2	
Eosinophils	0.7	%	0-3.3	
ABS Neutrophils	10.90	x10(9)/L	1.0-7.5	Higher Than Normal
ABS Lymphocytes	0.93	x10(9)/L	0.9-3.0	
ABS Monocytes	0.85	x10(9)/L	0.2-1.0	
ABS Eosinophils	0.09	x10(9)/L	.0-.40	
ABS Basophils	0.046	x10(9)/L	.0-.20	

Bleeding Time on 22 Nov 2005

Collection Date: 22 Nov 2005

Site/Specimen: BLOOD

Ordering Clinician: ARTATES, NEMESIA F

Comment:

Chem

Name	Value	Units	Range	Abnormal
Bleeding Time	7.5	min	2.5-8	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Protime Panel on 22 Nov 2005

Collection Date: 22 Nov 2005
 Ordering Clinician: ARTATES, NEMESIA F
 Comment:
 Chem

Site/Specimen: PLASMA

Name	Value	Units	Range	Abnormal
INR	1.063		0.81-1.197	
Protime	13.00	Sec	9.7-13.9	

APTT on 22 Nov 2005

Collection Date: 22 Nov 2005
 Ordering Clinician: ARTATES, NEMESIA F
 Comment:
 Chem

Site/Specimen: PLASMA

Name	Value	Units	Range	Abnormal
APTT	38.00	Sec	21.1-40.7	

CBC W/Diff on 22 Nov 2005

Collection Date: 22 Nov 2005
 Ordering Clinician: ARTATES, NEMESIA F
 Comment:
 Chem

Site/Specimen: BLOOD

Name	Value	Units	Range	Abnormal
RDW CV	10.0	%	9.8-12.8	
WBC	6.12	x10(9)/L	3.4-10.8	
RBC	4.67	x10(12)/L	4.2-5.6	
Hematocrit	40.0	%	38.1-49.3	
Hemoglobin	14.1	g/dL	13.2-17.0	
MCV	85.6	fL	80-100	
MCH	30.2	pg	27-31	
MCHC	35.3	g/dL	31-36	
MPV	7.3	fL	7.4-10.4	Lower Than Normal
Platelets	408	x10(9)/L	130-400	Higher Than Normal
Lymphocytes	23.0	%	12.4-46	
Monocytes	7.2	%	4-14.6	
Neutrophils	67.7	%	43.3-74.3	
Basophils	0.662	%	0-2	
Eosinophils	1.5	%	0-3.3	
ABS Eosinophils	0.09	x10(9)/L	.0-.40	
ABS Neutrophils	4.14	x10(9)/L	1.0-7.5	
ABS Lymphocytes	1.41	x10(9)/L	0.9-3.0	
ABS Monocytes	0.44	x10(9)/L	0.2-1.0	
ABS Basophils	0.041	x10(9)/L	.0-.20	

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Amylase on 19 Nov 2005

Collection Date: 19 Nov 2005
 Ordering Clinician: DINKEL, TROY A
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Amylase	44	IU/L	30-110	

Liver Function Panel on 19 Nov 2005

Collection Date: 19 Nov 2005
 Ordering Clinician: DINKEL, TROY A
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Protein	8.2	mg/dL	6.3-8.2	
Albumin	4.6	mg/dL	3.9-5.1	
Alkaline Phosphatase	75	U/L	38-126	
Aspartate Aminotransferase	26	U/L	5-40	
Alanine Aminotransferase	28	U/L	7-56	
Gamma-Glutamyl Transferase	17	U/L	8-78	
Lactate Dehydrogenase	495	U/L	313-618	
Bilirubin	0.4	mg/dL	0.2-1.3	
Bilirubin Direct	0.0	mg/dL	0.0-0.4	
Globulin	3.6	g/dL	2.4-3.5	Higher Than Normal
Albumin/Globulin	1.3		1.1-2.2	

Lipase on 19 Nov 2005

Collection Date: 19 Nov 2005
 Ordering Clinician: DINKEL, TROY A
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Triacylglycerol Lipase	66	U/L	23-230	

Basic Metabolic Panel on 19 Nov 2005

Collection Date: 19 Nov 2005
 Ordering Clinician: DINKEL, TROY A
 Comment:
 Chem

Site/Specimen: SERUM

Name	Value	Units	Range	Abnormal
Glucose	101	mg/dL	75-110	
Urea Nitrogen	13	mg/dL	9-21	
Creatinine	.9	mg/dL	0.8-1.5	

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Sodium	140	mmol/L	137-145
Potassium	4.1	mmol/L	3.6-5.0
Chloride	102	mmol/L	98-107
Carbon Dioxide	29.4	mmol/L	22-40
Urea Nitrogen/Creatinine	14.7	mg/dL	7-25
Anion Gap	12	mmol/L	10-20
GFR	114	mL/min	>=90

Interpretation:

A result of "0" (zero) for ages 17 and under is the same as not performed.

Reference Values:

>=90 = Normal GFR

60-89 = Mildly decreased GFR

30-59 = Moderately decreased GFR

15-29 = Severely decreased GFR

<15 = Kidney Failure

This is an estimated GFR only. The value has been derived from the modified MDRD equation: $GFR = 270 \times \text{serum creatinine}^{-1.007} \times \text{age}^{-0.180} \times BUN^{-0.169} (x0.755 \text{ if female})$. Values for African Americans should be adjusted by multiplying by 1.18. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. If a more accurate estimation is required, consider obtaining a Nuclear Medicine GFR determination or Nephrology consultation.

CBC W/Diff on 19 Nov 2005

Collection Date: 19 Nov 2005
Ordering Clinician: DINKEL, TROY A

Site/Specimen: BLOOD

Comment:

Chem

Name	Value	Units	Range	Abnormal
MCV	85.0	fL	80-100	
WBC	8.98	x10(9)/L	3.4-10.8	
RBC	4.68	x10(12)/L	4.2-5.6	
Hematocrit	39.8	%	38.1-49.3	
Hemoglobin	14.4	g/dL	13.2-17.0	
MCH	30.8	pg	27-31	
MCHC	36.3	g/dL	31-36	Higher Than Normal
RDW CV	10.1	%	9.8-12.8	
MPV	7.8	fL	7.4-10.4	
Platelets	105	x10(9)/L	130-400	Lower Than

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

				Normal
Lymphocytes	15.0	%	12.4-46	
Monocytes	3.9	%	4-14.6	Lower Than Normal
Neutrophils	79.5	%	43.3-74.3	Higher Than Normal
Basophils	0.388	%	0-2	
Eosinophils	1.2	%	0-3.3	
ABS Neutrophils	7.14	x10(9)/L	1.0-7.5	
ABS Lymphocytes	1.35	x10(9)/L	0.9-3.0	
ABS Monocytes	0.35	x10(9)/L	0.2-1.0	
ABS Eosinophils	0.10	x10(9)/L	.0-.40	
ABS Basophils	0.035	x10(9)/L	.0-.20	

Leukocyte Esterase on 03 Nov 2005

Collection Date:

03 Nov 2005

Site/Specimen:

VOIDED URINE

Ordering Clinician:

PADILLA, EDEN U

Comment:

Chem

Name	Value	Units	Range	Abnormal
Leukocyte Esterase	NEGATIVE			
Interpretation: THIS IS A LEUKOCYTE ESTERASE SCREEN NOT SPECIFIC FOR CHLAMYDIA.				

HIV-1 Ab on 03 Nov 2005

Collection Date:

03 Nov 2005

Site/Specimen:

SERUM

Ordering Clinician:

PADILLA, EDEN U

Comment:

Chem

Name	Value	Units	Range	Abnormal
HIV-1 Ab	Negative			

Glucose on 03 Nov 2005

Collection Date:

03 Nov 2005

Site/Specimen:

SERUM

Ordering Clinician:

PADILLA, EDEN U

Comment:

Chem

Name	Value	Units	Range	Abnormal
Glucose	96	mg/dL	75-110	

Varicella Virus Ab on 03 Nov 2005

Collection Date:

03 Nov 2005

Site/Specimen:

SERUM

Ordering Clinician:

PADILLA, EDEN U

Comment:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Chem

Name	Value	Units	Range	Abnormal
Varicella Zoster Virus Ab	IMMUNE			

1523 Inprocessing Panel on 03 Nov 2005

Collection Date:

03 Nov 2005

Site/Specimen:

BLOOD

Ordering Clinician:

PADILLA, EDEN U

Comment:

Chem

Name	Value	Units	Range	Abnormal
Sickle Cell Screen	NEGATIVE			
Glucose-6-Phosphate Dehydrogenase	NORMAL			
ABO Group	O			
Rh Type	POSITIVE			
Reagin Ab	NON-REACTIVE			

***** End of Resulted Labs *****

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Radiology

Chest PA And Lateral Upright Series Report on 22 Jun 2016

Procedure: Chest PA And Lateral Upright Series Report
Order Comment:
Reason for Order:
Exam #: 16227558
Exam Date/Time: 22 Jun 2016 12:38:00
Transcription Date/Time: 22 Jun 2016 13:08:00
Provider: WEATHERS, BRUCE KENT
Requesting Location: EMERGENCY RM BE WRNMMC BETHESDA, MD
Status: COMPLETE
Result Code:
Interpreted By: LUTYNSKI, MATTHEW LEO
Approved By: LUTYNSKI, MATTHEW LEO
Approved Date: 22 Jun 2016 13:08:00

Report Text

HISTORY: r/o abnormality

TECHNIQUE: Upright, PA and lateral chest radiographs. Two views.

COMPARISON: None.

FINDINGS: Lungs: Lungs are clear.

Pleura: No pleural effusion or visible pneumothorax.

Heart / Mediastinum: Within normal limits.

Upper Abdomen: Within normal limits.

Bones and Soft Tissues: No acute osseous abnormality.

IMPRESSION: Normal chest radiographs. _____

Electronically signed by: Dr. MATTHEW LEO LUTYNSKI Department of Radiology Walter Reed National Military Medical Center

Date: 06/22/16 Time: 13:08

MRI Brain With And Without Contrast Report on 15 Apr 2016

Procedure: MRI Brain With And Without Contrast Report
Order Comment:
Reason for Order:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Exam #: 16131283
 Exam Date/Time: 15 Apr 2016 04:48:00
 Transcription Date/Time: 15 Apr 2016 08:18:00
 Provider: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE WRNMMC BETHESDA, MD
 Status: COMPLETE
 Result Code:
 Interpreted By: DEMARCO, JAMES K
 Approved By: DEMARCO, JAMES K
 Approved Date: 15 Apr 2016 08:18:00

Report Text

Brain MRI without and with gadolinium: 04/15/16 04:48:00.

History: 31 y/o M with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad.

Technique: Sagittal T1, axial and coronal T2, axial T2 FLAIR, axial DWI, axial GRE, axial T1, axial post T1 FS, coronal post 3D SPGR of the brain. A total of 16 mL of ProHance was given intravenously as part of the study.

FINDINGS: No focal mass lesion or abnormal enhancement along the expected course of either olfactory bulb or groove is seen. There is normal appearance of both olfactory bulb and nerves.

Acute: No hemorrhage, herniation, or hydrocephalus. No evidence of acute ischemia.

Brain: Brain parenchyma is within normal limits in signal and volume for age.

Vessels: No abnormal intravascular signal to suggest thrombosis. There is note of a tubular enhancing structure posteriorly in the left cerebellar hemisphere compatible with an incidental developmental venous anomaly

Bones: No suspicious lesion in the calvarium or skull base.

Other: Extracranial soft tissues are unremarkable.

IMPRESSION:

1. No enhancing mass lesions along the expected course of either olfactory bulb or groove is seen. Both olfactory bulbs and nerves appear to be normally developed.

2. No intracranial pathology. No abnormal enhancement. _____

Electronically signed by: Demarco Department of Radiology Walter Reed National Military Medical Center

Date: 04/15/16 Time: 08:18

Left Ankle (3 Views) Series Report on 16 Feb 2016

Procedure: Left Ankle (3 Views) Series Report
 Order Comment:
 Reason for Order:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Exam #: 16054521
 Exam Date/Time: 16 Feb 2016 14:10:00
 Transcription Date/Time: 16 Feb 2016 14:55:00
 Provider: WILSON, BRYAN JAMES
 Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
 Status: COMPLETE
 Result Code:
 Interpreted By: FISHER, ZACHARY ETHAN
 Approved By: FISHER, ZACHARY ETHAN
 Approved Date: 16 Feb 2016 14:54:00

Report Text

Comparison: MRI October 5, 2014 and prior radiographs May 6, 2014

Findings: Routine radiographs of the ankle were obtained. Normal alignment is present without evidence for acute fracture or dislocation. There is mild lateral soft tissue swelling present. The ankle mortise and talar dome are intact. The joint spaces are preserved without significant degenerative changes.

Impression: Lateral soft tissue swelling without evidence for acute bony abnormality

Electronically signed by: Dr. ZACHARY ETHAN FISHER Department of Radiology Walter Reed National Military Medical Center

Date: 02/16/16 Time: 14:54

MRI Left Foot Report on 05 Oct 2014

Procedure: MRI Left Foot Report
 Order Comment:
 Reason for Order:
 Exam #: 14327819
 Exam Date/Time: 05 Oct 2014 14:43:00
 Transcription Date/Time: 06 Oct 2014 15:51:00
 Provider: AUSTIN, MARIE
 Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
 Status: COMPLETE
 Result Code:
 Interpreted By: LUTYNSKI, MATTHEW LEO
 Approved By: LUTYNSKI, MATTHEW LEO
 Approved Date: 06 Oct 2014 15:52:00

Report Text

HISTORY: Continuous pain following injury

COMPARISONS: Left foot and ankle radiographs dated 5/6/14

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

TECHNIQUE: WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS: ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons: Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments: Syndesmotic ankle ligaments: within normal limits.

Low lateral ankle ligaments: The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT: Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments: Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae: No evidence of Morton's neuroma or intermetatarsal bursitis.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION: Findings suggestive of prior lateral ankle sprain. _____

Electronically signed by resident: Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time:14:23

Electronically signed by:FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military Medical Center

Date: 10/06/14 Time:15:52

MRI Left Ankle Report on 05 Oct 2014

Procedure:	MRI Left Ankle Report
Order Comment:	
Reason for Order:	
Exam #:	14327823
Exam Date/Time:	05 Oct 2014 14:43:00
Transcription Date/Time:	06 Oct 2014 15:51:00
Provider:	AUSTIN, MARIE
Requesting Location:	INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
Status:	COMPLETE
Result Code:	
Interpreted By:	LUTYNSKI, MATTHEW LEO
Approved By:	LUTYNSKI, MATTHEW LEO
Approved Date:	06 Oct 2014 15:52:00

Report Text

HISTORY: Continuous pain following injury

COMPARISONS: Left foot and ankle radiographs dated 5/6/14

TECHNIQUE: WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS: ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons: Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments: Syndesmotic ankle ligaments: within normal limits.

Low lateral ankle ligaments: The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT: Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments: Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae: No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION: Findings suggestive of prior lateral ankle sprain. _____

Electronically signed by resident: Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time:14:23

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Electronically signed by: FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military Medical Center

Date: 10/06/14 Time: 15:52

Left Ankle (3 Views) Series Report on 06 May 2014

Procedure: Left Ankle (3 Views) Series Report
 Order Comment: with weight bearing
 left lateral ankle pain and swelling 2 weeks following a sprained ankle, re-evaluate for fracture
 Reason for Order: fracture
 Exam #: 14151527
 Exam Date/Time: 06 May 2014 15:03:00
 Transcription
 Date/Time: 06 May 2014 16:05:00
 Provider: UDE, ASSUMPTA O
 Requesting Location: AMHM01AREDKI KIMBROUGH ACC
 Status: COMPLETE
 Result Code: SEE RADIOLOGIST'S REPORT
 Interpreted By: MUNTER, FLETCHER M
 Approved By: MUNTER, FLETCHER M
 Approved Date: 06 May 2014 15:58:00

Report Text

CHCS 14151527

History: Ankle sprain 2 weeks ago.

Technique: 3 images of the left ankle were performed.

FINDINGS: No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. There is mild lateral swelling.

IMPRESSION: No fractures demonstrated.

Left Foot (3 Views) Weight Bearing Series Report on 06 May 2014

Procedure: Left Foot (3 Views) Weight Bearing Series Report
 Order Comment: NO BRIEF COMMENT
 Reason for Order: left foot pain x 2 weeks following a recent injury, re-evaluate for fracture
 Exam #: 14151531
 Exam Date/Time: 06 May 2014 15:03:00
 Transcription Date/Time: 06 May 2014 16:04:00
 Provider: UDE, ASSUMPTA O
 Requesting Location: AMHM01AREDKI KIMBROUGH ACC

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Status: COMPLETE
Result Code: SEE RADIOLOGIST'S REPORT
Interpreted By: MUNTER, FLETCHER M
Approved By: MUNTER, FLETCHER M
Approved Date: 06 May 2014 15:57:00

Report Text

CHCS 14151531

History: Left foot pain for 2 weeks.

Technique: AP and lateral weight-bearing images of the left foot were performed.

FINDINGS: No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. No soft tissue abnormality is identified.

IMPRESSION: Normal left foot.

Left Foot (3 Views) Series Report on 19 Apr 2014

Procedure: Left Foot (3 Views) Series Report
Order Comment:
Reason for Order:
Exam #: 14130311
Exam Date/Time: 19 Apr 2014 15:42:00
Transcription Date/Time: 20 Apr 2014 19:41:00
Provider: PIRRI, MICHAEL P
Requesting Location: EMERGENCY RM BE WRNMMC BETHESDA, MD
Status: COMPLETE
Result Code:
Interpreted By: NIELSEN, NATHAN S
Approved By: ABAN, KENRIC T
Approved Date: 20 Apr 2014 19:40:00

Report Text

History: Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique: Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident: Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Electronically signed by:Dr. Kenric T Aban Date: 04/20/14 Time:19:40

Left Ankle (3 Views) Series Report on 19 Apr 2014

Procedure:	Left Ankle (3 Views) Series Report
Order Comment:	
Reason for Order:	
Exam #:	14130312
Exam Date/Time:	19 Apr 2014 15:42:00
Transcription Date/Time:	20 Apr 2014 19:41:00
Provider:	PIRRI, MICHAEL P
Requesting Location:	EMERGENCY RM BE WRNMMC BETHESDA, MD
Status:	COMPLETE
Result Code:	
Interpreted By:	NIELSEN, NATHAN S
Approved By:	ABAN, KENRIC T
Approved Date:	20 Apr 2014 19:40:00

Report Text

History: Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique: Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident: Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Electronically signed by: Dr. Kenric T Aban Date: 04/20/14 Time: 19:40**MRI - Abdomen Report on 02 Nov 2012**

Procedure: MRI - Abdomen Report
Order Comment:
Reason for Order:
Exam #: 12359730
Exam Date/Time: 02 Nov 2012 07:18:00
Transcription Date/Time: 05 Nov 2012 09:56:00
Provider: COPSEY, HELEN C
Requesting Location: GSURG GI APU BE WRNMMC BETHESDA, MD
Status: COMPLETE
Result Code:
Interpreted By: MOLLURA, JOSEPH G
Approved By: JAVITT, MARCIA C
Approved Date: 05 Nov 2012 09:48:00

Report Text

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12 Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

Acute Abdomen Series Report on 10 Oct 2012

Procedure:	Acute Abdomen Series Report
Order Comment:	
Reason for Order:	
Exam #:	12343890
Exam Date/Time:	10 Oct 2012 22:58:00
Transcription Date/Time:	12 Oct 2012 07:26:00
Provider:	PUTKO, ROBERT M
Requesting Location:	BREAST CARE BE WRNMMC BETHESDA, MD
Status:	COMPLETE
Result Code:	
Interpreted By:	MOLLURA, JOSEPH G
Approved By:	BERNARD, JACQUELINE M
Approved Date:	12 Oct 2012 07:24:00

Report Text

ADDITIONAL HISTORY: Subxiphoid pain and associated thoracic back pain x 1 day.

TECHNIQUE: PA chest radiograph, supine and erect AP radiographs of the abdomen and pelvis.

COMPARISONS: None available..

FINDINGS:

Lungs are adequately inflated. No focal airspace consolidation. No pneumothorax or pleural effusion. Cardiomedial silhouette and pulmonary vascular markings are normal.

Relative paucity of bowel gas with several differential air-fluid levels. No dilated or distended loops. Air and stool visualized within the ascending and distal large bowel. No pneumatosis or pneumoperitoneum. No pathologic calcifications noted. Osseous structures are intact and appropriate for age.

IMPRESSION:

1. Nonspecific nonobstructive bowel gas pattern.
2. No acute cardiopulmonary findings. _____

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12 Time:07:22

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Electronically signed by: Dr. Jacqueline M Bernard Date: 10/12/12 Time: 07:24

CT Abdomen/Pelvis With Contrast Report on 11 Oct 2012

Procedure: CT Abdomen/Pelvis With Contrast Report
Order Comment:
Reason for Order:
Exam #: 12343907
Exam Date/Time: 11 Oct 2012 00:30:00
Transcription Date/Time: 12 Oct 2012 07:00:00
Provider: HARDWARE, LESLIE
Requesting Location: EMERGENCY RM BE WRNMMC BETHESDA, MD
Status: COMPLETE
Result Code:
Interpreted By: MOLLURA, JOSEPH G
Approved By: BERNARD, JACQUELINE M
Approved Date: 11 Oct 2012 08:16:00

Report Text

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12 Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12 Time:08:16

CT Abdomen/Pelvis With Contrast Report on 23 Nov 2005

Procedure:	CT Abdomen/Pelvis With Contrast Report
Order Comment:	NO BRIEF COMMENT
Reason for Order:	20y/o male dot 2-5 with intermittent abdominal pain x 4-5 years with rectal
Exam #:	05050343
Exam Date/Time:	23 Nov 2005 09:26:00
Transcription Date/Time:	29 Nov 2005 10:02:00
Provider:	ARTATES, NEMESIA F
Requesting Location:	COURAGE (WHITE) 1007 NBHC 1007/1017
Status:	COMPLETE
Result Code:	SEE RADIOLOGIST'S REPORT
Interpreted By:	MARINBERG, BORIS V
Approved By:	MARINBERG, BORIS V
Approved Date:	29 Nov 2005 12:25:00

Report Text

ba/DICTATION DATE: 23 November 2005

CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST:

Technique: 7.5 mm cross-sectional images of the abdomen and pelvis were obtained following oral and intravenous introduction of contrast.

Findings: There is a normal appearance of the liver, spleen, and pancreas. There is no gallstones. No dilatation of biliary ducts or pancreatic duct identified. There is no enlargement of the adrenal glands. There is no hydronephrosis. No renal stones are seen. There is no lymphadenopathy. No abnormal collection of fluid in the abdomen or pelvis identified. Moderate amount of fecal material noted throughout the colon. There is no changes of appendicitis. No aneurysmal dilatation of the abdominal aorta noted. There is no signs of bowel obstruction.

IMPRESSION: NORMAL COMPUTED TOMOGRAPHY OF THE ABDOMEN AND PELVIS.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

MODERATE AMOUNT OF FECAL MATERIAL THROUGHOUT THE COLON.

Acute Abdomen Series Report on 19 Nov 2005

Procedure: Acute Abdomen Series Report
Order Comment: NO BRIEF COMMENT
Reason for Order: ABD
Exam #: 05050057
Exam Date/Time: 19 Nov 2005 04:18:00
Transcription Date/Time: 23 Nov 2005 14:16:00
Provider: DINKEL, TROY A
Requesting Location: EMERGENCY MEDICAL CARE 200H NH GREAT LAKES, 200H
Status: COMPLETE
Result Code: SEE RADIOLOGIST'S REPORT
Interpreted By: KAMENETSKY, ALEX
Approved By: KAMENETSKY, ALEX
Approved Date: 23 Nov 2005 14:51:00

Report Text

djk/Dictated 11-20-2005

ABDOMEN OBSTRUCTIVE SERIES:

Views of the abdomen demonstrate a normal bowel-gas pattern. Pneumoperitoneum is not present. The psoas shadows are adequately visualized. There is no evidence of intra-abdominal mass or significant calcifications. The visualized osseous structures show no abnormality. The heart and lungs are normal

IMPRESSION: NORMAL OBSTRUCTIVE SERIES OF THE ABDOMEN.

CT Abdomen/Pelvis Without Contrast Report on 19 Nov 2005

Procedure: CT Abdomen/Pelvis Without Contrast Report
Order Comment: NO BRIEF COMMENT
Reason for Order: KIDNEY STONE PROTOCOL
Exam #: 05050058
Exam Date/Time: 19 Nov 2005 04:28:00
Transcription Date/Time: 23 Nov 2005 13:43:00
Provider: DINKEL, TROY A
Requesting Location: EMERGENCY MEDICAL CARE 200H NH GREAT LAKES, 200H
Status: COMPLETE
Result Code: SEE RADIOLOGIST'S REPORT
Interpreted By: KAMENETSKY, ALEX
Approved By: KAMENETSKY, ALEX
Approved Date: 23 Nov 2005 14:51:00

Report Text

djk/Dictated 11-19-2005

CT OF THE ABDOMEN AND PELVIS:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Examination is limited due to lack of IV or oral contrast.

As visualized, the liver, spleen, pancreas, abdominal aorta and both kidneys are intact. No evidence of renal stones or hydronephrosis is seen. The gallbladder is moderately distended.

Substantial amount of fecal matter is noted in the colon. No obvious inflammatory changes, masses or abnormal fluid collections are seen in the abdomen.

Imaging into the pelvic shows a large amount of fecal matter within the distal colon. The urinary bladder is intact.

IMPRESSION: NO CLEAR INDICATION OF ACUTE INTRA-ABDOMINAL ABNORMALITY.

SIGNIFICANT AMOUNT OF FECAL MATTER IS NOTED IN THE COLON.

OTHER FINDINGS AS DESCRIBED.

Acute Abdomen Series Report on 10 Nov 2005

Procedure:	Acute Abdomen Series Report
Order Comment:	NO BRIEF COMMENT
Reason for Order:	pain in lower abd. across umbilical area from r-l
Exam #:	05048946
Exam Date/Time:	10 Nov 2005 15:25:00
Transcription Date/Time:	16 Nov 2005 05:28:00
Provider:	MADAMBA, LUNINGNING G
Requesting Location:	COURAGE (WHITE) 1007 NBHC 1007/1017
Status:	COMPLETE
Result Code:	SEE RADIOLOGIST'S REPORT
Interpreted By:	NAUGLE, DAVID K
Approved By:	NAUGLE, DAVID K
Approved Date:	17 Nov 2005 14:37:00

Report Text

ba/DICTATION DATE: 14 November 2005

ACUTE ABDOMINAL SERIES:

Reason: 20 year old male with lower abdominal pain.

Comparison studies: None.

Findings: Single frontal view of the chest reveals normal cardiac and mediastinal silhouette. Lungs are clear without infiltrate, effusion, mass, or pneumothorax. Remaining bones and soft tissues are otherwise unremarkable. No free air is seen under the diaphragm.

Frontal views of the supine and upright abdomen reveal no dilated loops of bowel or abnormal air fluid levels. No abnormal calcifications or masses are seen. Remaining bones and soft tissues are otherwise unremarkable.

IMPRESSION: NO EVIDENCE OF ACUTE PULMONARY PROCESS.

NORMAL BOWEL GAS PATTERN.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

***** End of Radiology *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Immunizations

Vaccine	Series	VISVersion	Date	Manufacturer	Lot No.	Dose/Site	Exemption	Administered By
Influenza Split (Injectable - preservative free)	0		14 Dec 2016	SmithKline	92D9J	/	None	
Influenza Split (Injectable - preservative free)	0		05 Oct 2015	CSL Biotherapies, Inc.	UNK	/	None	
Influenza, live, intranasal, quadrivalent	0		14 Oct 2014	Unknown	CK2008	/	None	
Influenza Split (Injectable)	0		26 Nov 2013			/	None	
Meningococcal MCV4P	1	10/14/11	05 Aug 2013	Sanofi Pasteur	U4575BA	.5 mL/Right Arm	None	WRAY, KIM D
Meningococcal MPSV4	0		05 Aug 2013	Sanofi Pasteur	U4575BA	/	None	
IPPD	0		19 Mar 2013	Other	293239	.1 mL/Left Arm	None	WRAY, KIM D
Td (adult), adsorbed	0		19 Mar 2013	Sanofi Pasteur	U4422AA	/	None	
Tdap	1	01/24/12	19 Mar 2013	Sanofi Pasteur	U4422AA	.5 mL/Left Arm	None	WRAY, KIM D
Typhoid, ViCPs	1	05/29/12	19 Mar 2013	Sanofi Pasteur	H1481	.5 mL/Right Arm	None	WRAY, KIM D
Influenza, Live, Intranasal	0		24 Oct 2012	CSL Biotherapies, Inc.	AH2139	/	None	
Influenza, whole	1		02 Nov 2011	Sanofi Pasteur	ut423aa	.5 mL/Unknown	None	GRIMM, CHRISTOPHER T
Influenza, Live, Intranasal	0		15 Nov 2010	Transcribed	501061P	.25 mL/Intranasal	None	DAYS, LATAJIA W
IPPD	0		17 Mar 2010	Transcribed	TRANSCRIBE D	/Unknown	None	THOMAS, JOSHUA L
Anthrax	5		09 Mar 2010	Emergent BioDefense Operations Lansing	TRANSCRIBE D	/Unknown	None	THOMAS, JOSHUA L
Novel influenza-H1N1-09	0		22 Dec 2009	Novartis Pharmaceutical Corp.	104040P1	.5 mL/Left Arm	None	LINVILLE, TREVOR S
Influenza, Live, Intranasal	0		23 Sep 2009	MedImmune, Inc.	500719P	/	None	
Influenza, whole	0		23 Sep 2009	MedImmune, Inc.	500719P	.25 mL/Intranasal	None	LINVILLE, TREVOR S
Anthrax	4		05 May 2008	Unknown	UNK	/	None	
Typhoid -	0		19	Unknown	UNKNOWN	/	None	

Merwin, Daniel Dennis

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Parenteral		Feb 2008				
Influenza, unspecified formulation	0	16 Jan 2008	Unknown	UNKNOWN	/	None
Anthrax	3	13 Nov 2007	Other	FAV114	/	None
Anthrax	2	20 Oct 2007	Other	FAV114	/	None
Anthrax	1	01 Oct 2007	Other	FAV114	/	None
Hep A (Adult)	0	02 Apr 2007			/	Not Req
Hep B, adolescent or pediatric	0	02 Apr 2007			/	Not Req
Influenza, unspecified formulation	0	12 Nov 2006	Other	AFLUA219BA	/	None
Typhoid - Parenteral	0	14 Apr 2006	Unknown	UNKNOWN	/	None
Hep A (Adult)	2	14 Dec 2005	Unknown	UNKNOWN	/	None
Hep A-Hep B	1	14 Dec 2005	Other	AHABB043BA	/	None
Hep B - Adult	2	14 Dec 2005	Unknown	UNKNOWN	/	None
Yellow Fever	1	14 Dec 2005	Other	UE351AA	/	None
Hep A (Adult)	1	08 Nov 2005	Unknown	UNKNOWN	/	None
Hep A-Hep B	1	08 Nov 2005	Other	AHABB043BA	/	None
Hep B - Adult	1	08 Nov 2005	Unknown	UNKNOWN	/	None
Influenza, Split (incl. purified surface antigen)	0	08 Nov 2005	Other	U1911AA	/	None
IPV	1	08 Nov 2005	Other	Y0535	/	None
Meningococcal MPSV4	1	08 Nov 2005	Other	UE359AA	/	None
MMR	1	08 Nov 2005	Merck	0298R	/	None
Td (adult), adsorbed	1	08 Nov 2005	Other	U1586BA	/	None
Influenza, unspecified formulation	1	01 Nov 2005	MedImmune, Inc.	500388P	/	None

***** End of Immunizations *****

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Previous Encounters***14 Aug 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN***

Encounter ID: BETH-29328694 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **14 Aug 2017 1500 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 15 Aug 2017 1545 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 11
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: CBT****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he received updated IOP start date that is command approved. Patient is looking forward to this. Therapist and patient discussed this further. Patient stated that he received a call from MEB lawyer regarding his case. Patient will follow up as needed with lawyer. He stated that he is going to additional GI appointments to try other treatments. Further conversation focused on patient's isolation. He stated that he feels better staying at home and to himself as he's afraid of making mistakes or being misunderstood. Therapist and patient discussed how recent events have made the patient mistrust himself. Therapist and patient discussed next steps. He stated that he wants to focus on building his family relationships and identified ways that he is strengthening those bonds. Patient is identifying future oriented plans. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

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Created: 16 Aug 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance:	Limited
Resilience:	Yes
Good Reality Testing:	Yes

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DoD ID: 1286180538

Created: 16 Aug 2017

Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High
 Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Merwin, Daniel Dennis

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 15 Aug 2017 1547 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

3. Alcohol dependence, uncomplicated

Procedure(s):

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 15 Aug 2017 1548 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 15 Aug 2017 1548

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

14 Aug 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29304076 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **14 Aug 2017 1006 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **DELSESTO, BARBARA SUE**

Call Back Phone: [REDACTED]

AutoCites Refreshed by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT

Allergies

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. #0 RF0	NR	09 Aug 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY DAY #0 RF1	1 of 1	09 Aug 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Telephone Consult: Written by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT
 Case Management

Telephone Consult Comments: Written by DELSESTO, BARBARA @ 14 Aug 2017 1006 EDT
 IOP coordination

S/O Note Written by DELSESTO, BARBARA SUE @ 14 Aug 2017 1014 EDT

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Subjective

Spoke with Ms. Lisa Banks-Williams at the Intensive Outpatient Program and received a new start date for this patient for 29 August at 0700. Patient accepted this date and verbalized an understanding to call CM if any issue comes up. Dr. Paul and patient's Command also informed of the new date- CDR Yusko. All parties have CM information.

A/P Written by DELSESTO, BARBARA @ 14 Aug 2017 1014 EDT

1. Encounter for other administrative examinations

Disposition Written by DELSESTO, BARBARA @ 14 Aug 2017 1014 EDT

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 14 Aug 2017 1014

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

10 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29272515 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **10 Aug 2017 0801 EDT**
Clinic: **ATS ADULT BE**

Appt Type: **T-CON***
Provider: **HANGEMANOLE, DESPINA C**

Call Back Phone: [REDACTED]

S/O Note Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0803 EDT

Subjective

Tcon with client to notify him of PCS intake date. Intake will be on 29 August and client was aligned with this date. SM also agreed to check in with Patrick Deleon while this writer is on leave next week.

A/P Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0805 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1

Disposition Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0805 EDT

Follow up: as needed in the ATS ADULT BE clinic.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 10 Aug 2017 0805

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

09 Aug 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29260181 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **09 Aug 2017 0800 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

f/u

Appointment Comments:

jbf

S/O Note Written by HANGEMANOLE, DESPINA C @ 10 Aug 2017 0742 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Depressive Symptoms

S) SM reported that he spent the weekend watching movies and sleeping. SM stated that he did talk with his sister and his mother and examined with them some of the reasons for living. SM stated he has hopes of moving down to where they live and buying a plot of land to live on together. SM stated that his MEB is moving forward for his IBS. SM denied having an intake date with PCS right now. SM reported that he is still depressed and often thinks about his reasons for living. SM reported he went to one AA meeting but didn't really like it because there was "drama" and he didn't feel he got anything out of it. SM reported that he was triggered to drink one time after hearing people talk about craft beer on the radio. SM stated that he turned the radio off and the feeling passed. He stated that he thought about suicide over the weekend but did not have a plan or intent to harm himself. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP. SM would benefit from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker in two weeks.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0921 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0921 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by HANGEMANOLE, DESPINA C @ 09 Aug 2017 0916 EDT**Consult Order****Referring Provider:** TOBAR, EDEN**Date of Request:** 18 Jul 2017**Priority:** Routine**Provisional Diagnosis:**

Alcohol use disorder

Reason for Request:

32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlt to reach pt. Thank you.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 10 Aug 2017 0742

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Aug 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29245054 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Aug 2017 0930 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 08 Aug 2017 0949 EDT**Allergies**

•No Known Allergies

Vitals**Vitals** Written by JONES,ANDRUW JOHNBRUCE @ 08 Aug 2017 0927 EDT

BP: 127/86, HR: 78, WT: 160 lbs, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by JONES,ANDRUW @ 08 Aug 2017 0927 EDT

BP: 127/86, HR: 78, WT: 160 lbs, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 09 Aug 2017 1400 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #11

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

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Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we increased Effexor xr to 150mg every morning for mood and anxiety. Pt says today he thinks the dose increase is helpful for his IBS symptoms. He isn't sure about impact on anxiety. We discussed that has not been on it for long. He remains abstinent from alcohol and coffee and is participating in ATS program. HE has not had his sleep study yet. Review normal B12 lab. He is not having suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

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RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

09AUG17 phq9= 15 (#9=0); gad7= 16

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:**nkda**Medications:**

Chlorhexidine Gluconate 0.12%, Solution, Oral RINSE BY MOUTH ONE TIME PER DAY FOR 14 DAYS. 0 Active 09 Aug 2017@0001

NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH EVERY DAY 1 Active

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY DAY 1 Active 09 Aug 2017@0001

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS 0 Expired 06 Jun 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 3 Active

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PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
 Active 06 Jun 2017@0001
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY
 AS NEEDED FOR GAS 2 Active 18 May 2017@0001
 HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL DISSOLVE 1 TABLET UNDER
 TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN 3 Active
 10 May 2017@0001
 Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral TAKE ONE SCOOP EVERY DAY MIXED
 IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY 3 Active 10 May
 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

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Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: fair

Speech: talkative

Mood: anxious

Affect: full

Thought Process: somewhat circumstantial

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight: fair

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	<i>mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	

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RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)

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Aspartate Aminotransferase SERUM 20 U/L (0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)	
Barbiturates	URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)	
Cocaine	URINE	NEGATIVE <i>		(Negative)	
Opiates	URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)	
Cannabinoids	URINE	NEGATIVE <i>		(Negative)	
Methadone	URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: continue Effexor to 150 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

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Problem #3: alcohol use

Goal:pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. continue. have discussed adverse effects of alcohol on mood and sleep. Will refered for sleep study in July. Normal b12 panel drawn after July 2017 visit.

Measure:self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR,EDEN @ 09 Aug 2017 1507 EDT1. **Generalized anxiety disorder:** Med management 15 minutes; supportive therapy 15 minutes.

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -VENLAFAXINE XR--PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY #30 RF1

Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

-NALTREXONE--PO 50MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR,EDEN @ 09 Aug 2017 1508 EDT**Released w/o Limitations****Follow up:** 4 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR,EDEN @ 08 Aug 2017 1001 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 75MG CPSR 24H -

Signed By TOBAR, EDEN (Physician/Workstation) @ 09 Aug 2017 1508

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07 Aug 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN

Encounter ID: BETH-29226745 Primary Dx: Major depressive disorder, single episode, moderate

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **07 Aug 2017 0845 EDT**
 Clinic: **INT MED CL F MEDICAL HOME BE**

Appt Type: **FTR**
 Provider: **LINKER, MARTIN R**

AutoCites Refreshed by JASLIN, ALFREDO E @ 07 Aug 2017 0845 EDT

Allergies

•No Known Allergies

Reason for Appointment:

IBS-D Follow up

Appointment Comments:

Appt self-booked via TOL

Vitals

Vitals Written by JASLIN, ALFREDO E @ 07 Aug 2017 0842 EDT

BP: 123/80, HR: 81, RR: 12, T: 98.1 °F, HT: 69 in, WT: 160 lbs, SpO₂: 96%, BMI: 23.63,
 BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 3/10 Mild, Pain Scale Comments: Stomach

S/O Note Written by LINKER, MARTIN R @ 07 Aug 2017 1718 EDT

Chief complaint

The Chief Complaint is: Follow up on irritable bowel syndrome.

History of present illness

The Patient is a 32 year old male.

32 m presents today in follow up to IBS. Patient states he is currently having a flare.

Alert and oriented x 3 with no signs of distress. Vital signs within normal limits. No complaints of nausea vomiting diarrhea.

<<Note accomplished in TSWF-CORE>>

Spasms today. Expects unscheduled bowel movements today. States he does not eat much because he has abdominal cramps and diarrhea when the products of digestion reach and are in his colon. But also states that he eats enough to maintain his weight. He is unsure whether or not he is making psychological progress. Continues to participate in BH visits. Taking same dose of venlafaxine. No nausea. Unclear when intensive outpatient treatment will begin. Discussed writing of a letter to amend or clarify NAVMED 6100/5 in order to excuse him from company-level PT and allow him to participate in PT at his own pace. Spoke last week with gastroenterologist and with psychiatrist. Patient is to make follow-up appointment in GI Clinic. His BH follow-up visits are scheduled. Not drinking.

Discussed many issues. Has good insight. Calmer. Less despondent.

Bloating, abdominal pain, and diarrhea.

Anxiety, emotional lability, depression, sleep disturbances ...Thinks that he sleeps too much..., and decreased functioning ability.

Visit is not deployment-related.

Pain assessment

Location: stomach

Duration: intermittent

Quality: spasm

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 07 August 2017

NKDA

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Current medication

Medications as of 07 August 2017

Probiotic one packet po daily
 Simethicone 80 mg po qid prn
 Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily
 Naltrexone 50 mg po daily
 Venlafaxine XR 150 mg po daily
 MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history
 IBS-D
 Generalized anxiety disorder
 Major depressive disorder
 ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 Photorefractive keratectomy
 Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

.....

Annual Questions Date: 7/27/17.

Family history

Family medical history

M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Cardiovascular:** No palpitations.**Pulmonary:** No shortness of breath.**Gastrointestinal:** Appetite not normal. No early satiety.**Genitourinary:** No urinary symptoms.**Musculoskeletal:** No limb swelling.**Neurological:** No fainting.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Lungs:

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Heart Rate And Rhythm: ° Normal.
 Heart Sounds: ° Normal S1 and S2. ° No gallop was heard.
 Murmurs: ° No murmurs were heard.
 Edema: ° Not present.

Abdomen:

Visual Inspection: ° Abdomen was not distended.
 Auscultation: ° Bowel sounds were normal.
 Palpation: • Abdominal tenderness ...Tender over approximate course of colon.. ° Abdomen was soft.

Psychiatric:

• Exam: ...Discussed many issues. Has good insight. Less anxious. Less despondent.. ° No impairment in social interaction.
 ° No impairment in communication.
 Appearance: • Abnormal.
 Demonstrated Behavior: • Behavior demonstrated abnormalities.
 Affect: ° Normal.
 Thought Processes: ° Not impaired.
 Thought Content: ° Revealed no impairment.

Test conclusions

Medication list was updated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

A/P Written by LINKER.MARTIN @ 07 Aug 2017 1708 EDT

- 1. Major depressive disorder, single episode, moderate:** Today seems somewhat improved. Continuing BH interventions.
- 2. Generalized anxiety disorder:** Today seems somewhat improved. Continuing BH interventions.
- 3. Alcohol dependence, uncomplicated:** In sobriety.
- 4. Irritable bowel syndrome with diarrhea:** He will make appointment to be seen in GI Clinic.

Disposition Written by LINKER.MARTIN @ 07 Aug 2017 1708 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic. - Comments: To return after GI Clinic visit.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By LINKER, MARTIN (Contractor, MD) @ 07 Aug 2017 1721

CHANGE HISTORY

The following S/O Note Was Overwritten by LINKER.MARTIN @ 07 Aug 2017 0919 EDT:

S/O Note Written by JASLIN,ALFREDO E @ 07 Aug 2017 0838 EDT

Chief complaint

The Chief Complaint is: Follow up on irritable bowel syndrome.

History of present illness

The Patient is a 32 year old male.
 32 m presents today in follow up to IBS. Patient states he is currently having a flare.

Alert and oriented x3 with no signs of distress. Vital signs within normal limits. No complaints of nausea vomiting diaherra.
 <<Note accomplished in TSWF-CORE>>

Visit is not deployment-related.
 Pain Severity 3/ 10.
 Pain assessment
 Location: stomach
 Duration: intermittent
 Quality: spasm

Patient has NOT received other care since their last visit with this clinic.
 Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 7/27/17

NKDA

Current medication

Medications as of 27 July 2017

Probiotic one packet po daily
 Simethicone 80 mg po qid prn
 Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsuels po daily
 Naltrexone 50 mg po daily
 Venlafaxine XR 150 mg po daily
 MVI one po daily

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Merwin, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

31 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29166858 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **31 Jul 2017 0900 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **FTR**
 Provider: **HANGEMANOLE, DESPINA C**

S/O Note Written by HANGEMANOLE, DESPINA C @ 01 Aug 2017 1111 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Passive Suicidal Ideation

S) SM reported that he spent the weekend watching movies and sleeping. SM stated that he found himself wanting to sleep the weekend away to pass the time. SM reported that he has been feeling depressed and hopeless. He stated that he thought about suicide over the weekend but did not have a plan or intent to harm himself. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 01 Aug 2017 0723 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 01 Aug 2017 0724 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 01 Aug 2017 1112

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29135457 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Jul 2017 1400 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

f/u

Appointment Comments:

dei

Note Written by PAUL, SHERIN @ 27 Jul 2017 1502 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 10
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: CBT****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he decided not to pursue a court marital and instead accepted an NJP which resulted in loss of rank and half month's pay. Therapist and patient processed his feelings about the results. He stated that he's glad that they don't want to "kick me out" and knows that he has an opportunity to regain rank should he not be medically separated. Patient stated that he wrote a personal statement which he provided to his CO and read to his command. Patient read this in session. Patient stated that he wanted his command to know where he was coming from and provide context. Therapist provided positive reinforcement for this. Patient stated that he is focusing on next steps for care and recovery from the past several months. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Single Episode, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Merwin, Daniel Dennis

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL,SHERIN @ 27 Jul 2017 1504 EDT

1. Generalized anxiety disorder

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL,SHERIN @ 27 Jul 2017 1504 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 27 Jul 2017 1505

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by LINKER, MARTIN

Encounter ID: BETH-29125975 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **27 Jul 2017 0915 EDT**
 Clinic: **INT MED CL F MEDICAL HOME
 BE**

Appt Type: **FTR**
 Provider: **LINKER, MARTIN R**

AutoCites Refreshed by WESLEY, LATASHA @ 27 Jul 2017 0905 EDT**Allergies**

•No Known Allergies

Reason for Appointment:

med board

Appointment Comments:

kpg

Vitals**Vitals** Written by WESLEY, LATASHA @ 27 Jul 2017 0902 EDT

BP: 118/78, HR: 86, RR: 18, T: 98.0 °F, HT: 69 in, WT: 171 lbs, SpO₂: 100%, BMI: 25.25,
 BSA: 1.933 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Weight with shoes.**S/O Note** Written by LINKER, MARTIN R @ 27 Jul 2017 1813 EDT**Chief complaint**

The Chief Complaint is: Anxiety. Depression.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Has IBS-D. Triggers include certain foods (high FODMAPS), eating at certain times (breakfast time more so than lunch time)
 certain smells (e.g., perfume), physical activity, anxiety, stress.

Stools vary. Can have temporally closely spaced multiple stools. Lots of abdominal cramping preceeding bowel movements.
 Sometimes feels like he should go to the ED because of severe cramping pain. Has been evaluated in GI Clinic and given various
 treatments, all of which he states were unhelpful. Last GI Clinic visit cited in AHLTA was on 13 April 2017.

Has lots of stress and anxiety.

Taking venlafaxine. Was taking 75 mg daily. Dose increased today to 150 mg. Venlafaxine caused nausea. Nausea now
 resolved.

IOP planned -- start date not clarified.

Recent lost access to the building that he was working in. Now performs analysis on a computer -- lower stress. Recent reduction
 in pay grade. His mother and sisters live in SC, and he thinks that he will be better mentally if he were in SC and could develop his
 relationship with them.

Excellent general overall feeling /health.
 Gastrointestinal symptoms See HPI.
 Psychological symptoms See HPI.

Pain assessment 7/27/17

Location:

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

Least level:

What makes it better:

What makes it worse:

Pain Severity 0/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated 7/27/17

NKDA

Current medication

Medications as of 27 July 2017

Probiotic one packet po daily

Simethicone 80 mg po qid prn

Omega 3/DHA/EPA/fish oil 1000 mg, 2 capsules po daily

Naltrexone 50 mg po daily

Venlafaxine XR 75 mg po daily, to be increased to 150 mg po daily

MVI one po daily

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

Generalized anxiety disorder

Major depressive disorder

ETOH hx (previous inpatient treatment)

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

Photorefractive keratectomy

Jaw surgery

Personal history

Social history reviewed Tobacco -- none

Alcohol -- none

Single

No children.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history M -- Well

F -- DM. MI / stent at age 40. Melanoma.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

• Not oriented to time, place, and person.

Psychiatric:

° No impairment in social interaction.

Affect: ° Normal.

Test conclusions

Medication list was updated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

A/P Written by LINKER.MARTIN @ 27 Jul 2017 1816 EDT

1. Irritable bowel syndrome with diarrhea: Consider interplay between GI and psychiatry problems. Discuss case with gastroenterologist.

2. Generalized anxiety disorder: Consider interplay between GI and psychiatry problems. Discuss with psychiatrist and psychologist.

3. Major depressive disorder, single episode, moderate: Consider interplay between GI and psychiatry problems. Discuss with psychiatrist and psychologist.

Disposition Written by LINKER.MARTIN @ 27 Jul 2017 1817 EDT

Released w/o Limitations

Follow up: 2 week(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By LINKER, MARTIN (Contractor, MD) @ 27 Jul 2017 1817

CHANGE HISTORY

The following S/O Note Was Overwritten by LINKER.MARTIN @ 27 Jul 2017 1018 EDT:

S/O Note Written by WESLEY.LATASHA @ 27 Jul 2017 0852 EDT

Chief complaint

The Chief Complaint is: Med board forms.

History of present illness

The Patient is a 32 year old male.

He reported: Excellent general overall feeling /health.

Pain Severity 0/ 10.

Pain assessment 7/27/17

Location:

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

.....
Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 7/27/17

NKDA

animal dander.

Current medication

MVI one po daily

Effexor 37.5 mg po daily (started on July 11, 2017)

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS Naltrexone 15 mg po daily (started July 11, 2017)

verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

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GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK
 Jaw surgery

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☒ Never ☐

Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM: Rodak

Annual Questions Date: 7/27/17.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

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DoD ID: 1286180538

Created: 16 Aug 2017

27 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29123896 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Jul 2017 0800 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 27 Jul 2017 0830 EDT**Allergies**

•No Known Allergies

Vitals**Vitals** Written by WONG,CHARMIN A @ 27 Jul 2017 0736 EDT

BP: 128/79, HR: 76, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by WONG,CHARMIN A @ 27 Jul 2017 0736 EDT

BP: 128/79, HR: 76, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 27 Jul 2017 2205 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #10

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

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Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we increased Effexor xr to 75mg every morning for mood and anxiety as pt reported increasing distress surrounding facing a DRB the week of July 3rd for charges of allegedly sexually harassing a coworker. Pt says today he thinks the dose increase is helpful for his IBS symptoms. He isn't sure about impact on anxiety. We discussed that he is still on a low dose and hasn't been on it for long. HE is having trouble sleeping and is taking unisom at night but still struggles with sleep maintenance. He feels tired all the time. HE has been abstinent from alcohol for 18 days and is not drinking caffeine. He had an intake with ATS and is doing breathalyzers. HE decided not to challenge his NJP and has been reduced in rank to E5. HE is not having suicidal thoughts.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

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Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

27JUL17 phq9= 16 (#9=0); gad7= 16

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Effexor xr 75 mg po qam, naltrexone 50 mg po daily, unisom

VENLAFAXINE HCL, 150 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY

DAY 1 Active 27 Jul 2017@0001

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NALTREXONE HCL, 50 MG, TABLET, ORAL TAKE 1/2 TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY 0 Active 27 Jul 2017@0001

VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL TAKE ONE CAPSULE BY MOUTH EVERY MORNING 1 Ordered 18 Jul 2017@0001

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS 0 Expired 06 Jun 2017@0001

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY 3 Active
PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY 1
Active 06 Jun 2017@0001

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS 2 Active 18 May 2017@0001

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Merwin, Daniel Dennis

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Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: pt more guarded today

Speech: constricted

Mood: dysphoric

Affect: constricted

Thought Process: focused on MEB referral

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight: fair

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	<i>mL/min	(60->=60)	

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CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC BLOOD	5.6 x10(3)/mcL	(3.6-10.6)		
RBC BLOOD	4.86 x10(6)/mcL	(4.21-5.92)		
Hemoglobin	BLOOD 15.1 g/dL	(12.8-17.7)		
Hematocrit	BLOOD 44.4 %	(37.5-50.9)		
MCV BLOOD	91.4 fL	(79.5-96.8)		
MCH BLOOD	31.1 pg	(26.2-33.1)		
MCHC BLOOD	34.1 g/dL	(32.6-35.0)		
RDW CV BLOOD	12.9 %	(12.0-16.2)		
Platelets BLOOD	272 x10(3)/mcL	(162-427)		
MPV BLOOD	9.0 fL	(7.0-10.9)		
Neutrophils	BLOOD 59.4 %	(40.7-76.4)		
Lymphocytes	BLOOD 29.8 %	(15.9-47.8)		
Monocytes	BLOOD 8.9 %	(4.5-11.8)		
Eosinophils	BLOOD 1.5 %	(0.3-7.1)		
Basophils BLOOD	0.4 %	(0.2-1.2)		
ABS Neutrophils	BLOOD 3.3 x10(3)/mcL	(1.8-7.5)		
ABS Lymphocytes	BLOOD 1.7 x10(3)/mcL	(1.0-3.1)		
ABS Monocytes	BLOOD 0.5 x10(3)/mcL	(0.2-0.8)		
ABS Eosinophils	BLOOD 0.1 x10(3)/mcL	(0.0-0.5)		
ABS Basophils	BLOOD 0.0 x10(3)/mcL	(0.0-0.4)		
Differential Review	BLOOD MANUAL	DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM Negative <i>	(See-Below)		

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM Negative <i>	(Negative)		
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L 0-378		

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <r>			

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL (211-946)		

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L (4.0-15.4)		

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin SERUM	4.7 g/dL	(3.5-5.2)		
Alkaline Phosphatase	SERUM 53	U/L (40-129)		
Alanine Aminotransferase	SERUM 17	U/L (0-41)		
Bilirubin SERUM	0.4 mg/dL	(0.15-1.2)		
Urea Nitrogen	SERUM 13.8	mg/dL (6-20)		
Calcium SERUM	9.7 mg/dL	(8.6-10.2)		
Carbon Dioxide	SERUM 29	mmol/L (22-29)		
Chloride SERUM	98 mmol/L	(98-107)		
Creatinine	SERUM 0.96	mg/dL (0.7-1.2)		
Glucose SERUM	89 mg/dL	(74-106)		
Potassium	SERUM 4.4	mmol/L (3.5-5.1)		
Protein SERUM	7.6 g/dL	(6.6-8.7)		
Sodium SERUM	141 mmol/L	(136-145)		
Anion Gap	SERUM 14	mmol/L (7-16)		

Medical Record

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016	1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)	
Barbiturates	URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)	
Cocaine	URINE	NEGATIVE <i>		(Negative)	
Opiates	URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)	
Cannabinoids	URINE	NEGATIVE <i>		(Negative)	
Methadone	URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: increase Effexor xr to 150 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Merwin, Daniel Dennis

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Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.
Measure: self report

Problem #3: alcohol use

Goal:pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Again discussed ATS referral which pt agreed to today. have discussed adverse effects of alcohol on mood and sleep. Will refer for sleep study. Orderd b12 panel.

Measure:self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: three weeks

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR,EDEN @ 27 Jul 2017 2208 EDT

1. Generalized anxiety disorder: Med managemnet 25 minutes, supportive therapy 20 mnutes

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -VENLAFAXINE XR--PO 150MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY DAY #14 RF1

Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Laboratory(ies): -B12+FOLATE PANEL (Routine) Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Consult(s): -Referred To: SLEEP DISORDERS MTF BE (Routine) Specialty: SLEEP DISORDERS Clinic: SLEEP (PULM) CL BE Provisional Diagnosis: R/o obstructive sleep apnea

Disposition Written by TOBAR,EDEN @ 27 Jul 2017 2208 EDT

Released w/o Limitations

Follow up: 2 to 3 week(s) or sooner if there are problems.

Administrative Options: Consultation requested

Signed By TOBAR, EDEN (Physician/Workstation) @ 27 Jul 2017 2209

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SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Jul 2017 at WRNMMC, ATS Adult BE by HANGEMANOLE, DESPINA C

Encounter ID: BETH-29097351 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **25 Jul 2017 0900 EDT**
 Clinic: **ATS ADULT BE**

Appt Type: **SPEC**
 Provider: **HANGEMANOLE, DESPINA C**

Reason for Appointment:

Intake

Appointment Comments:

aga

S/O Note Written by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1155 EDT**History of present illness**

The Patient is a 32 year old male.

Focus Of Session: Intake Assessment

S) SM and this writer completed intake assessment. SM acknowledged that he understood the evaluation process and levels of care. SM reviewed alcohol use history. SM reported that he was referred after disclosing to his BH provider that he was drinking on medications. SM stated he isn't sure if he has an alcohol problem, despite being in treatment before. SM reported abuse of asthma inhaler while in high school and use of marijuana one time while in high school. SM reported some pain related to IBS. SM denied current SI/HI.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative during assessment. SM appears ambivalent about treatment related to his AUD. SM seems to be more comfortable relating his alcohol use to his depression and anxiety, and may not see it as a standalone issue.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker next week.

A/P Last Updated by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1125 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Last Updated by HANGEMANOLE, DESPINA C @ 25 Jul 2017 1126 EDT**Released w/o Limitations**

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker next week. 120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services) @ 25 Jul 2017 1156

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

20 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-29051489

Primary Dx:

Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **20 Jul 2017 0848 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **DELSESTO, BARBARA SUE**

AutoCites Refreshed by DELSESTO, BARBARA @ 20 Jul 2017 0849 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VENLAFAXINE HCL, 75 MG, CAP ER 24H, ORAL	Ordered	TAKE ONE CAPSULE BY MOUTH EVERY MORNING #0 RF1	1 of 1	18 Jul 2017
NALTREXONE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY #0 RF1	1 of 1	10 Jul 2017
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 20 Jul 2017 0848 EDT
 Case Management

Appointment Comments: Written by DELSESTO, BARBARA @ 20 Jul 2017 0848 EDT
 Care Coordination/Command Contact

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by DELSESTO, BARBARA SUE @ 20 Jul 2017 1344 EDT**Reason for Visit**

Visit for: Case Management. Spoke with this patient and his Commander- CDR Yusko:443-479-6067. Discussed the referral to WRNMMC's IOP. The patient had a start date for 7 August but the Commander is requesting a start date for after the Labor Day holiday so the legal issues for this patient can be worked out. CM notified Ms. Lisa Bank-Williams at the PCS clinic to request a new start date. Will let the patient know when it can be scheduled.

History of present illness

The Patient is a 32 year old male.

He reported: Military service Profile Type: Patient was recently placed on LIMDU for IBS and GAD. MEB was recommended by the PCM. Paperwork taken to bldg 17 to the MEB office and MEB set to proceed. His Commander was given a copy of the LIMDU.

Discussed the IOP program with the Commander and recommended that the patient be allowed to attend. Spoke with patient regarding his legal issues and he will schedule a time to talk with the Commander about the process. CM information provided to all parties and will keep working with both to get patient into the IOP and provide support through his legal issue.

A/P Written by DELSESTO, BARBARA @ 20 Jul 2017 1350 EDT**1. Encounter for other administrative examinations****Disposition** Written by DELSESTO, BARBARA @ 20 Jul 2017 1350 EDT**Released w/o Limitations**

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 20 Jul 2017 1350

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-29028197 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **18 Jul 2017 1330 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 18 Jul 2017 1344 EDT**Allergies**

•No Known Allergies

Vitals**Vitals** Written by FOX,THOMAS JOSEPH @ 18 Jul 2017 1312 EDT

BP: 112/66, HR: 74, RR: 18, T: 97.1 °F, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Reason for Appointment:

follow up

Appointment Comments:

ajj

Vitals**Vitals** Written by FOX,THOMAS J @ 18 Jul 2017 1312 EDT

BP: 112/66, HR: 74, RR: 18, T: 97.1 °F, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 19 Jul 2017 1532 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #9

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up appt. At our last meeting last week we started Effexor xr 37.5 mg every morning for mood and anxiety as pt reported increasing distress surrounding facing a DRB the week of July 3rd for charges of allegedly sexually harassing a coworker. Pt says he sent her pictures of himself with his dogs without his shirt on, and of his dogs licking a piece of meat, and that this was misconstrued to be sexually suggestive. Pt says today he has been having stomach upset and hasn't noticed an impact from the Effexor yet. We discussed it is too early for it to have an impact and right now we are gradually tapering it up to a therapeutic dose to ensure tolerability. He states he has been sober 9 days. HE has had some suicidal ideation without intent because he says his plan would be too expensive (buying a helium vent and gassing himself on helium). He continues to take naltrexone and thinks it is helpful for reducing alcohol use and maybe even his mood. His command wanted to NJP him and reduce him in rank to E-5, which he refused. He states they told him others find him narcissistic and hard to interact with. They told him he was 'unsalvageable'. Pt is consulting with a lawyer. Command states they are going to ad sep him under a general discharge. Pt wants to get out of the Navy but he wants an MEB. He took the limdu Dr Paul wrote and gave it to his PCM, who incorporated it into an MEB referral for that and IBS. I advised pt the Convening Authority for Behavioral Health, CDR Carr, contacted me about it as no behavioral health provider had signed it. I advised pt I agree with limdu referral but not MEB referral at this point as I don't believe he has exhausted all options for treatment; for example he is starting IOP on 07AUG. Pt voiced disappointment but said he would talk to PCM about resubmitting form. HE denies current suicidal intent.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he

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owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen

Rating scales:

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

19JUL17 phq9= 20 (#9=1); gad7= 18

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)

☒ Male ☐ History of family/friend suicide

☐ Chronic medical conditions ☒ Impulsivity

☒ History of abuse ☐ Chronic pain

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PROTECTIVE FACTORS (Strengths):

- | | |
|---|---|
| <input type="checkbox"/> Married, children | <input checked="" type="checkbox"/> Active treatment engagement |
| <input type="checkbox"/> Good coping/problem solving skills | <input checked="" type="checkbox"/> Hopefulness present |
| <input type="checkbox"/> Faith/religion commitment | <input type="checkbox"/> Positive future orientation |

Allergies: nkda**Medications:** none**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:pt more guarded today

Speech:constricted

Mood:dysphoric

Affect:constricted

Thought Process: focused on MEB referral

Thought Content: denies current suicidal intent/HI/AVH

Judgment: fair

Insight:fair

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	<i>mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	
Barbiturates	URINE	NEGATIVE <i>	(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)	
Cocaine	URINE	NEGATIVE <i>	(Negative)	
Opiates	URINE	NEGATIVE <i>	(Negative)	
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)	
Cannabinoids	URINE	NEGATIVE <i>	(Negative)	
Methadone	URINE	NEGATIVE <i>	(Not-Detected)	
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; r/o adjustment disorder with depressed mood ; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will continue medication

Intervention: increase Effexor xr to 75 mg po qam, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counseled pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Goal:pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: continue naltrexone 50 mg po daily. Again discussed ATS referral which pt agreed to today. have discussed adverse effects of alcohol on mood and sleep

Measure:self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one week

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Written by TOBAR,EDEN @ 19 Jul 2017 1534 EDT**1. Generalized anxiety disorder**

Medication(s):

-VENLAFAXINE XR--PO 75MG CPSR 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING
#30 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Consult(s):

-Referred To: BEHAVIORAL HEALTH MTF BE (Routine) Specialty: Clinic: RM BEH HLTH BE
Provisional Diagnosis: Alcohol use disorderDisposition Written by TOBAR,EDEN @ 19 Jul 2017 1534 EDT**Released w/ Work/Duty Limitations****Follow up:** 2 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requestedNote Written by TOBAR,EDEN @ 18 Jul 2017 1407 EDT**Additional A/P Information:**

Discontinued VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING

Signed By TOBAR, EDEN (Physician/Workstation) @ 19 Jul 2017 1534

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-29045775 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **18 Jul 2017 0800 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Note** Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 9
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he received the results of the DRB and he chose to pursue a court martial as he did not want to admit wrong doing to the extent which was recorded. He acknowledged that his behavior may have had unintentional negative impact but he does not agree with the presentation of his behavior as malicious or himself as manipulative. Patient became very despondent that others thought of him that way. He stated that although he understands that he struggles with empathy and caring for others, he never purposely would harm anyone. He expressed stress at financial strain that an admin sep will place and the potential to lose medical coverage. Patient has no suicidal plan or intent but fleeting ideation.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Recurrent, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Medical Record

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017*Reviewed with patient on:* 13 June 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT

1. Major depressive disorder, recurrent, moderate

2. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 19 Jul 2017 1425 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 19 Jul 2017 1426

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DoD ID: 1286180538

Created: 16 Aug 2017

13 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28978906 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **13 Jul 2017 1015 EDT**
 Clinic: **INT MED CL F MEDICAL HOME BE**

Appt Type: **FTR**
 Provider: **RODAK, COLLEEN M**

Reason for Appointment:

irritable bowel syndrome

Appointment Comments:

mjs

Vitals**Vitals** Written by BANGURA,JOHN A @ 13 Jul 2017 1002 EDT

BP: 124/82, HR: 78, RR: 18, T: 98.3 °F, HT: 69 in, WT: 78.6 kg, SpO₂: 95%, BMI: 25.59,
 BSA: 1.944 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 2/10 Mild, Pain Scale Comments: STOMACH

Questionnaire AutoCites Refreshed by BANGURA,JOHN A @ 13 Jul 2017 1007 EDT**Questionnaires**

Falls Risk Screening (Outpatient) Taken On: 13 Jul 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient patient a falls risk?: No

Anxiety & Depression Screening Taken On: 13 Jul 2017

Questionnaire Notes: PATIENT BEEN SEEN BY PSYCH

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Nearly every day
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Several days

S/O Note Written by RODAK, COLLEEN M @ 14 Jul 2017 1223 EDT**Chief complaint**

The Chief Complaint is: LIMDU and IBS.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and has been started on naltrexone since his last visit; he presents today requesting a LIMDU that with a request (question on LIMDU) to start a med board process.a.

Good general overall feeling /health.

Abdominal pain and diarrhea.

Visit is not deployment-related.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

Merwin, Daniel Dennis

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What makes it better:

What makes it worse:

.....

Pain Severity 2 / 10.

Patient reports that they are compliant with medications.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

MVI one po daily

Effexor 37.5 mg po daily (started on July 11, 2017)

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Naltrexone 15 mg po

verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Jaw surgery

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

.....

Annual Questions Date: 19Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Head: No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Heartburn and nausea. No vomiting, no bright red blood per rectum, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety, emotional lability, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.**Skin:** No rash.

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

The patient DID NOT experience illness during the trip.

Physical findings**General:**

- Physical examination Not indicated for visit / administrative visit.

Vital Signs:

- Temperature: Reviewed.
- RR: Reviewed.
- PR: Reviewed.
- Blood pressure: Reviewed.

General Appearance:

- ° Normal.
- ° Well developed.
- ° Well nourished.
- ° In no acute distress.

Test conclusions

Medication list was updated at the beginning of the visit.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Note Written by MINOR, TIFFANY @ 13 Jul 2017 1020 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. 7/13/17 at 10:20

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me

Note Written by BROWER, CARLA @ 13 Jul 2017 1428 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 7/13/17 Patient Name: Daniel Dennis Merwin Patient SSN: [REDACTED]
 Proposed start date for limited duty: 7/13/17 Proposed end date (≤ 6 months): 12/13/2017

This period of limited duty is for: (Select one)

- ☒ 1st LIMDU (≤ 6 months) Enlisted ADMM (no referral to service headquarters necessary).
☐ 2nd LIMDU (≤ 6 months) Enlisted ADMM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.
☐ 1st LIMDU (≤ 6 months) Officer ADMM (referral to service headquarters necessary).
☐ 2nd LIMDU (≤ 6 months) Officer ADMM (referral to service headquarters necessary).
☐ 3rd or subsequent LIMDU periods on Navy and Marine ADMM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").
☒ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) IBS - D/P ICD-9 CM Code K58.0
 (2) GAD ICD-9 CM Code 296.32
 (3) MOD recurrent mod ICD-9 CM Code _____

Circumstances of injury/illness:

The patient is a 32-year-old male who has anxiety, depression, and comorbid medical conditions that have significantly impacted his ability to function at home, work, and in his social environment.

Treatment plan:

The GI confirmed IBS-D is of such severity that it only intensifies with military ADUs.

He returned to IOP (mental health) as he is on multiple bowel

Limitations from full duty (including whether transfer/TEMU for treatment is indicated, and any PRT limitations):

He is allowed approximately 1 hr per day to attend appointments. He is not allowed to work on days he has close proximity to a weapon or a dog. He is not allowed to work on days he has close proximity to a dog or a gun. He is not allowed to work on days he has close proximity to a dog or a gun.

MARTIN A. LINKER MD 13 JUL 2017 CAPT, MCUSUR

SECTION 2: PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- ☐ Completion of Patient Information Sheet
☐ Notification to PSD/Personnel Office
☐ LOGO Requested from Parent Command (if LOGO required)
☐ Entry into MedBOLTT
☐ Briefing to Patient on Limited Duty/MEERs
☐ Notification to MTF LIMDU Coordinator
☐ Notification to Parent Command

Patient Administration Officer/Medical Boards Officer Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEER Case File, and PERS-4621 or MMSR-4

NAVMED 810015 (Rev. 08-2004)
 PREVIOUS EDITIONS OBSOLETE

A/P Written by RODAK, COLLEEN M @ 14 Jul 2017 1231 EDT

1. Encounter for other administrative examinations: See add notes

Disposition Written by RODAK, COLLEEN M @ 14 Jul 2017 1231 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 14 Jul 2017 1231

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 13 Jul 2017 1107 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 13 Jul 2017 1016 EDT

Chief complaint

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

The Chief Complaint is: LIMDU and IBS.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it will be starting IOP he presents today to obtain a 30 day SIQ.

Feeling tired (fatigue).

Abdominal pain and diarrhea.

Patient is an 32 yo male ADSD that presents with pain to his stomach 2/10 today. patient reports he would like limdu today for the IBS. patient reports no other concerns.

Good general overall feeling /health.

Abdominal pain and diarrhea.

Visit is not deployment-related.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

.....

Pain Severity 2 / 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

FISH OIL, MULTIVITAMIN, EFFEXOR, NALTREXONE

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): [x] English [] Other:

Preferred method of learning? [] Verbal [] Written [] Visual [] Other (Specify):

Learning disability, language barrier, hearing/vision deficit? [] Yes [x] No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? [] Never []

Rarely [] Sometimes [] Often [] Always

Advance directives completed? [] Yes [x] No

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact preference:
 PCM:

Annual Questions Date: 19Jun2017.

Family history

Family medical history Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Cr. Breast CA.
 Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Cr. Breast CA.

Review of systems**Systemic:** No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no bright red blood per rectum, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient HAS NOT traveled outside of the country in the past 90 days.

The patient DID NOT experience illness during the trip.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

The following S/O Note Was Overwritten by MINOR, TIFFANY @ 13 Jul 2017 1020 EDT:**S/O Note Written by BANGURA, JOHN A @ 13 Jul 2017 1002 EDT****Chief complaint**

The Chief Complaint is: LIMDU.

History of present illness

The Patient is a 32 year old male.

He reported: Good general overall feeling /health.

Visit is not deployment-related.

Pain Severity 2 / 10.

Pain assessment

Location: STOMACH

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level:

Worst level:

Least level:

What makes it better:

What makes it worse:

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated 7/13/2017

NKDA

animal dander.

Current medication

MEDICATION RECONCILIATION 7/13/2017

FISH OIL, MULTIVITAMIN, EFFEXOR, NALTREXONE

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital
 IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.
 Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Former 2007 2008 current no Tobacco - 1/4 pack a week time UK
 Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):

Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):

(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐

Rarely ☐ Sometimes ☐ Often ☐ Always

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

.....

Annual Questions Date: 19Jun2017.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient or patient's sexual partner HAS NOT traveled to a Zika affected area in the past 6 months and DO NOT plan to in the future.

Patient is NOT pregnant and DOES NOT plan to conceive in the next 6 months.

The patient DID NOT experience illness during the trip.

The patient HAS NOT traveled outside of the country in the past 90 days.

Practice Management

Patient engages in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Jul 2017 at WRNMMC, Integrative Hlth & Well BE by THOMAS, LAUREN A

Encounter ID: BETH-28963629 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **12 Jul 2017 0845 EDT** Appt Type: **FTR**
 Clinic: **INTEGRATIVE HLTH & WELL BE** Provider: **THOMAS, LAUREN A**

Reason for Appointment:

IBS diet

Appointment Comments:

Ist

Screening Written by THOMAS, LAUREN A @ 12 Jul 2017 0910 EDT**Reason For Appointment:** IBS diet**Reason(s) For Visit (Chief Complaint):** Patient Education - Dietary Counseling And Surveillance (New) ;**Vitals****Vitals** Written by THOMAS, LAUREN A @ 12 Jul 2017 0910 EDT

HT: 69 in, WT: 178 lbs, BMI: 26.29, BSA: 1.966 square meters, Tobacco Use: No, Alcohol Use: No

S/O Note Written by THOMAS, LAUREN A @ 12 Jul 2017 0923 EDT**History of present illness**

The Patient is a 32 year old male.

The SM was referred for medical nutrition therapy for IBS-D. BMI=26., LDL-C=140 mg Trig=262. PMH=Anxiety, depression. Is currently under a medical board. The SM states that he has had GI problems for many years. Also has a family hx of high cholesterol. Has decreased intake of red meat from 3x-1x/week. Triglycerides are likely elevated due to excessive alcohol intake. The SM states he has not lost weight but in fact has gained weight but that maybe from drinking alcohol. He stopped drinking 3 days ago and also stopped caffeine intake then too. He reports following the low FODMAP diet 1 1/2 years ago. Stopped following it and also was not completely following it. Started following it again 5 weeks ago. He states it has helped his symptoms. He reports 1 Bm/day that is watery, painful. He states that garlic and onion bother him as do cruciferous vegetables. He stated that no matter what I eat, I feel pain, discomfort. Diet recall reveals the patient is following the low FODMAP diet but is eating bread products with gluten. He states he doesn't feel gluten bothers him. B: none or Glucerna shake L: 3-4 oz chicken breast, 1/2 cup brown rice, water S: Jello D: Chicken/ turkey, rice or turkey burger on a potato roll, water. Supplements: Centrum Silver, Fish Oil, Probiotic.

Current medication

Including OTCs, vitamins, herbals, supplements, etc.

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GA.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Reported:

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital.

Lab Result Cited by THOMAS, LAUREN A @ 12 Jul 2017 0924 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

A/P Written by THOMAS,LAUREN A @ 12 Jul 2017 0934 EDT

1. Irritable bowel syndrome with diarrhea: Nutrition Diagnosis: Altered GI function RT stress, excessive alcohol, depression AEB patient symptoms

Intervention #1:

1. Discussed 2nd phase of FODMAP diet which includes gradual addition of some foods from one food group
2. Discussed returning to low FODMAP before adding foods from another group
3. Recommended patient make an appointment with IHWS Mind-Body therapist to learn skills for stress reduction/relaxation/mediation

Barriers: Limited ability to exercise

Monitoring/Evaluation

Goals:

1. Add in 1/2 banana then see how symptoms are
2. Add in another fruit from fruit group to assess tolerance
3. Next add in grains in similar way
4. Make an appt with Mind-Body therapist
5. F/u recommended- patient declined

Monitor symptoms with food journal

RD and clinic contact information given for follow-up, questions

Procedure(s): -Medical Nutrition Therapy Initial Assessment, Intervention x 3

Disposition Written by THOMAS,LAUREN A @ 12 Jul 2017 0937 EDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the INTEGRATIVE HLTH & WELL BE clinic.

45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By THOMAS, LAUREN A (Registered Dietitian, Walter Reed National Military Medical Center) @ 12 Jul 2017 0937

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-28936747 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **10 Jul 2017 1231 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **ACUT**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR, EDEN @ 10 Jul 2017 1249 EDT**Allergies**

•No Known Allergies

Vitals

No Vitals Found.

Reason for Appointment: Written by TOBAR, EDEN @ 10 Jul 2017 1231 EDT
 ED follow up

Vitals

Written by TOBAR, EDEN @ 10 Jul 2017 1056 EDT

BP: 130/86, HR: 81, T: 98.8 °F

Comments: vitals taken by clinic enlisted staff**Note** Written by TOBAR, EDEN @ 11 Jul 2017 2212 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #9

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 32 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Created: 16 Aug 2017

Currently treated: not answered

past attempts: 3 (as of 09/06/2016)

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for acute ED follow-up appt after being referred to the ED on 06JUL for reporting suicidal thoughts to his command that day. Pt states he faced a DRB last week. He has been having legal trouble at his command for allegedly sexually harassing a coworker. Pt says he sent her pictures of himself with his dogs without his shirt on, and of his dogs licking a piece of meat, and that this was misconstrued to be sexually suggestive. Pt says he has been having increasing suicidal ideation over the past couple of months because of the legal situation. He started researching ways to kill himself on a website called helpme.org and thought about carbon monoxide poisoning or shooting himself with a shotgun, although he doesn't own one and denies plan to buy one. He says he told a coworker last week who told his command who referred him to ED, where he was evaluated and released to outpatient. Pt says he wouldn't act on these thoughts due to his family and sister. He says after stopping his medications (Lexapro, lunesta and naltrexone) around the beginning of May he became increasingly depressed and started drinking more, up to a liter and a half a week of vodka. He also drank up to 3 coffees per day. Pt states he thinks he felt better on medication and would like to go back on a medication for his mood. He states he stopped drinking alcohol two days ago. He learned more about his family psychiatric history since we last met, specifically that both grandparents are on venlafaxine and find it helpful for their mood. Grandmother also is on Risperdal for bipolar disorder. Pt reports when he is programming, watching TV or movies he finds they are an escape and he does not feel tired. However, he otherwise feels tired much of the time. He felt tired on past trials of SSRIs as well.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHPD after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people , and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

11JUL17 phq9= 18 (#9=2); gad7= 18

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation

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Allergies: nkda**Medications:** none**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

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Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:mildly pressured

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD 44.4	%	(37.5-50.9)	
MCV	BLOOD 91.4	fL	(79.5-96.8)	
MCH	BLOOD 31.1	pg	(26.2-33.1)	
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD 12.9	%	(12.0-16.2)	

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Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7 g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM	53 U/L	(40-129)	
Alanine Aminotransferase	SERUM	17 U/L	(0-41)	
Bilirubin	SERUM	0.4 mg/dL	(0.15-1.2)	
Urea Nitrogen	SERUM	13.8 mg/dL	(6-20)	
Calcium	SERUM	9.7 mg/dL	(8.6-10.2)	
Carbon Dioxide	SERUM	29 mmol/L	(22-29)	
Chloride	SERUM	98 mmol/L	(98-107)	
Creatinine	SERUM	0.96 mg/dL	(0.7-1.2)	
Glucose	SERUM	89 mg/dL	(74-106)	
Potassium	SERUM	4.4 mmol/L	(3.5-5.1)	
Protein	SERUM	7.6 g/dL	(6.6-8.7)	
Sodium	SERUM	141 mmol/L	(136-145)	
Anion Gap	SERUM	14 mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	105.6 mL/min	(60->=60)	
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20 U/L	(0-40)	

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	

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Barbiturates	URINE	NEGATIVE <i>	(Negative)
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)
Cocaine	URINE	NEGATIVE <i>	(Negative)
Opiates	URINE	NEGATIVE <i>	(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will resume medication

Intervention: start Effexor xr 37.5 mg po qam with plan to increase to 75 mg poq am in one week if tolerated, as family members had good response to this medication. Monitor for emergence of manic symptoms. Counselor pt on risks/benefits and he consented to treatment.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will refrain from alcohol use

Intervention: restart naltrexone 25 mg po q day x 3 days, then increase to 50 mg po daily. Discussed ATS referral but he declines at this time. have discussed adverse effects of alcohol on mood and sleep

Measure: self-report, lab results

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Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one week

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

A/P Last Updated by TOBAR, EDEN @ 11 Jul 2017 2210 EDT**1. Generalized anxiety disorder**

Procedure(s): -Psychiatric Therapy For Crisis Intervention x 1

Medication(s): -VENLAFAXINE XR--PO 37.5MG CPER 24H - TAKE ONE CAPSULE BY MOUTH EVERY MORNING

#14 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

-NALTREXONE--PO 50MG TAB - T1/2 TABLET BY MOUTH EVERY DAY FOR 3 DAYS, THEN

INCREASE TO ONE TABLET BY MOUTH EVERY DAY #30 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR, EDEN @ 11 Jul 2017 2211 EDT**Released w/o Limitations****Follow up:** 1 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 12 Jul 2017 1513

CHANGE HISTORY*The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by TOBAR,EDEN @ 12 Jul 2017 1511 EDT:***Signed TOBAR, EDEN T (Physician/Workstation) @ 11 Jul 2017 2213**

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Created: 16 Aug 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-28931074 Primary Dx:

Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **10 Jul 2017 0918 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **DELSESTO, BARBARA SUE**

AutoCites Refreshed by DELSESTO, BARBARA @ 10 Jul 2017 0919 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 10 Jul 2017 0918 EDT
 Case Management

Appointment Comments: Written by DELSESTO, BARBARA @ 10 Jul 2017 0918 EDT
 Care Coordination/Command Contact

S/O Note Written by DELSESTO, BARBARA SUE @ 10 Jul 2017 1133 EDT

Reason for Visit

Visit for: Case Management. Patient was seen in the ED on 6 July and saw Dr. Paul this am at 0800. He was taken by his Command for a safety check/eval. He denies any safety concerns today. He will see his PCM for LIMDU paperwork and start the MEB process this week. Dr. Paul has written a temporary LIMDU for BH while patient continues to receive treatment. Both medical and BH conditions to be added to the permanent LIMDU.

History of present illness

The Patient is a 32 year old male.

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Spoke with patient's Commander- CDR Yusko regarding the Intensive Outpatient Program in the PCS clinic. Confirmed date to start is 7 August. Informed Command that the program is M-F /0700-1500 for at least 4 weeks. She stated that she can NOT commit to support this treatment at this time. I requested that she get back to me in the next 2 weeks regarding this treatment. The patient is currently pending some legal action for misconduct and his anxiety is elevated. He reports his IBS is causing some pain, more trips to the bathroom daily and he is picking his scalp until he bleeds and has sores develop. I discussed with the Commander that this patient should be bringing the LIMDU paperwork this week and the MEB action does not stop the legal action. Advocated that patient attend this IOP and continue with treatment. His condition is exacerbated by the legal action and the conflict at work but his condition was noted and treated well before this legal action occurred. He feels that he has had a good service record and has 11 years TIS. He has sought treatment around his work schedule and has tried to remain fit for duty. His record supports a permanent LIMDU and the medical board process will decide his fitness for duty going forward.

A/P Written by DELSESTO, BARBARA @ 10 Jul 2017 1148 EDT

1. Encounter for other administrative examinations: CM to follow this patient. CM information provided to this patient for questions/issues

Disposition Written by DELSESTO, BARBARA @ 10 Jul 2017 1149 EDT

Released w/o Limitations

Follow up: as needed in the PSYCHIATRY BE clinic. - Comments: f/u scheduled with Dr. Paul and Dr. Tobar 45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 10 Jul 2017 1149

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10 Jul 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28954544 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **10 Jul 2017 0800 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Note Written by PAUL, SHERIN @ 11 Jul 2017 1319 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 8
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he completed his Disciplinary Review Board which was a stressful experience. Patient described feeling overwhelmed by the accusations and assumptions on his character. He expressed confusion that he had not been previously told about any inappropriate behavior and offered corrective instruction. Patient stated that anxiety and IBS symptoms have risen. He acknowledged the interrelated nature of the two conditions. Patient is working with CDR Del Sesto to follow up with getting support with his command on behavioral health issues. Patient's command has not provided IOP approval as of yet. Patient expressed anxiety about the future and outcome of his career. Therapist and patient worked on coping skills to manage anxiety/depression.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and depressed and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder

Major Depressive Disorder, Recurrent, Moderate

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support, occupational/legal stressors

Axis V: 60

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	Yes

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Medical Record

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017*Reviewed with patient on:* 13 June 2017*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 11 Jul 2017 1319 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

2. Major depressive disorder, recurrent, moderate

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 11 Jul 2017 1320 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 11 Jul 2017 1320

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jul 2017 at WRNMMC, Psychiatry Be by WISE, JOSEPH E

Encounter ID: BETH-28914234 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Jul 2017 0816 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **WISE,JOSEPH EDWARD**

Call Back Phone: [REDACTED]

AutoCites Refreshed by WISE,JOSEPH E @ 07 Jul 2017 0817 EDT**Allergies**

•No Known Allergies

Vitals**Vitals** Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,
 BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,
 BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,
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BP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,
 BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87, HR: 81, RR: 20, T: 98.5 °F, HT: 69 in, WT: 178.5 lbs, SpO₂: 97%, BMI: 26.36,
 BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN,GERALDINE @ 12 Jun 2017 0902 EDT

BP: 127/82, HR: 86, RR: 20, T: 98.3 °F, HT: 69 in, WT: 180.7 lbs, SpO₂: 97%, BMI: 26.68,
 BSA: 1.978 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by GRIFFIN,GERALDINE @ 12 Jun 2017 0902 EDT

BP: 127/82, HR: 86, RR: 20, T: 98.3 °F, HT: 69 in, WT: 180.7 lbs, SpO₂: 97%, BMI: 26.68,
 BSA: 1.978 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild,
 Pain Scale Comments: Abdomen.

Vitals Written by PROVENCIO, ELISHA S. @ 07 Jun 2017 1006 EDT

BP: 129/75, HR: 75, RR: 16, HT: 69 in, WT: 168 lbs, BMI: 24.81, BSA: 1.918 square meters, Tobacco Use: No, Alcohol Use: No,
 Pain Scale: 0 Pain Free

Comments: no anti-histamines in last 7 days or more**S/O Note** Written by WISE,JOSEPH EDWARD @ 07 Jul 2017 0819 EDT**Subjective**

Record reviewed, in response to ER last night. I liaised with those providers. I called the pt; message left about psychiatric appointment options for earlier than 18 JUL, if needed. (note, he does have another appointment with his therapist prior to that.) We will await his call back.

A/P Last Updated by WISE,JOSEPH E @ 07 Jul 2017 0819 EDT**1. Generalized anxiety disorder****Disposition** Last Updated by WISE,JOSEPH E @ 07 Jul 2017 0819 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By WISE, JOSEPH E (Physician/Psychiatrist, Walter Reed NMMC) @ 07 Jul 2017 0820

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jul 2017 at WRNMMC, Int Med CL F Medical Home BE by MEADOR, KRISTINE P

Encounter ID: BETH-28914272 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **07 Jul 2017 0815 EDT**
Clinic: **INT MED CL F MEDICAL HOME
BE**Appt Type: **T-CON***
Provider: **MEADOR, KRISTINE P**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by MEADOR, KRISTINE P @ 07 Jul 2017 0815 EDT

PCM: RODAK

Telephone Consult Comments: Written by MEADOR, KRISTINE P @ 07 Jul 2017 0815 EDT

F/U FOR ER VISIT; DEPRESSION

Note Written by MEADOR, KRISTINE P @ 07 Jul 2017 0818 EDT

32 yo M Navy AD sent from Ft Meade for SI. Has had increasing SI for past 3 weeks. Attempted x 2 while in HS.

A/P Last Updated by SMITH, MICKALYNN J @ 10 Jul 2017 0747 EDT**1. Encounter for other administrative examinations**

Procedure(s): -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1

Disposition Last Updated by MEADOR, KRISTINE P @ 10 Jul 2017 0912 EDT**Released to Self Care****Note** Written by MEADOR, KRISTINE P @ 07 Jul 2017 1113 EDT

32 yo M seen in ED on 06Jul2017 for SI. F/u appt scheduled for psychiatry and PCP (see below). Left general message for pt to return call to Team Fox River.

PSYCHIATRY BE/WRNMMC PAUL, SHERIN 10Jul2017@0800 FTR/60 PENDING
Arrive 15 min earlyINT MED CL F MEDICAL/WRNMMC RODAK, COLLE 17Jul2017@0745 FTR/30 PENDING
Arrive 15 min early BPAD WEA**Note** Written by SMITH, MICKALYNN J @ 10 Jul 2017 0743 EDT**RN note**

Pt returned RN phone call. States he has f/u with PCm already scheduled and will talk with provider about ER visit at that meeting. TCON closed.

Signed By MEADOR, KRISTINE P (Physician) @ 10 Jul 2017 0913

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Jul 2017 at WRNMMC, Psychiatry Consult Liaison Be by WORKS, LINDSAY K

Encounter ID: BETH-28912169 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **06 Jul 2017 2027 EDT**
 Clinic: **PSYCHIATRY CONSULT
 LIAISON BE**

Appt Type: **ACUT**
 Provider: **WORKS,LINDSAY KAY EMIL**

Reason for Appointment: Written by WORKS,LINDSAY K @ 06 Jul 2017 2027 EDT
 safety check

Note Written by WORKS,LINDSAY K @ 06 Jul 2017 2027 EDT

Impression:

32yo single Caucasian AD USN E6 male with past psychiatric history of GAD, MDD, Adj disorder who presented at the request of command for safety eval due to recent suicidal thoughts. Biologically, the patient self-discontinued his Lexapro a few months ago, with noticeable worsening of symptoms since discontinuing. He has a history of heavy alcohol use, but denies recent binge use. He suffers from poor sleep as well. Psychologically, the patient struggles with chronic depression and suicidality. He has poor coping skills and turns to alcohol for relief. He is isolative but engaged in treatment. He is at times impulsive, as evidenced by self-discontinuing effective medications. Socially, the patient has a couple of close friends which he trusts and confides in. He also has a good therapeutic relationship with his outpatient provider.

Risk factors include prior suicide attempts, mental illness, acute stressors of job/finance/relationship, and family history. Protective factors include future orientation, interest in treatment, help-seeking, no access to guns, roommate. Hospital admission was discussed with the patient at length. He refused admission at this time and does not require involuntary admission for safety as he is not currently suicidal or homicidal and is able to care for self. He is chronically suicidal and trusts his outpatient provider enough that he called her on his way in and she made an appointment on Monday.

Dx: GAD, Adjustment D/O

Recommendations/Plan:

- Patient to be discharged from ED with outpatient BH follow-up
- BH psychology apt on Monday 0800
- emailed WRNMMC BH staff to arrange for psychiatric follow-up within 1 week
- return to the ED or call 911 if suicidal thoughts worsen or if you feel unsafe

D/w Dr. Molchan- staff psychiatrist

-

HPI:

Patient presented to the ED at the request of command due to expressing suicidal thoughts yesterday. Patient reports he has chronic suicidal thoughts "off and on" and that last night he was having thoughts and was "sort of researching different ways online" and told this to a civilian co-worker. That co-worker was concerned and reported it to his command, who then sent the patient to the ED. On the way into the ED, the patient contacted his therapist and told

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

her what was happening and she scheduled him for Monday 0800 appointment.

At the time of the evaluation, the patient denied any current suicidal thoughts. He stated that he was irritated that his friend reported him but understands that suicide is taken seriously. He denies that his thoughts are worse than usual but does admit that researching different ways is "not common but not rare". He denies any specific plan.

Yesterday the patient went before the DRB for misconduct and is facing separation or demotion as punishment. This was particularly upsetting to him and "stressed him out". He also self-discontinued his psychiatric medication (Lexapro) in April and since then has noticed an increase in depression and anxiety. He is interested in resuming the medication and would like to meet with his prior provider Dr. Tobar to discuss. The medication was stopped due to making him feel sleepy, but he feels the benefits out way the cost. Also, since being more stressed his IBS has increased which has caused more pain and has decreased appetite.

The DRB is in regards to accusations of sexual misconduct in regards to social media posts and conversations with a couple of female colleagues. The patient denies any misdoing.

Psych ROS

Depression: endorses poor sleep with early morning awakenings, guilt, hopeless and helpless at times, anhedonia (prior enjoyed gaming, less pleasure from it now). Chronic SI without plan or intent.

Anxiety: more anxious since stopping Lexapro, nervously picks at scalp to the point of having a bald patch. Endorses general anxiety, all day every day over small things.

Mania: denies

Psychosis: denies

PTSD: has thoughts of past abuse and at times feels uneasy around men, but denies overt avoidance/nightmares/flashbacks.

Psych History

Prior diagnosis: ETOH abuse, GAD, MDD

Prior suicide attempt: x2 in adolescence via alcohol and aspirin

Inpatient substance abuse treatment at ft. Belvoir April 2015

Currently in therapy and sees Dr. Tobar for medications.

Prior Lexapro 20mg qd, stopped in April

PMHx/PSHx:

Childhood asthma

IBS

HPV

PRK (2011)

Current Meds:

GasX

Fish Oil

Probiotic

Family History:

Sisters: suicide attempts, bipolar, substance abuse

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

MGMA- bipolar

Developmental/social Hx:

Born in CA, oldest of 3 siblings. Born to an intact union, divorced at age 3. Contentious divorce. Father won custody. Patient was bullied in school and abused by dad. Involved in track. Graduated HS with average grades. Went on to business school, dropped out and joined the military. Patient is straight, currently single. He recently ended a relationship, found out recently that following the break-up she began using drugs, which makes the patient feel guilty.

Military history:

11yrs TIS

USN E6

No deployments

Currently working on Med Board.

ETOH: has decreased use to 1-2 drinks per night, last few weeks less than 1 per night

Tobacco: denies

Illicit Drugs: denies

Allergies:

NKDA

Objective Findings

Vital Signs: HR 73, BP 144/94, R 16, Temp 97.9

MSE:

General: Caucasian male with orange hair, fair skin, appearing stated age. Well-nourished, well-groomed.

Behavior: calm and cooperative, good eye contact

Speech: regular rate, rhythm, volume, tone

Mood: "ok"

Affect: reactive, euthymic, smiling at times

Thought Process: logical, linear, goal directed, easy to follow

Thought Content: denies SI/HI, no evidence of hallucinations/delusions

Judgement: fair

Insight: fair

Impulse Control: Intact during interview

Labs: largely wnl

Time spent face to face with patient: 60minutes

A/P Last Updated by WORKS,LINDSAY K @ 06 Jul 2017 2028 EDT**1. Generalized anxiety disorder****2. Major depressive disorder, recurrent, moderate**Disposition Last Updated by WORKS,LINDSAY K @ 06 Jul 2017 2030 EDT**Released w/o Limitations**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Follow up: with PCM and/or in the PSYCHIATRY BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By WORKS, LINDSAY KAY EMIL (Physician) @ 06 Jul 2017 2030

Co-Signed By MOLCHAN, SUSAN E (Psychiatrist) @ 10 Jul 2017 1555

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Jul 2017 at WRNMMC, Psychiatry Be by DELSESTO, BARBARA S

Encounter ID: BETH-28903549

Primary Dx:

Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **06 Jul 2017 1030 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **DELSESTO, BARBARA SUE**

AutoCites Refreshed by DELSESTO, BARBARA @ 06 Jul 2017 1032 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 of 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2		18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

Reason for Appointment: Written by DELSESTO, BARBARA @ 06 Jul 2017 1030 EDT
 Case Management

Appointment Comments: Written by DELSESTO, BARBARA @ 06 Jul 2017 1030 EDT
 Care Coordination

S/O Note Written by DELSESTO, BARBARA SUE @ 07 Jul 2017 1045 EDT

Reason for Visit

Visit for: Case Management. Spoke with this patient regarding his referral to the Intensive Outpatient Program. I spoke with him about the situation at his unit-he is having some legal issues with his unit and is awaiting the outcome from this. He feels he is being mistreated by his Command and reached out to CM to talk with them about moving his duty assignment or a PCS LIMDU. The legal issues will need to be complete before he can PCS. CM to talk with his Commander about reducing this patient's stress level as it is making him more symptomatic with his IBS, anxiety, etc.

History of present illness

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

The Patient is a 32 year old male.

The start date for IOP is 7 August per Ms. Banks-Williams. Patient verbalized an understanding and CM will continue to try to contact his Commander for confirmation of support for the IOP and discuss his work environment.

A/P Written by DELSESTO, BARBARA @ 07 Jul 2017 1052 EDT

1. Encounter for other administrative examinations

Disposition Written by DELSESTO, BARBARA @ 07 Jul 2017 1052 EDT

Released w/o Limitations

Signed By DELSESTO, BARBARA (Nurse Case Manager, Walter Reed National Military Medical Center) @ 07 Jul 2017 1052

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28841296 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Jun 2017 1500 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

f/u

Appointment Comments:

rla

Note Written by PAUL, SHERIN @ 28 Jun 2017 1125 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 7
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he has received negative feedback from his command regarding LimDu and IOP. Patient expressed concerns that they think he is "faking" his behavioral health issues in order to "get out of trouble". Patient stated that he is well aware that despite neutral intentions, his behavior towards others related to sexual harassment allegation had a negative impact on the women it was directed to. Patient stated that he has been trying to "keep things going" despite regular daily stressors from Navy demands negatively impacting his mental and physical health (IBS). He stated that he is recognizing that he cannot keep going forward without further injuring himself. Therapist noted that his previous notes indicated that he experienced significant stress deciding to re-enlist and shortly after felt that he made an error in returning to Navy stressors. Patient feels that Navy demands are detrimental to his behavioral and physical health. Patient is following up with potential MEB with other providers. Patient indicated impulsive drive to "turn in my badge" because he just wants to get out of the department. However, he is concerned about how this will impact him long term. Therapist provided patient with contact info for NCM CDR Del Sesto to discuss his current situation and receive support.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and

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volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	

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Frustration Tolerance Limited
 Resilience: Yes
 Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 28 Jun 2017 1126 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 28 Jun 2017 1127 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 28 Jun 2017 1127

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by FINK, CAITLIN M

Encounter ID: BETH-28769305 Primary Dx: Epidermal cyst

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **21 Jun 2017 1203 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **PROC**
 Provider: **FINK,CAITLIN M**

AutoCites Refreshed by DIBLASI,DANIEL R @ 21 Jun 2017 1528 EDT**Allergies**

•No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL	Active	TAKE 2 BY MOUTH EVERY DAY #0 RF3	3 of 3	06 Jun 2017
PROBIOTIC (VSL#3) DS--PO PACK	Active	TAKE ONE PACKET BY MOUTH EVERY DAY #0 RF1	1 of 1	06 Jun 2017
SIMETHICONE, 80 MG, TAB CHEW, ORAL	Active	CHEW 1 TABLET BY MOUTH 2 OF 2 FOUR TIMES A DAY AS NEEDED FOR GAS #0 RF2	2 of 2	18 May 2017
HYOSCYAMINE SULFATE, 0.125 MG, TAB SUBL, SUBLINGUAL	Active	DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #0 RF3	3 of 3	10 May 2017
Psyllium Seed 3.4 g/Scoop + Sucrose Granules, Oral	Active	TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #0 RF3	3 of 3	10 May 2017
Pseudoephedrine Hydrochloride 6mg/mL, Liquid, Oral, 5mL	Active	DRINK 10ML EVERY 6 HOURS FOR CONGESTION #0 RF3	3 of 3	28 Apr 2017
IBUPROFEN, 100 MG/5ML, ORAL SUSP, ORAL	Active	DRINK 20ML (400MG) EVERY FOUR HOURS FOR BASELINE PAIN CONTROL #0 RF1	1 of 1	28 Apr 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE	Active		NR	14 Oct 2016
AFLURIA 2015-2016 (FLU VACC TS 2015-16(5YR,UP)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015

S/O Note Written by DIBLASI,DANIEL ROBERT @ 21 Jun 2017 1535 EDT**Chief complaint**

The Chief Complaint is: Excision.

History of present illness

The Patient is a 32 year old male.

32 y/o male presents for excision of scrotal cysts.

In the Navy and currently on active duty.

No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI.

Allergies

No known drug allergies.

Current medication

Current medications reviewed, confirmed and reconciled with patient.

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Past medical/surgical history**Diagnoses:**

No basal cell carcinoma of the skin
 No squamous cell carcinoma of the skin.
 No malignant melanoma of the skin

Personal history

Behavioral: No tobacco use.

Alcohol: Alcohol use.

Family history

No malignant melanoma of the skin.

Physical findings**Vital Signs:**

Vital Signs/Measurements

Value

Pain level by numeric rating scale

0

General Appearance:

° Well developed. ° Well nourished. ° In no acute distress. ° Not acutely ill.

Neurological:

° Oriented to time, place, and person.

Skin:

• Skin:: On exam the following lesions were identified and examined:
 Multiple round subcutaneous cysts on the scrotum. • Complexion type II.

A/P Last Updated by DIBLASI,DANIEL R @ 21 Jun 2017 1540 EDT

1. Epidermal cyst: 32 y/o male with multiple EICs on the scrotum. 3 lesions excised. Patient tolerated the procedure. Follow up as needed.

Staffed with Dr. Fink

Procedure(s):

-Excision Of Lesion Trunk Benign Up to .5cm x 1
 ADDITIONAL PROVIDER(S): FINK,CAITLIN M -
 Universal protocol was followed in compliance with WRNMMC standards.
 Patient's identification was checked (name and DOB). Procedure site(s) and side matches the consent form. The biopsy report and slide (if available) were reviewed. The site was marked and anesthetized with [2] mL of lidocaine 1% with epinephrine.
 The area was then prepped and draped in a sterile fashion. The lesions were then excised.
 Estimated blood loss was 1mL.
 Superficial skin opposition was achieved using 5-0 fast gut sutures.
 The wound was cleaned, Vaseline placed. Patient was instructed on wound care.
 The patient was instructed to return to clinic sooner for signs of symptoms of infection to include erythema, draining fluid or pain to palpation.
 Lesion Management:
 Initial size: [4]mm Margins: [0]mm Size of lesion with margins : [4]mm
 Final length of incision [0.5]cm

Laboratory(ies):

-TISSUE EXAM (Routine) Ordered By: DIBLASI,DANIEL R Ordering Provider: DIBLASI, DANIEL ROBERT

Disposition Last Updated by DIBLASI,DANIEL R @ 21 Jun 2017 1541 EDT**Released w/o Limitations****Follow up:** as needed in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note Written by FINK,CAITLIN M @ 21 Jun 2017 1545 EDT**

Agree with above assessment and plan. Note reviewed and in compliance with WRNMMC and JCAHO standards.

Signed By FINK, CAITLIN M (Physician, Staff Dermatologist) @ 21 Jun 2017 1545

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DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28732393

Primary Dx:

Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **19 Jun 2017 0915 EDT**
 Clinic: **INT MED CL F MEDICAL HOME BE**

Appt Type: **FTR**
 Provider: **RODAK, COLLEEN M**

Reason for Appointment:

Follow up for IBS. Notify the doctor of Physical Training and Smell trigger

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0927 EDT

BP: 132/87 Left Arm, Adult Cuff, HR: 81 Regular, Radial Artery, RR: 20, T: 98.5 °F Oral, HT: 69 in Stated, WT: 178.5 lbs,

SpO2: 97%, BMI: 26.36, BSA: 1.968 square meters, Tobacco Use: No, Alcohol Use: Yes,

Alcohol Comments: 4-5 per week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Questionnaire AutoCites Refreshed by GRIFFIN,GERALDINE @ 19 Jun 2017 0935 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 19 Jun 2017

Questionnaire Notes: Patient reports that he does not have any suicidal ideation and that he is being seen by Counselors from IBHS.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Nearly every day
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: More than half the days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Several days

Falls Risk Screening (Outpatient) Taken On: 19 Jun 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient patient a falls risk?: No

S/O Note Written by GRIFFIN,GERALDINE @ 19 Jun 2017 0910 EDT**Chief complaint**

The Chief Complaint is: IBS Information update 3/10 19Jun2017.

History of present illness

The Patient is a 32 year old male.

He reported: Good general overall feeling /health.

Pain assessment 3/10

Location: Abdomen

Duration:

Quality:

Factors that correlate with onset:

Frequency:

Average level: 6/10

Worst level: 10/10

Least level: 0/10

What makes it better: diet change, not eating

What makes it worse: food, smells of food, eating

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Merwin, Daniel Dennis

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Allergies

Allergies Verified and Updated 19Jun2017

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Medication Reconciled Jun2017

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference:

PCM:

.....

Annual Questions Date: 19Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

S/O Note Written by RODAK, COLLEEN M @ 21 Jun 2017 1552 EDT**Chief complaint**

The Chief Complaint is: IBS information update.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it will be starting IOP he presents today to obtain a 30 day SIQ.

Feeling tired (fatigue).

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Abdominal pain and diarrhea.

Pain Severity 2/ 10.

Current medication

June 19 2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS
verified CMR**Past medical/surgical history****Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No systemic symptoms and no generalized pain. No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort and no palpitations.**Pulmonary:** No dyspnea, no cough, and no wheezing.**Gastrointestinal:** Appetite not decreased. No dysphagia and no pain on swallowing. Heartburn. No nausea, no vomiting, no hematemesis, no bright red blood per rectum, and no constipation.**Genitourinary:** No hematuria, no change in urinary frequency, and no feelings of urinary urgency. No dysuria and no testicular symptoms were present. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety, emotional lability, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.**Physical findings****General:**

• Physical examination NA for today's visit.

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Note Written by MINOR, TIFFANY @ 19 Jun 2017 0921 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen Rodak, NP. 6/19/17 at 09:21

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

A/P Written by RODAK, COLLEEN M @ 21 Jun 2017 1601 EDT

1. Encounter for other administrative examinations: See add notes

Disposition Written by RODAK, COLLEEN M @ 21 Jun 2017 1601 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by DUVALL, MICHAEL R @ 20 Jun 2017 0945 EDT

WRNATMILMEDCENINST 6320.1E

QUARTERS/LIGHT DUTY LIST
WRNMMC 6320/8 (REV 1/9)
INSTRUCTIONS TO PATIENT:

WALTER REED NATIONAL MILITARY MEDICAL CENTER
WYTHESDA, MD 20889-5000

1. FOR ALL PERSONNEL - PRIOR TO LEAVING THE HOSPITAL AREA. TAKE THIS FORM TO THE PRIMARY CARE HEALTH CENTER TO BE PLACED ON THE QUARTERS/LIGHT DUTY LIST.
2. ENLISTED PERSONNEL - RETURN TO YOUR SERVICE AND SHOW THIS FORM TO YOUR SUPERVISOR.
3. OFFICERS - NOTIFY YOUR SERVICE TEAM LEADER OR IMMEDIATE SUPERVISOR IN YOUR CHAIN OF COMMAND.

INFORMATION: DURING THE PERIOD OF TIME IN A QUARTERS PATIENT STATUS, YOU WILL REMAIN IN THE CONFINES OF YOUR QUARTERS, UNLESS RELEASED BY THE MEDICAL OFFICER AND/OR YOUR SUPERIOR IN THE CHAIN OF COMMAND. MARRIED PERSONNEL AND THOSE LIVING ASHORE MAY BE PERMITTED TO GO HOME UPON OBTAINING PERMISSION FROM THE MEDICAL OFFICER AND/OR YOUR SUPERIORS IN YOUR CHAIN OF COMMAND. ALL PERSONNEL WILL RETURN TO THE PRIMARY CARE HEALTH CENTER ON THE TIME AND DATE INDICATED FOR POSSIBLE RETURN TO DUTY, EXTENSION IN A QUARTERS PATIENT STATUS, OR ADMISSION TO THE SICK LIST.

DATE: 6/19/17 TIME: 1005m

FROM: _____ MILITARY SICK CALL _____ EMERGENCY ROOM _____

SERVICE NAME

TO: COMMANDER/COMMANDING OFFICER

(NAME OF COMMAND TO WHICH MEMBER IS ATTACHED)

1. REQUEST THAT THE BELOW NAMED MEMBER BE PLACED IN THE FOLLOWING STATUS:

_____ QUARTERS PATIENT STATUS FOR _____ DAYS _____ LIGHT DUTY STATUS FOR 30 DAYS

MEMBER IS TO RETURN TO _____ CLINIC FOR FOLLOW-UP AND FURTHER DISPOSITION ON _____ (DATE AND TIME)

RESTRICTIONS:

_____ NO LIFTING/BENDING
_____ NO PFT/EXERCISING

_____ NO PROLONGED STANDING OR WALKING
_____ NO SHAVING

OTHERS: _____

DIAGNOSIS

185-D/pain

MEDICAL OFFICER SIGNATURE

IMPRINT PATIENT DATA

Merwin Daniel

DoD 1286180538

PATIENT ADDRESS WHILE IN QUARTERS/LIGHT DUTY STATUS

PATIENT PHONE NUMBER WHILE IN QUARTERS/LIGHT DUTY STATUS

WHITE COPY: MEMBER'S HEALTH RECORD YELLOW COPY: MEMBER'S SUPERVISOR PINK COPY: MFHC

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 21 Jun 2017 1602**CHANGE HISTORY***The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 21 Jun 2017 1600 EDT:**S/O Note Written by MINOR, TIFFANY JOHNETTA @ 19 Jun 2017 0912 EDT***Chief complaint**

The Chief Complaint is: IBS information update.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it has been recommended that the patient start IOP mental health / LIMDU

He presents today to update me on his mood and to discuss his sleep disturbances / IBS-D symptoms and its negative impact on his QOL / ability to perform work duties due to severity / frequency of symptoms.

Patient is an 32 yo male ADSD that's presents with pain 2/10 today in his stomach. patient reports 10/10 is the worst due to eating food. patient reports not eating or changing foods help the pain.

Feeling tired (fatigue).

Abdominal pain and diarrhea.

Pain Severity 2/ 10.

Current medication

Medication Reconciled 12Jun2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Former 2007 2008 current no.

Family history

Family medical history Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No systemic symptoms and no generalized pain. No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no bright red blood per rectum, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Jun 2017 at WRNMMC, Dermatology Clinic Bethesda by NICHOLAS, LUKE C

Encounter ID: BETH-28722514 Primary Dx: Anogenital (venereal) warts

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER-MEADE
 Patient Status: **Outpatient**

Date: **16 Jun 2017 0930 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **NICHOLAS,LUKE C**

Reason for Appointment:

Anogenital (venereal) warts

Appointment Comments:

MJ/IRMAC

S/O Note Written by DIBLASI,DANIEL ROBERT @ 16 Jun 2017 1154 EDT**Chief complaint**

The Chief Complaint is: Genital warts.

History of present illness

The Patient is a 32 year old male.

32 y/o male presents for evaluation/treatment of genital warts. Have been there for about 1 year. Has treated topically and with LN2 in the past and lesions have not resolved. Patient also c/o cysts on the scrotum.

In the Navy and currently on active duty.

No systemic symptoms, not feeling tired or poorly, no fever, and no chills. No skin symptoms - No skin symptoms other than described in the HPI.

Allergies

No known drug allergies.

Current medication

Current medications reviewed, confirmed and reconciled with patient.

Past medical/surgical history**Diagnoses:**

- No basal cell carcinoma of the skin
- No squamous cell carcinoma of the skin.
- No malignant melanoma of the skin

Personal history

Social history.

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value
Pain level by numeric rating scale	0

General Appearance:

- ° Well developed. ° Well nourished. ° In no acute distress. ° Not acutely ill.

Neurological:

- ° Oriented to time, place, and person.

Skin:

- Skin:: On exam the following lesions were identified and examined:
 Small skin colored papules in the pubic region and on the proximal penile shaft
 Multiple round, subcutaneous cysts on the scrotum. • Complexion type II.

A/P Last Updated by DIBLASI,DANIEL R @ 16 Jun 2017 1247 EDT

1. Anogenital (venereal) warts: 32 y/o male with genital warts. Did not improve with topical or destructive therapies in the past. Recommended repeat treatment with LN2 and then regular follow up every 4-6 weeks for repeat treatment until clear. Patient verbalized understanding.

Seen and staffed with Dr. Nicholas

Procedure(s): -Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent received, and cryo applied to lesions in standard fashion. Therapy was applied in a pulsed fashion to minimize collateral tissue injury. Patient was instructed to use Vaseline ointment to the area(s) until healed. Patient tolerated the procedure well and left in stable condition.

2. Epidermal cyst: Multiple scrotal EICs. Can schedule for excision. AHLTA and Outlook calendar unavailable at the time of encounter, so will contact patient to schedule.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Disposition Last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT**Released w/o Limitations****Follow up:** in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: I saw the patient with the resident and agree with the above assessment and plan.**Note** Written by DIBLASI,DANIEL R @ 16 Jun 2017 1154 EDT**Consult Order****Referring Provider:** RODAK, COLLEEN M**Date of Request:** 19 May 2017**Priority:** Routine**Provisional Diagnosis:**

Anogenital (venereal) warts

Reason for Request:

32 to with penile lesions Previously treated for genital warts with topicals and cryosurgery by dermatology; on PE --> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology please evaluate additional question is if this patient she undergo an anal PAP thank you

Signed By NICHOLAS, LUKE C (Physician-WRNMMC, Dermatologist) @ 19 Jun 2017 1241**CHANGE HISTORY****The following Disposition Note Was Overwritten by** NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT:

The Disposition section was last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT - see above.Previous Version of Disposition section was entered/updated by DIBLASI,DANIEL R @ 16 Jun 2017 1248 EDT.

Released w/o Limitations**Follow up:** in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28672871 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Jun 2017 0858 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 13 Jun 2017 1000 EDT**Subjective**

Provider was contacted by patient's command Chief Schooley regarding statements that patient made the previous day. Chief Schooley indicated that patient admitted to suicidal ideation and stated that the reason that he did not follow through with this was because he could not think of a painless way to die. Chief Schooley stated that the patient then followed up with stating that he was not thinking of hurting himself and no imminent risk was indicated. Chief Schooley indicated that he was concerned about the patient's safety. With expressed verbal permission of the patient, this provider indicated that patient had been seen this morning and screened for safety. Provider notified the caller that if in the future this or other sailors indicated suicidal harm, he has the option to recommend them for an immediate safety screen. Again with expressed verbal permission of the patient, this provider indicated that the patient will be placed on Limdu for behavioral health diagnoses. Further, patient is expected to start intensive outpatient program.

A/P Last Updated by PAUL, SHERIN @ 13 Jun 2017 1000 EDT

- 1. Generalized anxiety disorder**
- 2. Major depressive disorder, recurrent, moderate**

Disposition Last Updated by PAUL, SHERIN @ 13 Jun 2017 1000 EDT**Follow up:** in the PSYCHIATRY BE clinic.**Signed By PAUL, SHERIN** (Clinical Psychologist) @ 13 Jun 2017 1001

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

13 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28695800 Primary Dx: Major depressive disorder, recurrent, moderate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **13 Jun 2017 0700 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **FTR**
Provider: **PAUL, SHERIN****Reason for Appointment:**

Follow up

Appointment Comments:

DCM

Note Written by PAUL, SHERIN @ 14 Jun 2017 1245 EDT**WR ADULT BEHAVIORAL HEALTH CLINIC**
FOLLOW-UP NOTEPatient Name: Daniel Merwin
Patient last 4: 0538
Appt #: Intake + 6
Therapy time: 60 minutes
E&M time: 60 minutes**Identifying Data:** 32-year-old, Single, Caucasian, Male**Military Data:**Branch: USN
Rank: PO1
MOS: CTN
TIS: 11-years
Deployments: N/A
Deployment Related: N/A
Trauma: N/A
WTU: N/A
MEB in progress: N/A
AdmSep in progress: N/A
Special Clearance: Yes**Presenting Problem:**

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Treatment Planning****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that since previous session he was provided more information regarding sexual harassment allegation against him. He expressed frustration that his actions were perceived negatively and no one talked to him about it in person. He stated that he never meant to hurt anyone or make anyone feel uncomfortable. However, he agreed that some of the engagement on social media seems inappropriate. Patient expressed frustration that he does not have a good understanding of social norms. He noted that he has been feeling suicidal related to increase in stress. Patient expressed concern about his well-being. He is amenable to intensive outpatient program and LimDu. Therapist and patient completed this paperwork. Patient was also notified that provider had been contacted by Chief Schooley and plans on contacting him later in the day. Patient provided verbal consent for provider to present information regarding patient's treatment plan.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a week with no

Merwin, Daniel Dennis

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Created: 16 Aug 2017

plan or intent.

ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder
 Major Depressive Disorder, Recurrent, Moderate
 Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

Good Reality Testing: Yes
 Amenable to Treatment: Yes
 Social Support: No
 Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 13 June 2017

Reviewed with patient on: 13 June 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress: Patient continues to experience suicidal ideation with no intent/plan.

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Merwin, Daniel Dennis

DOB: [REDACTED]

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS** been written for patient by this writer today.

Provider initiated LimDu for patient.

A/P Written by PAUL, SHERIN @ 14 Jun 2017 1246 EDT

1. Major depressive disorder, recurrent, moderate

2. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 14 Jun 2017 1246 EDT

Released w/o Limitations

Follow up: 1 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 14 Jun 2017 1247

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28655557 Primary Dx: <No description for K58.2 in Medcin database>

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **12 Jun 2017 0845 EDT**
 Clinic: **INT MED CL F MEDICAL HOME BE**

Appt Type: **FTR**
 Provider: **RODAK, COLLEEN M**

Reason for Appointment:

Depression and Anxiety

Appointment Comments:

G G

Vitals**Vitals** Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0902 EDT

BP: 127/82 Left Arm, Adult Cuff, HR: 86 Regular, Radial Artery, RR: 20, T: 98.3 °F Oral, HT: 69 in Stated, WT: 180.7 lbs Upright Scale, Actual, With Shoes, SpO₂: 97%, BMI: 26.68, BSA: 1.978 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2-3 days a week., Pain Scale: 3/10 Mild, Pain Scale Comments: Abdomen.

Questionnaire AutoCites Refreshed by GRIFFIN, GERALDINE @ 12 Jun 2017 0906 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 12 Jun 2017

Questionnaire Notes: Patient reports that he is being seen by Counselors from IBHS.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Nearly every day
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: More than half the days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

Falls Risk Screening (Outpatient) Taken On: 12 Jun 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient a falls risk?: No

S/O Note Written by RODAK, COLLEEN M @ 13 Jun 2017 0943 EDT**Chief complaint**

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male.

This is a 32 yo male with a HX of depression, anxiety, IBS-D previous EtOH abuse requiring treatment (2013-2014) who recently has been experiencing acute exacerbation of his anxiety & depression; exacerbation is related to long standing family issues. He is actively engaged in BH and it has been recommended that the patient start IOP mental health / LIMDU. He presents today to update me on his mood and to discuss his sleep disturbances / IBS-D symptoms and its negative impact on his QOL / ability to perform work duties due to severity / frequency of symptoms.

Good general overall feeling /health.

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Metamucil one capsule daily
 Peridex wash
 Motrin 800 mg po twice daily prn
 MVI one po daily
 RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
 OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY
 PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS
 verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
 Alcohol - 3 drinks a week
 single / no children / CTN at fort Mead.
 Behavioral: No tobacco use history.
 Alcohol: Alcohol use AUDIT-C Date:
 History ANNUAL QUESTIONS
 Preferred language (written or spoken): ☒ English ☐ Other:
 Preferred method of learning? ☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):
 Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):
 (SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your
 doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always
 Advance directives completed? ☐ Yes ☒ No
 Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact preference: [REDACTED]
 PCM:

.....
 Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.

Review of systems**Systemic:** No fever and no chills.**Cardiovascular:** No palpitations.**Pulmonary:** No cough and no wheezing.**Gastrointestinal:** Appetite not decreased. No dysphagia, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no hematemesis. Abdominal pain and diarrhea. No constipation.**Genitourinary:** No hematuria and no change in urinary frequency. No dysuria and no testicular symptoms were present. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Psychological:** Anxiety, depression, sleep disturbances, and decreased functioning ability. Not thinking about suicide. No homicidal thoughts.**Skin:** No rash.

The patient HAS NOT traveled outside of the country in the past 90 days.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Lymph Nodes:

° Inguinal lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Back:

° No costovertebral angle tenderness.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Neurological:

• Not oriented to time, place, and person.

Psychiatric:

• Exam: anxious / sad effective but has insight into his mood and how the physiological symptoms are exacerbated by his mood state--> severe pain & explosive diarrhea. He is requesting a med board.

Mood: • Dysthymic.

Affect: • Abnormal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[3] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[] 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Test conclusions

Medication list was updated at the beginning of the visit.

Note Written by MINOR, TIFFANY @ 12 Jun 2017 0857 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen

Rodak, NP. 08:58 on 6/12/17

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

CBC W/o Diff	Site/Specimen	12 Apr 2017 1147
WBC	BLOOD	6.0
RBC	BLOOD	4.58
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	42.3
MCV	BLOOD	92.4

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 16 Aug 2017

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	262
RDW CV	BLOOD	13.1
MPV	BLOOD	8.7

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Basic Metabolic Panel	Site/Specimen	12 Apr 2017 1147
Urea Nitrogen	SERUM	16.0
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.88
Glucose	SERUM	112 (H)
Potassium	SERUM	4.9
Sodium	SERUM	140
Calcium	SERUM	9.9
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	113.7
GFR Calculated Black	SERUM	131.4 <i>

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

Lab Result Cited by RODAK, COLLEEN M @ 12 Jun 2017 0925 EDT

Hemoglobin A1c	Site/Specimen	18 May 2017 0835
Hemoglobin A1c	BLOOD	5.2 <i>

A/P Last Updated by RODAK, COLLEEN M @ 13 Jun 2017 0949 EDT

1. Mixed irritable bowel syndrome: anxious / sad effective but has insight into his mood and how the physiological symptoms are exacerbated by his mood state--> severe pain & explosive diarrhea. He is requesting a med board for his condition; he is currently in the process of entering an IOP of his depression / anxiety. He will FU in 2 weeks with a log of his symptoms and we will evaluate his symptoms / treatment / level of disability and the status of his mental health.

Disposition Last Updated by RODAK, COLLEEN M @ 13 Jun 2017 0950 EDT**Released w/o Limitations**

Follow up: as needed in 2 week(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 13 Jun 2017 0950

Note Written by DUVALL, MICHAEL R @ 13 Jun 2017 1129 EDT

(Added after encounter was signed.)

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: 06-13-2017 Patient Name: Daniel Dennis Merwin Patient SSN: [REDACTED]

Proposed start date for limited duty: 06-14-2017 Proposed end date (< 6 months): 12-13-2017

This period of limited duty is for: (Select one)

☒ 1st LIMDU (< 6 months) Enlisted AD5M (no referral to service headquarters necessary).

☐ 2nd LIMDU (< 6 months) Enlisted AD5M (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.

☐ 1st LIMDU (< 6 months) Officer AD5M (referral to service headquarters necessary).

☐ 2nd LIMDU (< 6 months) Officer AD5M (referral to service headquarters necessary).

☐ 3rd or subsequent LIMDU periods on Navy and Marine AD5M involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").

☐ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) Generalized Anxiety Disorder ICD-9 CM Code 300.02

(2) Major Depressive Disorder, Recurrent, Moderate ICD-9 CM Code 296.32

(3) IBS-D ICD-9 CM Code K58.0

Circumstances of injury/illness:

The patient is a 32-year-old male who presents with anxiety, depression, and co-morbid medical conditions that negatively impact his ability to function at home, work, and in social settings. The GI-confirmed IBS-d is of such severity that it daily interferes with military ADLs.

Treatment plan:

PT referred to IOP (mental health) RQ. He has on multiple bowel medications and his IBS-d severity requires that he have close proximity to RR facilities at all times.

Limitations from full duty (including whether transfer/TENDU for treatment is indicated, and any PRT limitations):

Ensure access to all medical appointments. Ensure opportunity for 8 consecutive hours of sleep every 24 hour period. The patient should not have access to weapons. The patient should not PCS, deploy, or be placed in austere environments.

PAUL SHERIN, 1511036794
Printed MEB Member Name and Signature/Date [Signature] Printed: CA Name and Signature/Date

SECTION 2: PATIENT INFORMATION, TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

- ☐ Completion of Patient Information Sheet ☐ Briefing to Patient on Limited Duty/MEBs
- ☐ Notification to PSD/Personnel Office ☐ Notification to MTF LIMDU Coordinator
- ☐ LODD Requested from Parent Command (if LODD required) ☐ Notification to Parent Command
- ☐ Entry into MedBOLTT

Patient Administration Officer/Medical Boards Official Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEHR Case File, and PERS-4821 or MMSR-4.

NAVJMED 6100/5 (Rev. 08-2004)
PREVIOUS EDITIONS OBSOLETE

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M. @ 12 Jun 2017 0942 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 12 Jun 2017 0905 EDT

Chief complaint

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male. This is my first visit with this 32 yo male AD5M with a HX of IBS-d/ pain, GAD/depression, EtOH abuse and genital warts. He presents today with concerns about his allergies and possible asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patients reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Patient is an 32 yo male AD5M that present with 3/10 stomach pain that been on going since he was young. Patient reports he is here to discuss mental health issues and concerns.

Good general overall feeling /health.

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS

OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY

PROBIOTIC (VSL#3) DS-PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY

SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery

Tonsillectomy

PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Alcohol use AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

☐ 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

☐ 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily**SCREENING for Alcohol Use (AUDIT-C)**☐ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)**The following S/O Note Was Overwritten by MINOR, TIFFANY @ 12 Jun 2017 0905 EDT:****S/O Note** Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0841 EDT**Chief complaint**

The Chief Complaint is: IBS, Mental Health, Abdomen-3/10 12Jun2017.

History of present illness

The Patient is a 32 year old male.

He reported: Good general overall feeling /health.

Pain Severity 3/ 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Allergies

Allergies Verified and Updated 12Jun2017

NKDA

animal dander, Cats.

Current medication

Medication Reconciled 12Jun2017

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Metamucil one capsule daily
 Peridex wash
 Motrin 800 mg po twice daily prn
 MVI one po daily
 RIFAXIMIN, 550 MG, TABLET, ORAL TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
 OMEGA-3/DHA/EPA/FISH OIL, 1000 MG, CAPSULE, ORAL TAKE 2 BY MOUTH EVERY DAY
 PROBIOTIC (VSL#3) DS--PO PACK TAKE ONE PACKET BY MOUTH EVERY DAY
 SIMETHICONE, 80 MG, TAB CHEW, ORAL CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK

Alcohol - 3 drinks a week

single / no children / CTN at fort Mead.

Behavioral: No tobacco use history.

Alcohol: Alcohol use AUDIT-C Date:

History ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:Preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other (Specify):Learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No (Specify):(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐Rarely ☐ Sometimes ☐ Often ☐ AlwaysAdvance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 12Jun2017.

Family history

Family medical history Mother A & W

Father DM/ CAD- MI / stent at 40 / melanoma

brother one half substance abuse

Sister three (one depression ; one substance abuse)

Denies a family hx of Crc. Breast CA.

Review of systems

The patient HAS NOT traveled outside of the country in the past 90 days.

Tests

ALCOHOL SCREENING

How often did you have a drink containing alcohol in the past year?

☒ 0=Never, 1=Monthly or less, 2=Two to three times a week, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 0=1 to 2 or does not drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

☐ 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

☐ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits (Conduct BRIEF counseling and consider referral to specialty care)

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)*The following S/O Note Was Overwritten by MINOR, TIFFANY @ 12 Jun 2017 0857 EDT:**S/O Note Written by GRIFFIN, GERALDINE @ 12 Jun 2017 0841 EDT***Allergies**

Allergies Verified and Updated

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
Tonsillectomy
PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
Alcohol - 3 drinks a week
single / no children / CTN at fort Mead.

Family history

Family medical history Mother A & W
Father DM/ CAD- MI / stent at 40 / melanoma
brother one half substance abuse
Sister three (one depression ; one substance abuse)
Denies a family hx of Crc. Breast CA

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

08 Jun 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28632267 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Jun 2017 1136 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **PAUL, SHERIN**

Call Back Phone: [REDACTED]

S/O Note Written by PAUL, SHERIN @ 08 Jun 2017 1139 EDT**Subjective**

Patient called provider due to feeling that his anxiety has become overwhelming and is significantly negatively impacting his ability to be a sailor. Therapist and patient discussed next steps including initiating LimDu and Intensive Outpatient Program. Patient to follow up on scheduled appointment next week.

A/P Last Updated by PAUL, SHERIN @ 08 Jun 2017 1139 EDT**1. Generalized anxiety disorder****Disposition** Last Updated by PAUL, SHERIN @ 08 Jun 2017 1139 EDT**Follow up:** in the PSYCHIATRY BE clinic.**Signed By** PAUL, SHERIN (Clinical Psychologist) @ 08 Jun 2017 1139

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jun 2017 at WRNMMC, Allergy Clinic Bethesda by PETERSEN, MAUREEN MICHELE

Encounter ID: BETH-28615590 Primary Dx: Allergic rhinitis due to animal (cat) (dog)
hair and dander

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **07 Jun 2017 1015 EDT**
Clinic: **ALLERGY CL BE**

Appt Type: **FTR**
Provider: **PETERSEN, MAUREEN
MICHELE**

Reason for Appointment:

F/U skin testing

Appointment Comments:

yyc

Vitals

Vitals Written by PROVENCIO, ELISHA S. @ 07 Jun 2017 1006 EDT

BP: 129/75, HR: 75, RR: 16, HT: 69 in, WT: 168 lbs, BMI: 24.81, BSA: 1.918 square meters, Tobacco Use: No,
Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: no anti-histamines in last 7 days or more

Note Written by ACKERMAN, JOI D @ 07 Jun 2017 1058 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

WRNMMC Aeroallergen
Skin Test Rep20 [REDACTED]
MERWIN, DANIEL DENNIS
SEX: M DOB: [REDACTED] 1985 AGE: 32
USN N11 POT NRPName:
SSN:Date:
DOB:

TREE POLLENS		Prick		MOLD SPORES		Prick					
		W	E			W	E				
1	Ash, White (1:20 W/V)			32	Alternaria Tenax (1:20 W/V)						
2	Beech (1:20 W/V)			33	Aspergillus Fumigatus (1:20 W/V)						
3	Birch Mix (1:20 W/V)			34	Cladosporium Mix (1:20 W/V)						
4	Box Elder (1:20 W/V)			35	Curvularia Specifera (1:20 W/V)						
5	Cedar, MTN (1:20 W/V)			36	Epicoccum Nigrum (1:40 W/V)						
6	Cottonwood, Common (1:20 W/V)			37	Helminthosporium Iler (1:20 W/V)						
7	Elm, Amer (1:20 W/V)			38	Mucor Racemosus (1:20 W/V)						
8	Maple, Red (1:20 W/V)			39	Penicillium Notatum (1:20 W/V)						
9	Mesquite (1:20 W/V)										
10	Mulberry, Red (1:20 W/V)										
11	Oak, Mix (B,R,W) (1:20 W/V)										
12	Pecan (1:20 W/V)										
13	Sycamore, East (1:20 W/V)										
14	Walnut, Black (1:20 W/V)										
GRASS POLLENS		W		E		PERENNIALS		W		E	
15	Bahia (1:20 W/V)					40	Cat Hair (10,000BAU/ml)				
16	Bermuda (10,000BAU/ml)					41	AP Dog (1:100W/V)				
17	Bluegrass, KY (10,000BAU/ml)					42	Mite Mix (5,000 AU/ml)				
18	Johnson (1:20 W/V)					43	Cockroach Mix (1:20 W/V)				
19	Rye Perennial (10,000BAU/ml)										
20	Timothy (10,000BAU/ml)										
WEED POLLENS		W		E		OTHER		W		E	
21	Dock/Sorrel Mix (1:20 W/V)										
22	Kochia (1:20 W/V)										
23	Lamb's Quarters (1:20 W/V)										
24	Marshelder Mix (1:20 W/V)										
25	Pigweed-Careless Mix (1:20 W/V)										
26	Plantain, English (1:20 W/V)										
27	Ragweed Mix (1:20 W/V)										
28	Ragweed West (1:20 W/V)										
29	Russian Thistle (1:20 W/V)										
30	Sage, Mugwort (1:20 W/V)										
31	Wingscale (1:20 W/V)										

CONTROLS

- 50% Glycerin	2	4
+ Histamine 10mg/ml	8	80

NP= Not Performed
W = Wheal (mm)
E = Erythema (mm)
P = Pseudopod

Skin Test Protocol and Standards

Last use of antihistamine (or other medication affecting response to histamine): _____ days
Location of skin test: Arm ☒ Back ☐
Device used for prick test: Greer Pick (GP-1)
All extracts are manufactured by Greer Laboratories, Lenoir North Carolina
Results are determined by measuring the largest diameter of induration (W) by the largest diameter of erythema (E).

Testing Technician:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record	WRNMMC Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	
1. OPERATION or PROCEDURE (Describe)		
Allergen Skin Test		
A. IDENTIFICATION		SIDE (MARK ONE)
		<input type="checkbox"/> Right <input type="checkbox"/> Bilateral
		<input type="checkbox"/> Left <input type="checkbox"/> Not Applicable
B. STATEMENT OF REQUEST		
<p>2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):</p> <p>The purpose of allergen skin test is to identify the substances causing allergic symptoms. It is performed by applying an extract of an allergen to your skin, scratching or pricking the skin to allow exposure, and then evaluating the skin's reaction. It may also be done by injecting the allergen under the skin, or by applying it to a patch that is worn on the skin for a specified period of time. Allergy may also be detected by a blood test. Risks are local discomfort, allergic reaction including hives, swelling, cough, wheezing, shortness of breath, nose symptoms, throat closure, blood pressure drop, and rarely shock.</p> <p>which is to be performed by or under the direction of:</p> <p>3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.</p> <p>4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.</p> <p>5. Exceptions to surgery or anesthesia, if any, are (if "none", so state):</p> <p>6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which it may be necessary to remove.</p> <p>7. I understand that photographs and x-rays may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and the observation of the operation by authorized personnel, subject to the following conditions:</p> <p>a. The name of the patient and his/her family is not used to identify said pictures.</p> <p>b. Said pictures are used only for purposes of medical/clinical study or research.</p> <p>8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present: (Cross out any parts above which are not applicable)</p>		
C. SIGNATURES (Approval items in parts A & B must be completed before signing.)		
9. COUNSELING Provider: I have counseled the patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to regional anesthesia, sedation, and significant alternative therapies.		
Provider's Signature:	[Signature]	
Provider's Printed Name:	Maureen Petersen, MD	
10. PATIENT/Guardian: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.		
Patient/Guardian's Signature:	[Signature]	
Witness' Signature:	[Signature]	
	Date (MM/DD/YYYY)	Time (HH:MM)
	06/17/2017	10:30
D. UNIVERSAL PROTOCOL / TIME OUT		
"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:		
1. CORRECT PATIENT (Full Name / Birth Date).....	<input type="checkbox"/> YES	
2. CORRECT PROCEDURE	<input type="checkbox"/> YES	
3. CORRECT SITE**	<input type="checkbox"/> YES	
4. REQUIRED EQUIPMENT AVAILABLE	<input type="checkbox"/> YES <input type="checkbox"/> N/A	
5. IMAGES / LABS AVAILABLE, PROPERLY LABELED	<input type="checkbox"/> YES <input type="checkbox"/> N/A	
** The site must be marked and verified for procedures involving right/left distinction, multiple sites (e.g. right), or multiple levels (see to spinal procedures) per WRNMMC policies.		
Signature below indicates the procedure may be started. If any element is not completed as required, procedure may NOT be started.		
Timeout Verified by:	[Signature]	
	Date (MM/DD/YYYY)	Time (HH:MM)
	06/17/2017	10:30
PATIENT'S IDENTIFICATION (For typed verification, give Name - Last, First Middle Initial, SSN or with Hospital or Medical Facility)		
<p>20 [REDACTED]</p> <p>MERWIN, DANIEL DENNIS</p> <p>SEX: M DOB: [REDACTED] AGE: 32</p> <p>USN N11 P01 NRP</p> <p>STAFF PATIENT</p>		
<p>REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES</p> <p>Medical Record</p> <p>LOCAL FORM 522 (Rev. 2/2012)</p> <p>Prescribed by GBA/DAIR FMR (41 CFR 102-193.346)</p> <p>Dist. Exempt to OF 522 approved by OGA</p>		

Note Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1412 EDT
32 yo M who presents for skin testing.

Patient with significant PMH for anxiety and IBS was previously seen for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking zyrtec for these symptoms.

No history of food/medication/venom allergies, eczema, or history of anaphylaxis.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

NKDA.

Current medication

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.

Personal history

Social history reviewed Denies etoh and tobacco abuse

Pets: none.

Family history

Family medical history

non-contributory.

Review of systems**Systemic:** No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.**Head:** No headache, no facial pain, and no sinus pain.**Eyes:** No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort and no palpitations.**Pulmonary:** Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Skin:** No pruritus. No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Middle Ear: ° No fluid in middle ear.

Nose:

General/bilateral:

Discharge: ° No nasal discharge seen.

External Deformities: ° No external nose deformities.

Cavity: ° Nasal septum normal. ° Nasal mucosa normal. ° Nasal turbinate not erythematous. ° Nasal turbinate not swollen.

Sinus Tenderness: ° No sinus tenderness.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Neurological:

° Oriented to time, place, and person.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Allergic rhinitis: 32 yo M with skin testing only positive to Cat. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass (picture of back shown to me by patient today is c/w large urticaria on back). Exam today WNL.

-Cont treatment with albuterol prn symptoms

-Discussed acute urticaria and rhinitis. Plan for daily Zyrtec to prevent urticaria and prevent symptoms in the presence of cats.

Discussed avoidance measures.

-Would avoid Singulair use in this patient due to behavioral health issues (Singulair has a black box warning regarding SI)

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

A/P Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT**1. Allergic rhinitis due to animal (cat) (dog) hair and dander:** See above.

Procedure(s):

-Allergy Percutaneous tests - allergenic extracts x 45 ADDITIONAL PROVIDER(S): ACKERMAN, JOI D -

Benefits and risks of skin testing discussed to include the risk of discomfort, bleeding/bruising, and allergic reactions. Patient agreed to proceed and consent signed. Positive and negative controls were placed along with a full aeroallergen panel. Test was read at 15 minutes and results were recorded.

Disposition Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT**Released w/o Limitations****Follow up:** as needed with PCM. - Comments: f/u prn; meds reconciled.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By PETERSEN, MAUREEN M** (Staff Attending, WRNMMC Allergy, Immunology, & Immunizations) @ 10 Jun 2017 1418

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Jun 2017 at WRNMMC, Int Med CL C Medical Home BE by SMITH, MICKALYNN J

Encounter ID: BETH-28606622 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **06 Jun 2017 1409 EDT**
 Clinic: **INT MED CL C MEDICAL HOME BE**

Appt Type: **T-CON***
 Provider: **SMITH,MICKALYNN J**

Call Back Phone: **close****Reason for Telephone Consult:** Written by DUVALL,MICHAEL R @ 06 Jun 2017 1409 EDT

PCM/DR. RODAK - RELAY HEALTH

Telephone Consult Comments: Written by DUVALL,MICHAEL R @ 06 Jun 2017 1409 EDT

From Daniel Merwin

To Ms. Colleen Rodak, NP

Provider Ms. Colleen Rodak NP

Patient Daniel Merwin

Sent Date Jun 06, 2017 10:23 AM

Subject Mental Health - Service

Message I think that being in the Navy is compounding my stress and anxiety levels so much that it is not helping me in my behavior health treatment and IBS. Additionally I have not been able to have in person relationship with my mom or two sisters ever. Also being away for so long makes it even more difficult. Being able to live near them and properly develop a relationship for the first time with my mom and sisters (I never lived with or saw my mom or even saw her much in life) would significantly improve my healing, learning and ability to cope. Unfortunately they live in South Carolina. I am not technically able to be "mobilized or deployed" with the IBS issues that I am having and my mental health is causing problems with my day to day living with the numerous extra responsibilities required of me as a Sailor on top of just showing up to do my technical job. I am unable to be productive and get past the fact I have no one locally and my family that I want to build a relationship with beyond a phone are distant and I have never had the opportunity to do so. For my mental health I feel that it is critical as well as I am unsure that I am mentally fit for service.

R,

Daniel Merwin

Questionnaire AutoCites Refreshed by GRIFFIN,GERALDINE @ 06 Jun 2017 1520 EDT**Questionnaires****Note** Written by SMITH,MICKALYNN J @ 06 Jun 2017 1603 EDT**RN note**

Spoke with pt who denies SI/ HI and having a plan. Pt has hx of anxiety dx, and is being treated in BH. Pt would like to be seen to assess his continued treatment and ways to develop relationships and support systems while in the armed forces. Pt scheduled with PCM. TCON closed.

A/P Written by SMITH,MICKALYNN J @ 07 Jun 2017 0837 EDT**1. Encounter for other administrative examinations**

Procedure(s):
 -Non-Physician Phone Call To Patient/Provider Brief (5-10min) x 1
 -Internet Med Svc Qual Nonphys Healthcare Prof Estab Patient x 1

Disposition Last Updated by SMITH,MICKALYNN J @ 07 Jun 2017 0837 EDT**Referred for Appointment****Note** Written by GRIFFIN,GERALDINE @ 06 Jun 2017 1541 EDT

Patient scheduled an appointment with Provider pls. see below.

INT MED CL F MEDICAL/WRNMMC RODAK,COLLE 12Jun2017@0845 FTR/30 PENDING
 Arrive 15 min early

Signed By SMITH, MICKALYNN J (Registered Nurse) @ 07 Jun 2017 0837

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Jun 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28555023 Primary Dx: Other specified counseling

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Jun 2017 1159 EDT**
 Clinic: **INT MED CL F MEDICAL HOME**
BE

Appt Type: **T-CON***
 Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by KAMARA, KADIDJA B @ 01 Jun 2017 1159 EDT

Correspondance with Gastroenterology

Telephone Consult Comments: Written by KAMARA, KADIDJA B @ 01 Jun 2017 1159 EDT

From Daniel Merwin

To Ms. Colleen Rodak, NP

Provider Ms. Colleen Rodak NP

Patient Daniel Merwin

Sent Date Jun 01, 2017 7:53 AM

Subject Correspondance Between Gastroenterology

Message Just provided a copy of the correspondence I have sent to Gastroenterology relating to the last appointment.

=== Start Email ===

I was just wanting to update you on how the last appointment changes went.

Taking a fiber supplement has stopped some of the diarrhea symptom and at least made my stool softened; as long as I take 2 x 0.52 grams "Psyllium Husk Fiber" capsules. The problem with this is I still have pain; the pain is now lasting a lot longer up to a few hours now at a time instead of 15-60 minutes. A few of the days this week the pain was all day. Additionally I feel a lot more bloated. I have had work interrupted on several occasions due to the pain or need to use the bathroom. I have actually almost felt like lost control of holding it in twice and nearly went in my pants.

The Simethicone has not reduced my gas.

The Hyoscyamine does not help the pain at all.

=== End Email ===

View/Print Never Updated Merwin, Daniel -- DOB Feb 16, 1985

Lab Result Cited by RODAK, COLLEEN M @ 01 Jun 2017 1610 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

A/P Last updated by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT**1. Other specified counseling**

2. Irritable bowel syndrome with diarrhea: Symptoms of diarrhea & pain ; chart reviewed & patient called-PLAN:

1. HLD --> (confirmed fasting) will start omega 3 FA 2 po daily, referred to nutrition & repeat lipids in 3 months

2. For IBS symptoms --> Rifaximin 550 mg po Q 8 h x 14 days & FU with GI after completion

patient verbalized understanding

Medication(s):

-OMEGA-3/DHA/EPA/FISH OIL--PO 1,000MG CAP - TAKE 2 BY MOUTH EVERY DAY R3 #180 RF3
 -RIFAXIMIN--PO 550MG TAB - TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR 14 DAYS
 R0 #42 RF0

Disposition Written by RODAK, COLLEEN M @ 01 Jun 2017 1614 EDT**Follow up:** as needed with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Note Written by KAMARA,KADIDJA B @ 01 Jun 2017 1221 EDT

Patient was last seen in the internal medicine on 05/17/2017. Patient is sending a correspondence he had with Gastroenterology.Please review and advise. Thank you.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 01 Jun 2017 1614

CHANGE HISTORY

The following A/P Note Was Overwritten by RODAK,COLLEEN M @ 01 Jun 2017 1614 EDT:

The A/P section was last updated by RODAK,COLLEEN M @ 01 Jun 2017 1614 EDT - see above.Previous Version of A/P section was entered/updated by KAMARA,KADIDJA B @ 01 Jun 2017 1202 EDT.

1. Other specified counseling

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 May 2017 at WRNMMC, Allergy Clinic Bethesda by BANKS, TAYLOR ALLEN

Encounter ID: BETH-28494443 Primary Dx: Dyspnea, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **25 May 2017 0930 EDT**
 Clinic: **ALLERGY CL BE**

Appt Type: **SPEC**
 Provider: **BANKS,TAYLOR ALLEN**

Reason for Appointment:

Encounter for other general examination

Appointment Comments:

MJ/IRMAC

Vitals**Vitals** Written by ACKERMAN,JOI D @ 25 May 2017 1001 EDT

BP: 124/83, HR: 74, RR: 16, HT: 69 in, WT: 165 lbs, SpO₂: 96%, BMI: 24.37, BSA: 1.903 square meters,
 Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

S/O Note Written by HERNANDEZ,CAMELLIA L @ 25 May 2017 1036 EDT**Chief complaint**

The Chief Complaint is: Concern for asthma.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

32 yo M without significant PMH presents for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking zyrtec for these symptoms.

No history of food/medication/venom allergies, eczema, or history of anaphylaxis.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated

NKDA.

Current medication

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.

Past medical/surgical history**Reported:**

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

.

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.

Personal history

Social history reviewed Denies etoh and tobacco abuse

Pets: none.

Family history

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Family medical history
non-contributory.

Review of systems

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.

Head: No headache, no facial pain, and no sinus pain.

Eyes: No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.

Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.

Gastrointestinal: No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.

Musculoskeletal: No back pain.

Neurological: No lightheadedness.

Skin: No pruritus. No skin lesions and no rash.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Nose:

General/bilateral:

Discharge: ° No nasal discharge seen.

External Deformities: ° No external nose deformities.

Cavity: ° Nasal septum normal. ° Nasal mucosa normal. ° Nasal turbinate not erythematous. ° Nasal turbinate not swollen.

Sinus Tenderness: ° No sinus tenderness.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Neurological:

° Oriented to time, place, and person.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Test conclusions

[x] Written care plan and [] clinical summary of today's visit was provided to patient.

Practice Management

Preventive medicine services.

A/P Last Updated by HERNANDEZ,CAMELLIA L @ 25 May 2017 1055 EDT

1. Dyspnea, unspecified: 32 yo M without significant PMH presents with symptoms of chest tightness and difficulty getting air in on exposure to cats, dogs and grass. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass. Exam today WNL. Spirometry performed today also WNL. History and symptoms could be consistent with allergic asthma, however, could also be due to VCD.

-Could not perform SPT today due to recent antihistamine use, however, Pt will follow up on June 7th at 10:15 for SPT to the aeroallergens. Pt will discontinue Zyrtec 5 days prior to next apt.

-Cont treatment with albuterol prn symptoms

-If SPT negative, would consider referral to pulmonology for consideration of MCCT vs laryngoscopy to evaluate for asthma and VCD

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

Procedure(s):

-Spirometry Pre-bronchodilator x 1 ADDITIONAL PROVIDER(S): BANKS,TAYLOR ALLEN - Interpretation: The patient has normal baseline spirometry.

Disposition Last updated by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT**Released w/o Limitations****Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by HERNANDEZ,CAMELLIA L @ 25 May 2017 0953 EDT**Consult Order****Referring Provider:** RODAK, COLLEEN M**Date of Request:** 17 May 2017**Priority:** Routine**Provisional Diagnosis:**

Encounter for other general examination

Reason for Request:

This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander --> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you

Note Written by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT

I saw and evaluated the patient. Discussed with resident/fellow and reviewed the history/PE and assessment and plan as documented in the note and agree.

Signed By BANKS, TAYLOR ALLEN (WRNMMC Allergy-Immunology Staff Physician, Physician/Workstation) @ 25 May 2017 2031

CHANGE HISTORY**The following Disposition Note Was Overwritten** by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT:

The Disposition section was last updated by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT - see above. Previous Version of Disposition section was entered/updated by HERNANDEZ,CAMELLIA L @ 25 May 2017 1056 EDT.

Released w/o Limitations**Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**The following Allergy was Deleted:** OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1038 EDT:**The following Allergy was Deleted:** OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1037 EDT:**The following Allergy was Deleted:** OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1037 EDT:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28460959 Primary Dx: Other hyperlipidemia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **23 May 2017 0843 EDT**
 Clinic: **INT MED CL F MEDICAL HOME
 BE**

Appt Type: **T-CON***
 Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

AutoCites Refreshed by RODAK, COLLEEN M @ 23 May 2017 0844 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by RODAK, COLLEEN M @ 23 May 2017 0843 EDT

Lipid panel

Questionnaire AutoCites Refreshed by RODAK, COLLEEN M @ 23 May 2017 0844 EDT**Questionnaires****Lab Result** Cited by RODAK, COLLEEN M @ 23 May 2017 0847 EDT

Lipid Panel	Site/Specimen	18 May 2017 0835
Cholesterol	SERUM	224 <i>
Triglyceride	SERUM	262 <i>
HDL Cholesterol	SERUM	49 <i>
Cholesterol/HDL Cholesterol	SERUM	4.6
LDL Cholesterol Direct	SERUM	140 <i>
Cholesterol Non-HDL	SERUM	175 <i>

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Last Updated by RODAK, COLLEEN M @ 23 May 2017 0852 EDT

1. Other hyperlipidemia: Called patient and confirm that lab was fasting; reviewed lipid panel. DAL the potential long term risk of HLD and I have requested he see nutrition for a consultation. Additionally I have placed him on FA and will repeat lipids in 3 months. (Aug. 2017)

Medication(s): -OMEGA-3/DHA/EPA/FISH OIL--PO 1,000MG CAP - TAKE ONE CAPSULE BY MOUTH THREE TIMES A DAY R3 #270 RF3

Laboratory(ies): -LIPID PANEL (Routine) Start Date: 08/01/2017

Disposition Last Updated by RODAK, COLLEEN M @ 23 May 2017 0845 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 23 May 2017 0859

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28447547 Primary Dx: Other specified counseling

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **22 May 2017 1022 EDT**
 Clinic: **INT MED CL F MEDICAL HOME
 BE**

Appt Type: **T-CON***
 Provider: **RODAK, COLLEEN M**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by RAYMOND, KEVIN D @ 22 May 2017 1022 EDT
 message sent via relayhealth - rodak

Telephone Consult Comments: Written by RAYMOND, KEVIN D @ 22 May 2017 1022 EDT

Prescription

Message I have not picked up the probiotic as they did not have it in stock. I will make a follow up with dermatology.

Respectfully,
 Daniel Anderson

Questionnaire AutoCites Refreshed by KAMARA, KADIDJA B @ 22 May 2017 1517 EDT
Questionnaires

A/P Last updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT

1. Other specified counseling: Noted

Disposition Last Updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT

Note Written by KAMARA, KADIDJA B @ 22 May 2017 1522 EDT

Pt wants to inform you that medication is not in stock for pick up but will follow up with dermatologist. Please review and advise.
 Thank you.

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 23 May 2017 0914

CHANGE HISTORY

The following A/P Note Was Overwritten by RODAK, COLLEEN M @ 23 May 2017 0913 EDT:

The A/P section was last updated by RODAK, COLLEEN M @ 23 May 2017 0913 EDT - see above. Previous Version of A/P section was entered/updated by KAMARA, KADIDJA B @ 22 May 2017 1521 EDT.

1. Other specified counseling

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 305
AR 2292

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 May 2017 at WRNMMC, Int Med CL F Medical Home BE by RODAK, COLLEEN M

Encounter ID: BETH-28408872 Primary Dx: Encounter for other general examination

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **17 May 2017 1345 EDT**
 Clinic: **INT MED CL F MEDICAL HOME
 BE**

Appt Type: **FTR**
 Provider: **RODAK, COLLEEN M**

Reason for Appointment:

referral allergy testing

Appointment Comments:

mjs

Vitals**Vitals** Written by KAMARA, KADIDJA B @ 17 May 2017 1415 EDT

BP: 116/78 Left Arm, Adult Cuff, HR: 85, RR: 18, T: 98.4 °F Oral, HT: 69 in Stated, With Shoes,
 WT: 82.2 kg Upright Scale, Actual, With Shoes, SpO₂: 98%, BMI: 26.76, BSA: 1.981 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: 2 TO 3 PER WEEK, Pain Scale: 6/10 Moderate, Pain Scale
 Comments: Tooth and facial pain

Questionnaire AutoCites Refreshed by KAMARA, KADIDJA B @ 17 May 2017 1428 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 17 May 2017

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: More than half the days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: More than half the days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

Falls Risk Screening (Outpatient) Taken On: 17 May 2017

1. Patient's age: Less than 65 years old
2. History of fall in the past year?: No
3. **Physical appearance: No concerns;**
4. **Balance: No concerns with balance;**
5. Is the patient a falls risk?: No

S/O Note Written by RODAK, COLLEEN M @ 19 May 2017 1032 EDT**Chief complaint**

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

This is my first visit with this 32 yo male AD/SM with a HX of IBS-d/ pain, GAD/depression, EtOH abuse and genital warts. He presents today with concerns about his allergies and possible asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patient reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated

NKDA

animal dander.

Current medication

Metamucil one capsule daily

Peridex wash

Motrin 800 mg po twice daily prn

MVI one po daily

Verified CMR

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical/surgical history**Reported:**

Medical: Reported medical history IBS-D
 GAD / depression
 HX of EtOH abuse (previous inpatient treatment)
 HPV genital

Surgical / Procedural: Surgical / procedural history Jaw surgery
 Tonsillectomy
 PRK.

Personal history

Social history reviewed Tobacco - 1/4 pack a week time UK
 Alcohol - 3 drinks a week
 single / no children / CTN at fort Mead.

Family history

Family medical history Mother A & W
 Father DM/ CAD- MI / stent at 40 / melanoma
 brother one half substance abuse
 Sister three (one depression ; one substance abuse)
 Denies a family hx of Crc. Breast CA.

Review of systems

Systemic: No fever, no chills, no night sweats, and no recent weight loss.

Head: No headache. Facial pain.

Eyes: No vision problems.

Cardiovascular: No chest pain or discomfort. Palpitations.

Pulmonary: No cough and no wheezing.

Gastrointestinal: Heartburn. No nausea and no vomiting. Abdominal pain and diarrhea. No constipation.

Genitourinary: No hematuria and no testicular symptoms were present. No abnormal urethral discharge.

Neurological: No motor disturbances and no sensory disturbances.

Psychological: Anxiety, depression, and thinking about suicide passive once a month in CBT / discusses these thoughts ; one previous suicide attempt took large amounts of ASA --> no treatment. No homicidal thoughts.

Skin: No pruritus. Skin lesion: No rash. Nails are normal.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

External: ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • Nasal discharge seen clear.

Cavity: • Nasal turbinate erythematous. • Nasal turbinate swollen.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Abnormal + braces speaking with reduced opening of mouth due to recent surgery / no erythema, (pain improving QD) no head / neck LAD / no clinical evidence of infectious process ; + PND.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Test conclusions

Medication list was updated at the beginning of the visit.

Note Written by MINOR, TIFFANY @ 17 May 2017 1414 EDT

The HPI section was prepared by Tiffany Minor as Scribe, and reviewed by Colleen

Rodak, NP. on May 17, 2017 at 14:14

Colleen Rodak NP: The scribe's documentation in the HPI section has been prepared and reviewed by me in its entirety. I confirm that the note above accurately reflects all work, treatment, procedures, and medical decision making performed by me.

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232
Gamma-Glutamyl Transferase	SERUM	49

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232
Albumin	SERUM	4.9
Alkaline Phosphatase	SERUM	58
Alanine Aminotransferase	SERUM	34
Aspartate Aminotransferase	SERUM	24
Bilirubin	SERUM	0.3
Bilirubin Direct	SERUM	<0.2
Protein	SERUM	7.6

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

CBC W/o Diff	Site/Specimen	12 Apr 2017 1147
WBC	BLOOD	6.0
RBC	BLOOD	4.58
Hemoglobin	BLOOD	14.4
Hematocrit	BLOOD	42.3
MCV	BLOOD	92.4
MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	262
RDW CV	BLOOD	13.1
MPV	BLOOD	8.7

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lab Result Cited by RODAK, COLLEEN M @ 17 May 2017 1439 EDT

Basic Metabolic Panel	Site/Specimen	12 Apr 2017 1147
Urea Nitrogen	SERUM	16.0
Carbon Dioxide	SERUM	28
Chloride	SERUM	99
Creatinine	SERUM	0.88
Glucose	SERUM	112 (H)
Potassium	SERUM	4.9
Sodium	SERUM	140
Calcium	SERUM	9.9
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	113.7
GFR Calculated Black	SERUM	131.4 <i>

A/P Written by RODAK, COLLEEN M @ 19 May 2017 1032 EDT

1. Encounter for other general examination: This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander --> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you

Medication(s): -CETIRIZINE--PO 10MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF0
 -ALBUTEROL--PO 90MCG/PUFF MDI - INHALE 2 PUFFS BY MOUTH EVERY FOUR HOURS AS NEEDED FOR COUGH, WHEEZE, OR SHORTNESS OF BREATH #1 RF0

Laboratory(ies): -HEMOGLOBIN A1C (Routine); LIPID PANEL (Routine)

Consult(s): -Referred To: ALLERGY NCR (Routine) Specialty: ALLERGY Clinic: RM ALLERGY IR Provisional
 Diagnosis: Encounter for other general examination

2. Irritable bowel syndrome with diarrhea: He has a long HX of IBS -D / pain and is followed closely by GI; he denies changes to his baseline.

Medication(s): -PROBIOTIC (VSL#3 DS)--PO PACK - TAKE ONE BY MOUTH EVERY DAY R1 #3 RF1
 -SIMETHICONE--PO 80MG TBCH - CHEW 1 TABLET FOUR TIMES A DAY AS NEEDED FOR GAS #100 RF2

3. Anogenital (venereal) warts: Previously treated with topicals and cryosurgery by dermatology; on PE --> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology will refer to dermatology.

Referred to dermatology--> 32 to with penile lesions Previously treated for genital warts with topicals and cryosurgery by dermatology; on PE --> 3 less than 05mm circular flat lesions consistent with warts on penis shaft; patient is very anxious about the recurrence and is requesting to be evaluated by dermatology please evaluate additional question is if this patient should undergo an anal PAP thank you

Consult(s): -Referred To: DERMATOLOGY NCR (Routine) Specialty: DERMATOLOGY Clinic: RM
 DERMATOLOGY IR Provisional Diagnosis: Anogenital (venereal) warts Order Date: 05/19/2017 10:31

Disposition Written by RODAK, COLLEEN M @ 19 May 2017 1042 EDT**Released w/o Limitations**

Follow up: as needed in 6 month(s) with PCM and/or in the INT MED CL F MEDICAL HOME BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Signed By RODAK, COLLEEN M (Civilian, Nurse Practitioner) @ 19 May 2017 1042

CHANGE HISTORY

The following S/O Note Was Overwritten by RODAK, COLLEEN M @ 17 May 2017 1443 EDT:

S/O Note Written by MINOR, TIFFANY JOHNETTA @ 17 May 2017 1406 EDT

Chief complaint

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Patient is an 32 yo male ADPM that's presents with concerns about his allergies and asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his mouth due to root canal. Patients reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Past medical/surgical history**Reported:**

Surgical / Procedural: Surgical / procedural history

Jaw surgery April.

Family history

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Family medical history Dad diabetic sister diabetic

The following S/O Note Was Overwritten by KAMARA,KADIDJA B @ 17 May 2017 1422 EDT:
S/O Note Written by MINOR, TIFFANY JOHNETTA @ 17 May 2017 1406 EDT

Chief complaint

The Chief Complaint is: Asthma, allergy and warts.

History of present illness

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

Patient is an 32 yo male ADSM that's presents with concerns about his allergies and asthma. Patient reports he had surgery on his mouth on April 26, 2017. Patient reports pain 6/10 today in his month due to root canal. Patients reports he has an appointment tomorrow for an follow for his mouth. Patient reports he has genital warts as well that he would like to address.

Pain Severity 6 / 10.

Past medical/surgical history

Reported:

Surgical / Procedural: Surgical / procedural history
Jaw surgery April.

Family history

Family medical history Dad diabetic sister diabetic

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 May 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-28427406 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 May 2017 1400 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Appointment Comments:
 djs

Note Written by PAUL, SHERIN @ 19 May 2017 0658 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 5
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male**Military Data:**

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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DoD ID: 1286180538

Created: 16 Aug 2017

that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:

Treatment modality currently used: Psychoeducation & Behavior Mod

Pain: 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that since his last visit, he received feedback that he had been observed in inappropriate conversation at work which was reported by a coworker. Patient expressed surprise that this happened as he tries to be a positive leader and role model. He noted that he teaches the ethics and sexual harassment seminars. However, he acknowledged that he may have felt too comfortable with someone and said something inappropriate for the workplace. Patient expressed guilt and embarrassment about this. He stated that he needed to work on how to filter his conversations better. Therapist and patient discussed how he felt about making a mistake of this level that was reported to authority figures. Patient described difficult process in not feeling ashamed to go into work. He stated that he tries to remind himself that this incident was a mistake and not representative of who he is as a whole person. Therapist encouraged continuing to follow up with therapy more regularly.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 01 March 2017

Reviewed with patient on: 01 March 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

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Created: 16 Aug 2017

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 19 May 2017 0700 EDT

1. Generalized anxiety disorder

Procedure(s):

-Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 19 May 2017 0700 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 19 May 2017 0700

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

16 May 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-28385488 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **16 May 2017 0930 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 16 May 2017 0950 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by DAVIS,ANNETTE R @ 16 May 2017 0934 EDT

BP: 116/68, HR: 88, RR: 18, HT: 69 in, WT: 170 lbs, BMI: 25.1, BSA: 1.928 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: Social Drinker, Pain Scale: 5/10 Moderate, Pain Scale Comments: Acute Fluctuating Jaw pain

Comments: Denies fever and or chills in the past 72 hours.**Appointment Comments:**

djs

Vitals**Vitals** Written by DAVIS,ANNETTE R @ 16 May 2017 0934 EDT

BP: 116/68, HR: 88, RR: 18, HT: 69 in, WT: 170 lbs, BMI: 25.1, BSA: 1.928 square meters, Tobacco Use: No,
 Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: Social Drinker, Pain Scale: 5/10 Moderate, Pain Scale Comments: Acute Fluctuating Jaw pain

Comments: Denies fever and or chills in the past 72 hours.**Note** Written by TOBAR,EDEN @ 16 May 2017 2051 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #8

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Patient presents for follow-up. Since we last met two months ago he's had his dental surgery. He admits he stopped taking his Lexapro several weeks ago because he felt more flat on it. He does not want to take psychiatric medication. He would rather work on himself through therapy. He notes lately he's under increased stress at work because he has been told he's under investigation and he's not sure why. He was drinking 1 to 2 beers a night before his surgery. He tried drinking a beer after his surgery and didn't like how he felt so hasn't drank since. He is not taking a Lunesta as he does not like how he feels on it. He has an appointment with Dr. Paul later today. We discussed his symptoms may be best to respond to therapy alone. Reviewed his psychologic testing results, which he went over with the testing psychologist.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people , and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medications: Lexapro 20 mg po daily, naltrexone 50 mg po daily , lunesta 1-2 mg po qhs prn insomnia

Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)	

Hepatic Function Panel	Site/Specimen	04 Jan 2017 1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM 58	U/L	(40-129)	
Alanine Aminotransferase	SERUM 34	U/L	(0-41)	
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)	
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)	
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)	
Protein	SERUM 7.6	g/dL	(6.6-8.7)	

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD 44.4	%	(37.5-50.9)	
MCV	BLOOD 91.4	fL	(79.5-96.8)	
MCH	BLOOD 31.1	pg	(26.2-33.1)	
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD 12.9	%	(12.0-16.2)	
Platelets	BLOOD 272	x10(3)/mcL	(162-427)	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	
Barbiturates	URINE	NEGATIVE <i>	(Negative)	

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Benzodiazepines	URINE	NEGATIVE <i>	(Negative)
Cocaine	URINE	NEGATIVE <i>	(Negative)
Opiates	URINE	NEGATIVE <i>	(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in psychotherapy

Intervention: pt declines pharmacotherapy and it is not absolutely indicated. Have discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep
Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Medical Record

Merwin, Daniel Dennis

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: prn

Referrals:pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR,EDEN @ 16 May 2017 2056 EDT

1. Generalized anxiety disorder

Disposition Written by TOBAR,EDEN @ 16 May 2017 2057 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR,EDEN @ 16 May 2017 1000 EDT

Additional A/P Information:

Discontinued ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY

Note Written by TOBAR,EDEN @ 16 May 2017 1000 EDT

Additional A/P Information:

Discontinued NALTREXONE--PO 50MG TAB - TAKE 1/2 TABLET BY MOUTH EVERY DAY X 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 16 May 2017 2058

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

19 Apr 2017 at WRNMMC, Int Med CL F Medical Home BE by SMITH, MICKALYNN J

Encounter ID: BETH-28097609 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **19 Apr 2017 1152 EDT**
Clinic: **INT MED CL F MEDICAL HOME
BE**Appt Type: **T-CON***
Provider: **SMITH,MICKALYNN J**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by RAYMOND,KEVIN D @ 19 Apr 2017 1152 EDT
referral request sent via relayhealth - rodak**Telephone Consult Comments:** Written by RAYMOND,KEVIN D @ 19 Apr 2017 1152 EDT

I have in the past been seen for breathing issues around cats. I have been getting burning sensations on my skin/eyes from grass and animals; sometimes dust will seem to cause breathing issues. I think I have allergies and or asthma related to allergies. Previously I have been seen and given an inhaler which worked for the breathing but I am not under and long term treatment or related to the skin/eyes. This effects me during Physical Training sessions and sometimes in the office (dust). I was not sure if it would be better to email about this over making an appointment just to get a referral.

Questionnaire AutoCites Refreshed by SMITH,MICKALYNN J @ 19 Apr 2017 1400 EDT
Questionnaires**A/P** Written by SMITH,MICKALYNN J @ 21 Apr 2017 1539 EDT**1. Encounter for other administrative examinations**

Procedure(s): -Non-Physician Phone Call To Pt/Provider Intermed (11-20 min) x 1

Disposition Last Updated by SMITH,MICKALYNN J @ 21 Apr 2017 1539 EDT
Referred for Appointment**Note** Written by SMITH,MICKALYNN J @ 20 Apr 2017 0924 EDT

LEft general message for pt to call back to Team Fox River.

Note Written by SMITH,MICKALYNN J @ 21 Apr 2017 0832 EDT

Left general message for pt to call back to Team Fox River.

Note Written by SMITH,MICKALYNN J @ 21 Apr 2017 1536 EDT

Pt returned Team Fox River phone call, scheduled with NP RODAK, COLLE 17May2017@1345. Pt agreed with appt time. TCON Closed.

Signed By SMITH, MICKALYNN J (Registered Nurse) @ 21 Apr 2017 1539

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

13 Apr 2017 at WRNMMC, GI Clinic Bethesda by WONG, ROY KWOCK

Encounter ID: BETH-28042661 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **13 Apr 2017 1500 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **WONG,ROY KWOCK HUNG**

****Limited System Patient Data at time of Encounter******Reason for Appointment:**

follow up

Appointment Comments:

Ima/irmac

Vitals**Vitals** Written by KNIGHT,ASIA L @ 13 Apr 2017 1449 EDT

BP: 129/90, HR: 72, T: 98.1 °F, HT: 69 in, WT: 165.5 lbs, SpO₂: 95%, BMI: 24.44, BSA: 1.906 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

S/O Note Written by HALL,NOAH MONTGOMERY @ 13 Apr 2017 1739 EDT**History of present illness**

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. He reports minimal improvement since starting a low-FODMAP diet and is not following this strictly currently. He denies any benefit from avoiding dairy, caffeine, and sugar-substitutes.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

Allergies

Allergies Verified and Updated

NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.

Lexapro (stopped recently)

Past medical/surgical history**Reported:**

Medical: Reported medical history
 Anxiety/depression
 IBS-D

Surgical / Procedural: Surgical / procedural history
 Tonsillectomy
 PRK

Personal history

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Family history

Family medical history

No malignant neoplasm of the gastrointestinal tract.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Eyes:** No eye pain. No red eyes.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Appetite not decreased. No dysphagia, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no hematemesis. Abdominal pain. No jaundice and no bright red blood per rectum. Diarrhea. No constipation.**Musculoskeletal:** No back pain, no localized joint pain, and no localized joint swelling.**Neurological:** No lightheadedness.**Skin:** No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Nose:

General/bilateral:

External Deformities: ° No external nose deformities.

Cavity: ° Nasal septum normal.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Submandibular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: ° Mobility was not limited.

Other:

General/bilateral: ° No muscle tenderness.

Neurological:

° Oriented to time, place, and person. ° Remote memory was not impaired. ° Recent memory was not impaired.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

A/P Last Updated by HALL,NOAH M. @ 13 Apr 2017 1746 EDT**1. Irritable bowel syndrome with diarrhea:**

32 y/o male with IBS-D reports minimal benefit with dietary modification. Predominant symptom is abdominal pain and episodes are closely associated with anxiety.

- Will start trial of Metamucil for stool bulking
- If bloating/flatulence becomes an issue, consider transition to a non-fermentable fiber (citrucel OTC)
- Will also provide Levsin SL for symptomatic relief
- Recommended continued f/u with Behavioral Health provider, and could discuss a trial of a low-dose TCA at bedtime as a centrally-acting pain modulator
- F/u in GI clinic in 3-4 months
- Could consider a trial of Rifaximin in the future if no benefit

Medication(s):

-PSYLLIUM/SUCROSE--PO 3.4GM/SCOOP POWD - TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #2 RF3 Ordered By: HALL,NOAH M. Ordering Provider: HALL, NOAH MONTGOMERY

-HYOSCYAMINE IR--PO 0.125MG TBSL - DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #30 RF3 Ordered By: HALL,NOAH M. Ordering Provider: HALL, NOAH MONTGOMERY

Disposition Last Updated by HALL,NOAH M. @ 13 Apr 2017 1747 EDT**Released w/o Limitations****Follow up:** as needed in 3 to 4 month(s) in the GI CL BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** WONG, ROY KWOCK (Physician/Workstation, WRAMC) @ 14 Apr 2017 0925

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 Apr 2017 at WRNMMC, Medical Readiness Clinic Bethesda by RENTA, DANA K

Encounter ID: BETH-27946761

Primary Dx:

EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE MEMBER
PERIODIC HEALTH ASSESSMENT
(PHA)Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **05 Apr 2017 1100 EDT**
Clinic: **MEDICAL READINESS CL BE**Appt Type: **WELL**
Provider: **RENTA,DANA KAY**AutoCites Refreshed by RENTA,DANA K @ 05 Apr 2017 1159 EDT**Allergies**

- OTHER: (Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: (Reaction(s): Unknown; Note: SEE MED RECORD)
- OTHER: Unknown (SEE MED RECORD)

VitalsVitals Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1106 EDT

BP: 123/77 Right Arm, Adult Cuff, HR: 72 Regular, Radial Artery, RR: 20, T: 98.4 °F Oral, HT: 69 in Actual, With Shoes,
 WT: 165 lbs Upright Scale, Actual, With Shoes, SpO₂: 96%, Uncorr OD: 20/40, Uncorr OS: 20/40,
 Uncorr OU: 20/40, BMI: 24.37, BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: 4 Drink per week., Pain Scale: 0 Pain Free

Comments: SM:Presents to Medical Readiness for PHA. Arrives in civilian attire . States feeling good at this time but in several days he feeling down . Reports no H/O of Positive PPD. Referred to speak with Ms. Herbert (Health Educator for Anxiety & Depression screening and Epworth sleepiness scale.)

Reason for Appointment:

pha/navy

Appointment Comments:

ash4105625345

Screening Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1057 EDT**Reason For Appointment:** pha/navy

Allergen information verified by VASQUEZ, BLANCA T @ 05 Apr 2017 1057 EDT

VitalsVitals Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1106 EDT

BP: 123/77 Right Arm, Adult Cuff, HR: 72 Regular, Radial Artery, RR: 20, T: 98.4 °F Oral, HT: 69 in Actual, With Shoes,
 WT: 165 lbs Upright Scale, Actual, With Shoes, SpO₂: 96%, Uncorr OD: 20/40, Uncorr OS: 20/40,
 Uncorr OU: 20/40, BMI: 24.37, BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: 4 Drink per week., Pain Scale: 0 Pain Free

Comments: SM:Presents to Medical Readiness for PHA. Arrives in civilian attire . States feeling good at this time but in several days he feeling down . Reports no H/O of Positive PPD. Referred to speak with Ms. Herbert (Health Educator for Anxiety & Depression screening and Epworth sleepiness scale.)

Questionnaire AutoCites Refreshed by RENTA,DANA K @ 05 Apr 2017 1159 EDT**Questionnaires**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

EPWORTH Sleepiness Scale Version: 1 Completed On: 05 Apr 2017

Questionnaire Notes: EPWORTH : 19

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3
2. How likely are you to doze off or fall asleep while WATCHING TV?: 1
3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 2
4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3
5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 3
6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 2
7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 3
8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 2

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 05 Apr 2017

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis(i.e. with persistent cough, weight loss, night sweats, and/or fever)?: No

2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations?: No

3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: NONE

4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No

5. Have you had a prior history of TB or prior treatment for Latent TB?: No

6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No

7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade?: No

8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use?: No

Anxiety & Depression Screening Taken On: 05 Apr 2017

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Several days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by RENTA,DANA KAY @ 07 Apr 2017 1930 EDT**Chief complaint**

The Chief Complaint is: Face to Face PHA. Active Duty Navy.

Reason for Visit

Visit for: Face to Face PHA.

History of present illness

The Patient is a 32 year old male.

He reported: Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

[] Y [X] N Deployment/Shipboard limiting conditions identified

Allergies

No allergies NKDA.

Past medical/surgical history**Reported:**

Past medical history Myopia (resolved initially with PRK however degraded now); Irritable Bowel Syndrome (predominance: diarrhea)- chronic; Alcohol Abuse (s/p self-referred treatment) stable; Anxiety/Depression (dx GAD since childhood)- stable (continues BH treatment); Left ankle sprain (resolved), anogenital warts (Feb16) s/p podofil; Allergic rhinitis, folliculitis, exercise induced asthma, fx right 5th MC casted (2008); Lifetime hx of concussions: no incidents.

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [X] No.

Surgical / Procedural: Surgical / procedural history Wisdom Teeth Extraction (4); PRK (2011); Dental surgery pending - jaw alignment with orthodontic braces replaced (27Apr17); tonsillectomy (2003); s/p skin biopsies benign (x2);

Medications: Medication history: Lexapro, Naltrexone (prn alcohol); +multivitamins; no protein supplements;

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

- 3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No
- 4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [] No
- 5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No.

Personal history

Behavioral: Caffeine use. No tobacco use none. (remote one year in Hookah sometimes in Japan -- none since 2007);
 Alcohol: Alcohol two to three drinks a couple of times per week. not bingeing. very different now and knows the difference and behaving differently. doesn't like getting drunk or feeling poorly the following day.

Family history

Family medical history paternal addiction-- sister drug; dad-alcohol problem; maternal aunt- alcohol;
 Father is alive not in contact
 Mother is alive No DM, No CAD. healthy
 Cancer Dad- melanoma;
 Heart disease dad/PGF- CAD; dad- stent 2v (alcohol); Dad/PGM/PGF/sister- DM,
 Dad- AMI (s/p heart surgery); no CVA.

Review of systems**Head:** No head symptoms.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Otolaryngeal:** No otolaryngeal symptoms.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms.**Pulmonary:** No pulmonary symptoms.**Gastrointestinal:** No gastrointestinal symptoms.**Genitourinary:** No genitourinary symptoms.**Endocrine:** No endocrine symptoms.**Hematologic:** No hematologic symptoms.

Musculoskeletal: No musculoskeletal symptoms Exercises Aerobic three hours minimum weekly. Enjoys running however his IBS causes problems during exercise. PRT passes easily. Doing about one hour weekly strengthening exercises weekly. Meets recommendations of 150 minutes aerobic exercise and 30-60 minutes strengthening exercises weekly.

Neurological: No neurological symptoms.

Psychological: Psychological symptoms refer to BH screening questionnaire above. No suicidal/homicidal ideation; sleeps 6-7 hours nightly; unrested; tired often; has good routine; discussed sleep hygiene. problems staying asleep and can go back easily asleep; already did a the process for the sleep study; doesn't want to see someone. Wants to sleep all the time. Not narcoleptic.

Skin: No skin symptoms.**Allergic and Immunologic:** No allergic/immunologic symptoms.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing.

Head:

Appearance: ° Head normocephalic.

Neurological:

° Level of consciousness was normal. ° Cognitive functioning was normal.

Speech: ° Normal.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Appearance: ° Normal.

Mood: ° Pleasant.

Affect: ° Normal.

Thought Processes: ° Not impaired.

Skin:

• Skin: very fair skin with many freckles of same tone, nothing.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Fully Medically Ready ()

Partially Medically Ready ()

Not Medically Ready (xxx)

Medical Readiness Indeterminant ()

Comments: undergoing evaluation by GI for IBS predominantly diarrhea

Therapy

- The likelihood of a heart attack was not recorded CVSP: FRAMINGHAM RISK SCORE:presumed to be less than 1%.

Lab Result Cited by RENTA,DANA K @ 05 Apr 2017 1126 EDT**HIV-1/O/2 Ab****Site/Specimen****16 Feb 2016 1430**

Units

Ref Rng

HIV-1/O/2 Ab

SERUM

Negative <r>

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1101 EDT**Varicella Zoster Virus DFA****Site/Specimen****29 Sep 2015 1730**

Varicella Zoster Virus Ag

SKIN

NO VZ ANTIGEN DETECTED <i>

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1100 EDT**Lipid Panel****Site/Specimen****10 Apr 2014 0951**

Cholesterol

SERUM

208 (H) <i>

Triglyceride

SERUM

158 (H) <i>

HDL Cholesterol

SERUM

64.0 (H)

LDL Cholesterol

SERUM

112 <i>

VLDL Cholesterol

SERUM

32

Cholesterol/HDL Cholesterol

SERUM

3.25

Lab Result Cited by VASQUEZ,BLANCA T @ 05 Apr 2017 1100 EDT**Basic Metabolic Panel****Site/Specimen****22 Jun 2016 1240**

Urea Nitrogen

SERUM

14.8

Carbon Dioxide

SERUM

28

Chloride

SERUM

98

Creatinine

SERUM

1.00

Glucose

SERUM

89

Potassium

SERUM

4.5

Sodium

SERUM

139

Calcium

SERUM

10.1

Anion Gap

SERUM

13

GFR Calculated Non-Black

SERUM

99.8

GFR Calculated Black

SERUM

115.4 <i>

A/P Last updated by RENTA,DANA K @ 07 Apr 2017 1942 EDT

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225: SM is NOT MEDICALLY READY as is undergoing evaluation for IBS (diarrhea predominance). however is capable, of conducting PRT with understanding he may leave to go to restroom. has further GI assessment pending.

Face to Face PHA today. Updated in MRRS today.

All significant PMH and ROS noted above. Medications reviewed. SM to f/u with PCM for active concerns.

No suicidal or homicidal ideation noted.

TB Exposure Risk Assessment questionnaire completed.

SM currently meets/exceeds weekly aerobic Exercises at least 150 minutes and 30-60 minutes strengthening exercises

Patient has is current with:

Influenza vax completed.

Audiology assessment

Sleep --continue as recommended for 6-8 hours daily.

HIV current (22Feb16)

Merwin, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Lifetime concussions: no incident

Procedure(s):
-(G8420) BMI IS DOC W/IN NORMAL PARAMETERS &NO FOLLOW-UP PLAN IS REQD x 1
ADDITIONAL PROVIDER(S): VASQUEZ,BLANCA T
-(99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S):
VASQUEZ,BLANCA T
-(94760) Pulse Oximetry x 1 ADDITIONAL PROVIDER(S): VASQUEZ,BLANCA T
-(G0444) ANNUAL DEPRESSION SCREENING, 15 MINUTES x 1 ADDITIONAL PROVIDER(S):
VASQUEZ,BLANCA T

2. Other specified counseling Z71.89: SM does not use tobacco products.

Discussed use of condoms to protect self and partner from potential STIs. Educated SM on PreP Program at Infectious Disease for HIV prophylaxis.

Continue to balance professional goals with personal goals.

Disposition Written by RENTA,DANA K @ 07 Apr 2017 1942 EDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1118 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Health Risk Assessment

Page 1 of 4

NMCPHC HRA Website HRA Tool Home HRA Helpdesk Email (757-953-0737)

NMCPHC Workplace HRA - Participant Report

UIC/Command: 00168 - NATNAVMECEN BETHESDA

You rated your health as Good. Personal perception about how healthy you are is usually quite accurate. Your Personal Health Risk Appraisal Report identified 1 risk categories from the answers you provided on key topics that relate to overall health, which places you in a LOW risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the "low risk" category by reducing the number of behavioral risks, and for those already at low risk, to avoid increasing the number of risk factors over time.

**Tobacco Use - Current Tobacco Usage - No**

<http://www.usanavy2.org>
<http://ReTobaccofree.hhs.gov/>

Being tobacco free is a great choice! You are healthier, more fit, mission ready and are saving money.

**Alcohol Use - Binge Drinking - Once or twice per year**

<http://www.rethinkingdrinking.niaaa.nih.gov/>

Many Sailors and Marines occasionally drink more heavily than usual during celebrations or special events. Plan ahead to avoid alcohol related incidents. DUB will put your career in danger.

**Alcohol Use - Alcohol Use Driving - Never (i.e., not during the past year)**

<http://www.rethinkingdrinking.niaaa.nih.gov/>

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol related incidents by looking out for those who try to drink and drive- and help them get home safely.

**Injury Prevention - Seatbelts - Always**

<http://www.nhtsa.gov/Creating+Safety/>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

**Injury Prevention - Vehicle Helmet - Always**

<https://www.nhtsa.gov/road-safety/motorcycles>

Your use of a protective helmet provides significant protection against head injury or death. Wearing other protective gear, maintaining control of your vehicle, and driving defensively can also reduce your risk.

**Injury Prevention - Safety Equipment - Always**

<http://www.cdc.gov/niosh/topics/safety.html>

<https://nmcpch-hpwebsvr.med.navy.mil/HRA/Pages/Results.aspx>

4/5/2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Health Risk Assessment

Page 2 of 4

You are protecting yourself against injuries and disease at your workite by using appropriate safety equipment.

**Stress Management - Life Satisfaction - Mostly satisfied**

<http://www.nlm.nih.gov/medlineplus/stress.html>
<https://afterdeployment.dcoe.mil/>

You are mostly satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationship and social activities can all contribute to life satisfaction.

**Stress Management - Overall Stress - Sometimes**

<http://www.med.navy.mil/sites/nmcid/mccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx>
<https://afterdeployment.dcoe.mil/>

Occasional stress in your work or at home is common. Problem-solving or discussing possible solutions with someone else may help reduce or eliminate some of your stress.

**Stress Management - Personal Support - Most of the time**

<http://www.med.navy.mil/sites/nmcid/mccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx>
<https://afterdeployment.dcoe.mil/>

Expressing your feelings can help you see that you are not alone in how you feel. Talking with others can also provide you with strategies to successfully manage your concerns.

**Sexual Health - Condom Use - Always**

http://nationalcoalitionforsexualhealth.org/tools/communicating-to-the-public/document/SexualHealthGuide_national.pdf

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection.

**Physical Activity - Aerobic Exercise - 3 weeks per month**

<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

The national goal for Americans is to get at least 2 hours and 30 minutes (150 minutes) of moderate-intensity aerobic activity every week. Cardiovascular (aerobic) exercise has many benefits, including giving you more energy and higher endurance; preventing many chronic diseases, like diabetes, high blood pressure, and high cholesterol; and maintaining a healthy body weight. Continue to include this type of exercise into your lifestyle.

**Physical Activity - Muscular Exercise - 2 or more days per week**

<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

You routinely engage in strength training, which improves your strength, maintains lean body mass, builds strong bones, and decreases many of the risk factors associated with coronary heart disease.

**Nutrition - High Fat - 3-5 times per week**

<http://www.cdc.gov/nutrition/everyone/basics/fat/index.html>

<https://nmcpeh-hpwebsvr.med.navy.mil/HRA/Pages/Results.aspx>

4/5/2017

Medical Record

Merwin, Daniel Dennis

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

Health Risk Assessment

Page 3 of 4

Some dietary fat is needed for good health, but high levels of fat in your diet may lead to excessive weight gain and may increase your risk of certain cancers. Eating foods high in saturated and trans-fats also increases your risk of heart disease. Select foods low in saturated fats, trans fats, and cholesterol; eat plenty of grains, vegetables and fruits; and choose low fat milk products and lean meats.

**Nutrition - Fruits - One**

<http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is to consume at least two servings of fruits per day. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individual's age, gender, and level of physical activity.

**Supplements - Supplement Use - Seldom**

<http://humanperformancecenter.org/dietary-supplements>

Some dietary supplements can provide additional health and nutrition benefits, but many supplements may be unnecessary or even have adverse side effects in some individuals, especially if used in large amounts. Before using any dietary supplement, ask: "What are the potential benefits?" and "What are the risks?" The Dietary Supplements Classification Table on the link above was developed to assist in making informed decisions about supplements, ranking them on a scale of low, moderate, or high potential benefit and safety risk.

**Dental - Flossing - Daily**

<http://www.adfa.org/habit.asp>

You are to be commended for flossing your teeth daily. Flossing removes plaque and food particles from between the teeth and under the gum line, which prevents gum disease, tooth loss, decay, and bad breath.

**Nutrition - Vegetables - One**

<http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is three servings of vegetables per day, with at least one being a dark green or orange vegetable. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individual's age, gender, and level of physical activity.

**Sleep - Sleep Deprivation - Most of the time**

<http://www.med.navy.mil/sites/nmcpeh/health-promotion/psychological-emotional-wellbeing/Pages/sleep.aspx>

People who get enough restful sleep are able to concentrate on their activities, have more energy, and generally feel better.

**Sexual Health - Pregnancy - My partner or I are correctly and consistently using birth control ALL the time**

<https://bedsider.org/>

There is a wide range of new, safe and effective contraception options available. Some are permanent and others work for years and are easily and quickly reversible when you're ready to have a baby. Some methods require no devices or medication at all. But not all form contraception are equally reliable. It makes sense to be informed about contraception so you and your partner can select the most reliable option that works for you.

Print

Print

<https://nmcpeh-hpwebsvr.med.navy.mil/HRA/Pages/Results.aspx>

4/5/2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Health Risk Assessment

Page 4 of 4

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<https://nmcpch-hpwebsvr.med.navy.mil/HRA/Pages/Results.aspx>

4/5/2017

Signed By RENTA, DANA K (COL, MC, WRNMMC) @ 07 Apr 2017 1942**CHANGE HISTORY*****The following A/P Note Was Overwritten by RENTA,DANA K @ 05 Apr 2017 1308 EDT:***

The A/P section was last updated by RENTA,DANA K @ 05 Apr 2017 1308 EDT - see above. Previous Version of A/P section was entered/updated by VASQUEZ,BLANCA T @ 05 Apr 2017 1058 EDT.

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225

Procedure(s):

- (99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): VASQUEZ,BLANCA T
- (94760) Pulse Oximetry x 1 ADDITIONAL PROVIDER(S): VASQUEZ,BLANCA T
- (G0444) ANNUAL DEPRESSION SCREENING, 15 MINUTES x 1 ADDITIONAL PROVIDER(S): VASQUEZ,BLANCA T

The following S/O Note Was Overwritten by RENTA,DANA K @ 05 Apr 2017 1127 EDT:***S/O Note Written by VASQUEZ,BLANCA T @ 05 Apr 2017 1106 EDT*****History of present illness**

The Patient is a 32 year old male.

He reported: Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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**Page 336
AR 2323**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

[] Y [X] N Deployment/Shipboard limiting conditions identified

Allergies

No allergies.

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready ()

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Mar 2017 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-27723764 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **16 Mar 2017 1156 EDT**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **COPSEY, HELEN C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 16 Mar 2017 1156 EDT

Patient email

S/O Note Written by COPSEY, HELEN C. @ 16 Mar 2017 1157 EDT**Subjective**

Hi Daniel, Given the severity of your symptoms I'm surprised that you have not been back for a follow-up or contacted me since last November. I am glad you made an appointment. There are many options for treatment of IBS, but it will require several follow-up visits to discuss and implement. I agree if we are unable to manage your symptoms better, you'll need to undergo an MEB, but again, there are many options available that you have not yet tried. V/R, Helen -----Original Message----- From: Merwin, Daniel D [mailto:ddmerwi@radium.ncsc.mil] Sent: Thursday, March 16, 2017 10:44 AM To: Copsey, Helen C CTR (US) Cc: Lafranchise, David M; Fisher, Christopher M Subject: RE: Follow-Up - Pain Helen, I CCed my chain of command so they know that I have been seen on and off for this issue over the years and are aware of anything on-going. I scheduled an appointment for 13 April with Dr. Hall which was the next available in the clinic. Even with management of my diet, I still have 4-6 severe episodes a week or more (spasms, pain, expedient evacuation and diarrhea). Every episode is extremely draining of me. A lot of times after an episode I just want to lay down and sleep because of the extreme intensities. A few of the most recent issues almost had me call 911 due to the extreme pain. I scheduled the appointment for a few reasons. 1. Currently I have the note you provided which makes me technically non-deployable and this needs to be discussed. 2. I really need to try anything available within the military system to help manage the episodes if there is nothing else then I would like to start medical separation in order to seek alternative treatments. Respectfully, CTN1 (IW/SW/AW) Merwin, Daniel D NIOC Maryland Work: 667-812-2006 Cell: [REDACTED]

A/P Last Updated by COPSEY, HELEN C @ 16 Mar 2017 1157 EDT**1. Irritable bowel syndrome with diarrhea****Disposition** Last Updated by COPSEY, HELEN C @ 16 Mar 2017 1157 EDT**Follow up:** in the GI CL BE clinic.**Signed By** COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 16 Mar 2017 1158

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Mar 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-27574008 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Mar 2017 1100 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:
 FOLLOW UP

Appointment Comments:
 aap

Note Written by PAUL, SHERIN @ 02 Mar 2017 1049 EDT

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 4
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 32-year-old, Single, Caucasian, Male

Military Data:

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Psychoeducation & Behavior Mod****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he was doing well. He stated that he received the results of the psychological testing but was unsure of the content. Therapist and patient reviewed diagnostic results which confirmed diagnosis of GAD and identified Schizoid traits. Therapist provided psychoeducation regarding diagnoses. Further conversation focused on patient's positive progress towards his goals. He stated that he has been interacting more with people. Therapist and patient discussed differences between rigidity and appropriate boundaries. Final conversation focused on identifying goals for next weeks.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in casual attire. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Diagnosis:

Axis I: Generalized Anxiety Disorder
Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:*Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

Medical Record

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History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 01 March 2017

Reviewed with patient on: 01 March 2017

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

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Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 02 Mar 2017 1050 EDT

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 02 Mar 2017 1051 EDT

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 02 Mar 2017 1051

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

01 Mar 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-27554297 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Mar 2017 0800 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 01 Mar 2017 0818 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by DAVIS,ANNETTE R @ 01 Mar 2017 0803 EST

BP: 120/80, HR: 64, RR: 18, T: 98.4 °F, HT: 69 in, WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes,

Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by DAVIS,ANNETTE R @ 01 Mar 2017 0803 EST

BP: 120/80, HR: 64, RR: 18, T: 98.4 °F, HT: 69 in, WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes,

Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 02 Mar 2017 1243 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #7

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and

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DoD ID: 1286180538

Created: 16 Aug 2017

undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for follow up with this provider. At our last meeting pt was advised to resume naltrexone 50 mg po qam to reduce alcohol use. Today he says he drinks less when he drinks (1-2 drinks at a time now) and thinks the medication is helpful. He has dental surgery at the end of April so we discussed stopping naltrexone 3-7 days before the surgery and resuming it a week after the surgery as he believes he will be prescribed opiate pain medication. He takes lunesta rarely. He continues to experience variable sleep. He already had CBT-I and had a sleep study that was negative for sleep apnea. He is stressed about work as he juggles many responsibilities and wishes he didn't reenlist. He is trying to pursue a med board for his GI symptoms. He has psychologic testing but hasn't had his feedback session about it yet. He denies having suicidal thoughts since we last met.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Merwin, Daniel Dennis

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Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):

TBI/CONCUSSION SCREEN: Negative Screen

Rating scales:

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

01MAR17 phq9= 9 (#9=0); gad7= 10

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)

☒ Male

☐ History of family/friend suicide

☐ Chronic medical conditions

☒ Impulsivity

☒ History of abuse

☐ Chronic pain

PROTECTIVE FACTORS (Strengths):

☐ Married, children

☒ Active treatment engagement

☐ Good coping/problem solving skills

☒ Hopefulness present

☐ Faith/religion commitment

☐ Positive future orientation

Allergies: nkda

Medications: Lexapro 20 mg po daily, naltrexone 50 mg po daily , lunesta 1-2 mg po qhs prn insomnia

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Past Behavioral Health History:

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes Cups/Day Equivalent: 4

Tobacco/e-cigs: none PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

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Page 347
AR 2334

Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: easy to establish

Speech: normal tone and kinetics

Mood: mildly anxious

Affect: full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight: wnl

Impulsivity: none at time of interview

Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Gamma Glutamyl Transferase	Site/Specimen	04 Jan 2017	1232	Units	Ref Rng
Gamma-Glutamyl Transferase	SERUM 49	U/L	(10.0-71.0)		

Hepatic Function Panel		Site/Specimen	04 Jan 2017	1232	Units	Ref Rng
Albumin	SERUM 4.9	g/dL	(3.5-5.2)			
Alkaline Phosphatase	SERUM 58	U/L	(40-129)			
Alanine Aminotransferase	SERUM 34	U/L	(0-41)			
Aspartate Aminotransferase	SERUM 24	U/L	(0-40)			
Bilirubin	SERUM 0.3	mg/dL	(0.15-1.2)			
Bilirubin Direct	SERUM <0.2	mg/dL	(0.0-0.3)			
Protein	SERUM 7.6	g/dL	(6.6-8.7)			

Basic Metabolic Panel		Site/Specimen	22 Jun 2016	1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)			
Carbon Dioxide	SERUM 28	mmol/L	(22-29)			
Chloride	SERUM 98	mmol/L	(98-107)			
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)			
Glucose	SERUM 89	mg/dL	(74-106)			
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)			
Sodium	SERUM 139	mmol/L	(136-145)			
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)			
Anion Gap	SERUM 13	mmol/L	(7-16)			
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)			
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)			

CBC W/Diff		Site/Specimen	22 Jun 2016	1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)			
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)			
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)			
Hematocrit	BLOOD 44.4	%	(37.5-50.9)			
MCV	BLOOD 91.4	fL	(79.5-96.8)			
MCH	BLOOD 31.1	pg	(26.2-33.1)			
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)			
RDW CV	BLOOD 12.9	%	(12.0-16.2)			
Platelets	BLOOD 272	x10(3)/mcL	(162-427)			
MPV	BLOOD 9.0	fL	(7.0-10.9)			
Neutrophils	BLOOD 59.4	%	(40.7-76.4)			
Lymphocytes	BLOOD 29.8	%	(15.9-47.8)			

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Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i> pg/mL	(211-946)	

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L (4.0-15.4)	

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7 g/dL	(3.5-5.2)	
Alkaline Phosphatase	SERUM	53 U/L	(40-129)	
Alanine Aminotransferase	SERUM	17 U/L	(0-41)	
Bilirubin	SERUM	0.4 mg/dL	(0.15-1.2)	
Urea Nitrogen	SERUM	13.8 mg/dL	(6-20)	
Calcium	SERUM	9.7 mg/dL	(8.6-10.2)	
Carbon Dioxide	SERUM	29 mmol/L	(22-29)	
Chloride	SERUM	98 mmol/L	(98-107)	
Creatinine	SERUM	0.96 mg/dL	(0.7-1.2)	
Glucose	SERUM	89 mg/dL	(74-106)	
Potassium	SERUM	4.4 mmol/L	(3.5-5.1)	
Protein	SERUM	7.6 g/dL	(6.6-8.7)	
Sodium	SERUM	141 mmol/L	(136-145)	
Anion Gap	SERUM	14 mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	105.6 mL/min	(60->=60)	
GFR Calculated Black	SERUM	122.1 <i> mL/min	(60->=60)	
Aspartate Aminotransferase	SERUM	20 U/L	(0-40)	

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>	(Negative)	
Barbiturates	URINE	NEGATIVE <i>	(Negative)	
Benzodiazepines	URINE	NEGATIVE <i>	(Negative)	
Cocaine	URINE	NEGATIVE <i>	(Negative)	
Opiates	URINE	NEGATIVE <i>	(Negative)	

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1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Phencyclidine, UA	URINE	NEGATIVE <i>	(Negative)
Cannabinoids	URINE	NEGATIVE <i>	(Negative)
Methadone	URINE	NEGATIVE <i>	(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Generalized Anxiety Disorder per psychologic testing; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: Continue Lexapro 20 mg po daily. Advised pt not to take lunesta 1-2 mg po qhs prn insomnia if he is sleeping well without it. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Continue naltrexone 50 mg po daily. Have discussed at referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor Measure: self-report, lab results

Therapy Type:

Not Set

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one month

Referrals:pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**Can Service Member perform MOS duties? **Yes**A/P Written by TOBAR,EDEN @ 02 Mar 2017 1244 EDT**1. Generalized anxiety disorder:** Med management 30 minutes; psychotherapy 20 minutes

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Medication(s): -ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #70 RF3 Ordered
By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN TDisposition Written by TOBAR,EDEN @ 02 Mar 2017 1244 EDT**Released w/o Limitations****Follow up:** 6 to 8 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Note Written by TOBAR,EDEN @ 01 Mar 2017 0900 EST**Additional A/P Information:**

Discontinued ESZOPICLONE--PO 1MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP

Signed By TOBAR, EDEN (Physician/Workstation) @ 02 Mar 2017 1244

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-27327225 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Feb 2017 0700 EST**
 Clinic: **PSYCHOLOGY ASSESSMENT
 BE**

Appt Type: **SPEC**
 Provider: **BENTON, JIKESHA R**

AutoCites Refreshed by BENTON, JIKESHA R @ 10 Feb 2017 1306 EST**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- no family history of malignant neoplasm of large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- paternal history of preliminary background HPI [use for free text] (Father)
- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
NALTREXONE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED #0 RF3	2 of 3	01 Feb 2017
ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3	0 of 3	01 Feb 2017
ESZOPICLONE, 1 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1	1 of 1	04 Jan 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml	Active		NR	14 Oct 2016

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

SYRINGE

PODOFILOX, 0.5 %, SOLUTION, TOPICAL

Active

APPLY TWICE A DAY FOR 3 2 of 2
DAYS THEN STOP FOR 4
DAYS, REPEAT WEEKLY AS
NEEDED #0 RF2

24 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-
16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

Active

NR

05 Oct 2015

Reason for Appointment:

Dx Interview

Appointment Comments:

CAC

Note Written by BENTON, JIKESHA R @ 10 Feb 2017 1406 EST

SM Merwin is as 31 year old, single, Caucasian, male, AD USN E-6 Cryptologist. SM was seen for a 1 hour clinical interview by LT Martinez on 02FEB17 under Dr. Benton's supervision. This writer engaged in 2 hours of chart review and 5 hours of psychological report preparation and writing. A 1 hour feedback session was scheduled after the conclusion of the clinical interview. LT Martinez administered the MCMI-III, MMPI-2, and RISB on 02FEB17.

Initial Impressions

Psychological testing results were consistent with the established diagnoses of Generalized Anxiety Disorder. SM Merwin does not meet criteria for Borderline Personality Disorder. SM Merwin endorsed anxious ruminative thoughts and stress caused by feelings of guilt. SM Merwin's pattern of unstable relationships appears to be more in line with Schizoid personality traits that may have been adaptive at a young age in the context of his childhood physical and emotional abuse. SM Merwin exhibits a lack of interest in social relationships, a tendency towards a solitary lifestyle, emotional coldness, and apathy. Individuals with Schizoid traits may also demonstrate a rich, elaborate and exclusively internal fantasy world. SM Merwin indicated he enjoys the fantasy world of movies and frequently finds himself daydreaming.

Mental Status Exam

Mental status examination revealed an alert, fully oriented, appropriately dressed and groomed male who appeared his stated age. SM Merwin presented with a pleasant mood and congruent affect. Throughout the session, SM Merwin's mood and affect appeared unchanged, even when discussing difficult or emotional topics. SM Merwin maintained appropriate eye contact throughout the session. SM Merwin was engaged in the interview and testing. His speech was normal in tone and rate. Cognition was grossly intact and abstraction was adequate. Recent and remote memory was intact. Thought process was clear and goal oriented. SM Merwin did not exhibit ideas of reference, paranoia, or delusions. There was no evidence of mania. Judgment and impulse control were good. No indication of psychomotor retardation or agitation. SM Merwin denied current suicidal or homicidal ideation, plans, or intent.

Risk Assessment

SM Merwin has a history of suicidal ideation occurring approximately once a month since adulthood. His protective factors include his job, his hobby of creating video games, and wanting to find purpose in his life. SM Merwin has low social support, but this does not seem to be a significant stressor. SM Merwin does not have a history of attempts and denies access to lethal means. He denied current ideation, plan, or intent. SM Merwin is currently assessed at a mild risk for suicide, and should continue to be monitored by his healthcare providers.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Comprehensive Examination x 1
-Psychologic Testing And Report Administered By Physician x 8

Disposition Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 10 Feb 2017 1407

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

02 Feb 2017 at WRNMMC, Psychology Assessment Be by BENTON, JIKESHA R

Encounter ID: BETH-27275465 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **02 Feb 2017 0800 EST**
 Clinic: **PSYCHOLOGY ASSESSMENT
 BE**

Appt Type: **PROC**
 Provider: **BENTON, JIKESHA R**

AutoCites Refreshed by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST**Problems**

- Generalized anxiety disorder F41.1
- Counseling, unspecified Z71.9
- EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225
- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

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- family history of test conclusions [Use for free text] (General FHx)
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- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
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- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
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Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
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ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3	0 of 3	01 Feb 2017
ESZOPICLONE, 1 MG, TABLET, ORAL	Active	TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1	1 of 1	04 Jan 2017
FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE, INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml	Active		NR	14 Oct 2016

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

SYRINGE

PODOFILOX, 0.5 %, SOLUTION, TOPICAL

Active

APPLY TWICE A DAY FOR 3 2 of 2
DAYS THEN STOP FOR 4
DAYS, REPEAT WEEKLY AS
NEEDED #0 RF2

24 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-
16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml
SYRINGE

Active

NR

05 Oct 2015

Reason for Appointment:

Generalized anxiety disorder

Appointment Comments:

mta

Note Written by BENTON, JIKESHA R @ 07 Feb 2017 1531 EST**Reason for Visit**

Visit for: Psychological Testing. Assessment time 5.5 hrs. PT denied any physical pain. He c/o'ed of issues w/ interpersonal relationships. PT discussed his history of physical and emotional abuse by his father. He was cooperative and no management problem. The raw data can be found in room 7131. The report will be uploaded once complete.

History of present illness

The Patient is a 31 year old male.

He reported: Feeling numb; he appeared apathetic w/ a flat affect. Not thinking about suicide. No homicidal thoughts, no hallucinations, and not hearing voices when no one is talking.

Compliant with testing: Y /

Oriented X4 Y /

Risks reported to patient treatment team NA/ none at this time

Provider follow-up scheduled Y /

If yes date is: ___ scheduled for the Dx interview w/ 2 LT Hannah Martinez; the feedback session is pending.

Subjective

The patient was seen to discuss participation in a psychological evaluation requested by his provider. The purpose, nature and limits of confidentiality were explained to the patient and all questions were answered.

Tests

He completed the RISB and the LNA.

Laboratory Studies:

Psychometric:

Minnesota Multiphasic Personality Inventory (MMPI), Millon clinical multi-axial inventory, and projective administration of psychologic test.

A/P Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST**1. Generalized anxiety disorder**

Procedure(s):

-Psychologic Testing And Report Administered By Physician x 6 ADDITIONAL PROVIDER(S):
MARTINEZ, HANNAH R

Disposition Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST**Consult Order****Referring Provider:** PAUL, SHERIN**Date of Request:** 08 Dec 2016**Priority:** Routine**Provisional Diagnosis:**

Generalized anxiety disorder

Reason for Request:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 07 Feb 2017 1541

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Feb 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-27297932 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Feb 2017 1500 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

F/U

Appointment Comments:

AAP

Note Written by PAUL, SHERIN @ 06 Feb 2017 0945 EST

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 3
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 31-year-old, Single, Caucasian, Male**Military Data:**

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Behavior Mod****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he has been reading through his mother's journals from his childhood. He stated that he feels reassured that his perceived experiences are in line with what actually happened. Patient and therapist discussed abusive home and abusive interactions that he had with his father. He expressed concern that he has become like his father in rigidity, emotional detachment, and isolation. However, patient agreed that he has a level of insight that his father does not. He expressed interest in working on these trends. He identified a goal for the week.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT**Diagnosis:**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Axis I: Generalized Anxiety Disorder
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support
 Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016

Reviewed with patient on: 15 November 2016

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.

2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 06 Feb 2017 0946 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 06 Feb 2017 0946 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Feb 2017 0946

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Feb 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-27255467 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **01 Feb 2017 1130 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 01 Feb 2017 1154 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by NATHAN,YOGESWARI S @ 01 Feb 2017 1120 EST

BP: 131/82, HR: 66, RR: 16, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: Drinks 1-2 a week 3-4 drinks at a time.

No SX of fever or chills.

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by NATHAN,YOGESWARI S @ 01 Feb 2017 1120 EST

BP: 131/82, HR: 66, RR: 16, HT: 5' 9", WT: 162 lbs, BMI: 23.92, BSA: 1.889 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: Drinks 1-2 a week 3-4 drinks at a time.

No SX of fever or chills.

Note Written by TOBAR,EDEN @ 01 Feb 2017 1225 EST**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #6

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Anger Problems: Yes Spouse/Sig Other Problems: No
 Legal Problems: No Financial Problems: Yes
 Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his fifth appt with this provider. At our last meeting we added naltrexone 50 mg po qam to reduce alcohol use. We also added lunesta 1-2 mg prn for sleep. Today pt states he took the naltrexone for a week and found it helped him desire to drink less, but he was taking it at night and waking up frequently so he stopped taking it. He doesn't think the lunesta is helpful so hasn't been taking it. He has stopped drinking during the week and over the weekend drank four beers on Saturday night and two beers on Sunday. He stopped drinking caffeine two days ago. He has felt more awake and slept well last night. He asked his mother for a copy of her journal from the 1990s when he was a child, which he brought to today's appt. He states it is 357 pages. He pointed out a few pages that indicate his father, who had custody of pt and his sisters, was physically abusive to pt and his sisters. Pt plans to show journal to Dr Paul later today. He has psychologic testing scheduled for tomorrow. He denies having nightmares about the journal. He denies having suicidal thoughts since we last met.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Medical Record

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Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

01FEB17 phq9= 7 (#9=0); gad7= 10

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method?

Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan?

Yes

Over lifetime, Suicide Behavior?

Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, wellbutrin xl 300 mg po qam, unisom OTC**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it. Wellbutrin

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Dec16 not tolerated.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old. Father had custody of pt and his sisters because, pt states, of an incident in which mother disciplined sister and left red marks. Father was physically abusive to them, however.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

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Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly dysphoric

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel		Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM	28	mmol/L	(22-29)	
Chloride	SERUM	98	mmol/L	(98-107)	
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM	89	mg/dL	(74-106)	
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM	139	mmol/L	(136-145)	
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM	13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)	

CBC W/Diff		Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD	44.4	%	(37.5-50.9)	
MCV	BLOOD	91.4	fL	(79.5-96.8)	
MCH	BLOOD	31.1	pg	(26.2-33.1)	
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD	12.9	%	(12.0-16.2)	
Platelets	BLOOD	272	x10(3)/mcL	(162-427)	
MPV	BLOOD	9.0	fL	(7.0-10.9)	
Neutrophils	BLOOD	59.4	%	(40.7-76.4)	
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)	
Monocytes	BLOOD	8.9	%	(4.5-11.8)	
Eosinophils	BLOOD	1.5	%	(0.3-7.1)	
Basophils	BLOOD	0.4	%	(0.2-1.2)	
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	

Medical Record

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Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L 0-378		
HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <r>			
Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL (211-946)		
Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L (4.0-15.4)		
Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM 4.7	g/dL (3.5-5.2)		
Alkaline Phosphatase	SERUM 53	U/L (40-129)		
Alanine Aminotransferase	SERUM 17	U/L (0-41)		
Bilirubin	SERUM 0.4	mg/dL (0.15-1.2)		
Urea Nitrogen	SERUM 13.8	mg/dL (6-20)		
Calcium	SERUM 9.7	mg/dL (8.6-10.2)		
Carbon Dioxide	SERUM 29	mmol/L (22-29)		
Chloride	SERUM 98	mmol/L (98-107)		
Creatinine	SERUM 0.96	mg/dL (0.7-1.2)		
Glucose	SERUM 89	mg/dL (74-106)		
Potassium	SERUM 4.4	mmol/L (3.5-5.1)		
Protein	SERUM 7.6	g/dL (6.6-8.7)		
Sodium	SERUM 141	mmol/L (136-145)		
Anion Gap	SERUM 14	mmol/L (7-16)		
GFR Calculated Non-Black	SERUM 105.6	mL/min (60->=60)		
GFR Calculated Black	SERUM 122.1 <i>	mL/min (60->=60)		
Aspartate Aminotransferase	SERUM 20	U/L (0-40)		
ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE Negative <i>	ng/mL Cutoff=250		
Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE NEGATIVE <i>		(Negative)	
Barbiturates	URINE NEGATIVE <i>		(Negative)	
Benzodiazepines	URINE NEGATIVE <i>		(Negative)	
Cocaine	URINE NEGATIVE <i>		(Negative)	
Opiates	URINE NEGATIVE <i>		(Negative)	
Phencyclidine, UA	URINE NEGATIVE <i>		(Negative)	
Cannabinoids	URINE NEGATIVE <i>		(Negative)	
Methadone	URINE NEGATIVE <i>		(Not-Detected)	
Oxycodone	URINE NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: [] Not Elevated [x] Low [x] Intermediate [] High

Harm to Others: [] Not Elevated [x] Low [] Intermediate [] High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

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Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: Continue Lexapro 20 mg po daily. Advised pt not to take lunesta 1-2 mg po qhs prn insomnia if he is sleeping well without it. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: have discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Encouraged pt to restart naltrexone 25 mg po daily for reduction in alcohol use x 1 week, then increase to 50 mg po daily, and take it in the morning. Discussed at referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: one month

Referrals: pt had therapy intake with Dr Paul on 18NOV

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Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**
Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR,EDEN @ 01 Feb 2017 1227 EST

1. Anxiety disorder, unspecified: Med management 15 minutes; psychotherapy 15 minutes.

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. Major depressive disorder, recurrent, unspecified

Disposition Written by TOBAR,EDEN @ 01 Feb 2017 1228 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 01 Feb 2017 1228

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DoD ID: 1286180538

Created: 16 Aug 2017

04 Jan 2017 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26995185 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Jan 2017 1400 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:
 f/u

Note Written by PAUL, SHERIN @ 06 Jan 2017 1442 EST

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 2
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 31-year-old, Single, Caucasian, Male

Military Data:

Branch: USN
 Rank: PO1
 MOS: CTN
 TIS: 11-years
 Deployments: N/A
 Deployment Related: N/A
 Trauma: N/A
 WTU: N/A
 MEB in progress: N/A
 AdmSep in progress: N/A
 Special Clearance: Yes

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Behavior Mod****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He reported that he was contacted by psych testing regarding diagnosis clarification and he will follow through on scheduling appointment. Patient reported that he spent time with his mother's side of the family which was a positive experience. He stated that he learned a lot about his parent's early relationship. Therapist and patient processed his feelings about this. Patient recognized that throughout childhood, his experiences with his father shaped his behavior. He acknowledged keeping people away from him as he cannot contend with guilt or disappointing others. He stated that when he does engage with others it feels overwhelming because he goes above and beyond standards to make others happy. However, this has led to isolation as he does not want to risk disappointing others. Patient also identified rigidity of behavior, especially in regards to cleanliness, which is also an outdated defense mechanism from childhood. Therapist and patient discussed engaging in uncomfortable target behaviors to help ease rigidity and to encourage social development.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

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ASSESSMENT**Diagnosis:**

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor**Patient's capacity** to participate in and benefit from therapy is evidenced by:**(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan****Safety Risk:***Non-Modifiable Factors:*

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No

Medical Record

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Religious Beliefs Contrary to Suicide:

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:Harm to Self: () Not Elevated () Low **(X) Intermediate** () HighHarm to Others: **(X) Not Elevated** () Low () Intermediate () High**TREATMENT PLAN**

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____**Safety Plan:**

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.**Treatment Team:**

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016*Reviewed with patient on:* 15 November 2016*Does patient agree with plan?* Yes**Problem #1** Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.**Follow-up's scheduled:** 2-weeks**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

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DoD ID: 1286180538

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Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 06 Jan 2017 1443 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Written by PAUL, SHERIN @ 06 Jan 2017 1443 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 06 Jan 2017 1444

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

04 Jan 2017 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26957487 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Jan 2017 0930 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 04 Jan 2017 1026 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by TEKELENBURG,JAAP @ 04 Jan 2017 0947 EST

BP: 138/99, HR: 89, RR: 14, T: 97.2 °F, Pain Scale: 0 Pain Free

Appointment Comments:

ett/phq9/gad7

Vitals**Vitals** Written by TEKELENBURG,JAAP @ 04 Jan 2017 0947 EST

BP: 138/99, HR: 89, RR: 14, T: 97.2 °F, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 04 Jan 2017 1243 EST**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #5

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his fourth follow-up with this provider. At our last meeting we added Wellbutrin xl 150 mg po qam to target mood at his request as his mother and sister take it and find it helpful. Today pt states he continued to feel tired on it so started taking it at night about a week. He has had disrupted sleep. He has also continued to drink 3-4 drinks 3-4 nights per week. He didn't drink any alcohol over Christmas as he was visiting his relatives who don't drink, but drank 18 Corona beers over the four-day New Year's holiday (he did not have to work). Discussed with pt he shouldn't be drinking while taking his medications as they won't work while on alcohol, and his fatigue and sleep disturbance could be caused by his drinking. He acknowledges this though also states he drinks to help him sleep because he can't turn his mind off at night. Discussed he should not take Wellbutrin at night as this will also impair his sleeping. Noted increased phq9 and gad7 scores. He thinks he feels more anxious since starting Wellbutrin so we agreed to stop it. His work is going well. Dr Paul referred him for psychologic testing but he missed the phone call to make the appt. He plans to call back to schedule it. His abdominal pain has improved.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

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Created: 16 Aug 2017

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

04JAN17 phq9= 16 (#9=0); gad7= 14

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, wellbutrin xl 300 mg po qam, unisom OTC**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

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Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in civilian clothing.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements: normal gait. No abnormal movements apparent.

Rapport: easy to establish

Speech: normal tone and kinetics

Mood: mildly dysphoric

Affect: full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: fair

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Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD 44.4	%	(37.5-50.9)	
MCV	BLOOD 91.4	fL	(79.5-96.8)	
MCH	BLOOD 31.1	pg	(26.2-33.1)	
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD 12.9	%	(12.0-16.2)	
Platelets	BLOOD 272	x10(3)/mcL	(162-427)	
MPV	BLOOD 9.0	fL	(7.0-10.9)	
Neutrophils	BLOOD 59.4	%	(40.7-76.4)	
Lymphocytes	BLOOD 29.8	%	(15.9-47.8)	
Monocytes	BLOOD 8.9	%	(4.5-11.8)	
Eosinophils	BLOOD 1.5	%	(0.3-7.1)	
Basophils	BLOOD 0.4	%	(0.2-1.2)	
ABS Neutrophils	BLOOD 3.3	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	BLOOD 1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	BLOOD 0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	BLOOD 0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	BLOOD 0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM Negative <i>		(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM Negative <i>		(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <r>			

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293	pg/mL	(211-946)	

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM 8.9 <i>	mcmol/L	(4.0-15.4)	

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin SERUM 4.7	g/dL	(3.5-5.2)		
Alkaline Phosphatase SERUM 53	U/L	(40-129)		
Alanine Aminotransferase SERUM 17	U/L	(0-41)		
Bilirubin SERUM 0.4	mg/dL	(0.15-1.2)		
Urea Nitrogen SERUM 13.8	mg/dL	(6-20)		
Calcium SERUM 9.7	mg/dL	(8.6-10.2)		
Carbon Dioxide SERUM 29	mmol/L	(22-29)		
Chloride SERUM 98	mmol/L	(98-107)		
Creatinine SERUM 0.96	mg/dL	(0.7-1.2)		
Glucose SERUM 89	mg/dL	(74-106)		
Potassium SERUM 4.4	mmol/L	(3.5-5.1)		
Protein SERUM 7.6	g/dL	(6.6-8.7)		
Sodium SERUM 141	mmol/L	(136-145)		
Anion Gap SERUM 14	mmol/L	(7-16)		
GFR Calculated Non-Black SERUM 105.6	mL/min	(60->=60)		
GFR Calculated Black SERUM 122.1 <i>	mL/min	(60->=60)		
Aspartate Aminotransferase SERUM 20	U/L	(0-40)		

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines URINE	NEGATIVE <i>		(Negative)	
Barbiturates URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines URINE	NEGATIVE <i>		(Negative)	
Cocaine URINE	NEGATIVE <i>		(Negative)	
Opiates URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA URINE	NEGATIVE <i>		(Negative)	
Cannabinoids URINE	NEGATIVE <i>		(Negative)	
Methadone URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o GAD; r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Safety Plan:

- ☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: discontinue Wellbutrin xl by tapering back down from 300 mg to 150 mg po qam x 3 days, then stopping. Continue Lexapro 20 mg po daily. May start lunesta 1-2 mg po qhs prn insomnia to address racing thoughts at night, with plan for short term use. Pt told not to take with alcohol or unisom. Counseled pt on risks/benefits and he consented to treatment. Discussed sleep hygiene.

Measure: gad7, pcl, phq9

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal: pt will minimize alcohol use/stop drinking

Objective: pt will minimize alcohol use

Intervention: discussed adverse effects of alcohol on mood and sleep. Ordered GGT and LFTs. Start naltrexone 25 mg po daily for reduction in alcohol use x 1 week, then increase to 50 mg po daily if tolerated. Discussed at referral. Pt self-referred in past and says he is not drinking as much as he was then and does not think he needs it now. He agrees to try AA meetings, which he has already been to but has not found one where he feels a rapport yet. Continue to monitor

Measure: self-report, lab results

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

- ☐ good insight/judgment, ☒ a desire to resolve their disorder, ☒ verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Follow-up: one month

Referrals: pt had therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security

Merwin, Daniel Dennis

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

A/P Written by TOBAR,EDEN @ 04 Jan 2017 1245 EST

1. Generalized anxiety disorder: Medication management 30 minutes; psychotherapy 15 minutes

Procedure(s): -Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management x 1

Medication(s): -ESZOPICLONE--PO 1MG TAB - TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #30 RF1 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T
-NALTREXONE--PO 50MG TAB - T1/2 TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERAT #30 RF3 Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Laboratory(ies): -G-GLUTAMYL TRANSFERASE (Routine) Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T; HEPATIC FUNCTION PANEL (Routine) Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR,EDEN @ 04 Jan 2017 1246 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR,EDEN @ 04 Jan 2017 1055 EST

Additional A/P Information:

Discontinued buPROpion XL--PO 150MG TBER 24H - TAKE ONE TABLET BY MOUTH EVERY MORNING FOR 1 WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY MORNING IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 04 Jan 2017 1246

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Dec 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26743398 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Dec 2016 0900 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **PAUL, SHERIN**

Reason for Appointment:

f/u

Appointment Comments:

jc

Note Written by PAUL, SHERIN @ 08 Dec 2016 1424 EST

WR ADULT BEHAVIORAL HEALTH CLINIC
FOLLOW-UP NOTE

Patient Name: Daniel Merwin
 Patient last 4: 0538
 Appt #: Intake + 1
 Therapy time: 60 minutes
 E&M time: 60 minutes

Identifying Data: 31-year-old, Single, Caucasian, Male**Military Data:**

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

Presenting Problem:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

SUBJECTIVE/OBJECTIVE**Recent Outcome Measures (last 30 days):**

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.
9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported

Notes from Today's Session:**Treatment modality currently used: Supportive****Pain:** 0/10

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Therapy:

Patient presented for therapy on time. He stated that he visited his family recently and confirmed that both his grandmother and mother were diagnosed with Bipolar Disorder. He stated that his mother at least has been treated with Wellbutrin in the past. Patient's two other sisters also have been diagnosed with Depression and Bipolar disorder. Therapist and patient discussed patient's diagnosis and find that a referral to psychological testing is warranted to clarify diagnosis. Further conversation focused on patient's perfectionism and difficulty with emotional/relational/physical intimacy.

Response to treatment: [] None [**X**] Some [] Significant [] Marked

Mental Status Exam:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

ASSESSMENT**Diagnosis:**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Axis I: Generalized Anxiety Disorder
 Alcohol Abuse Disorder
 Axis II: Diagnosis deferred on Axis II
 Axis III: Deferred
 Axis IV: Financial stress, lack of social support
 Axis V: 65

Prognosis: () Excellent **(X) Good** () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

Safety Risk:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No
Age (risk factor if <25 or >60):	No

Modifiable:

Suicidal Ideation/Plans/Intent:	Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No
Access to Lethal Means:	No
Poor Treatment Compliance:	No
Hopelessness:	Yes
Psychic Pain/Anxiety:	Yes
Acute Event:	No
Insomnia:	No
Low Self-Worth:	No
Impulsivity:	Yes
Substance Abuse:	Yes, previously
Financial Stress:	Yes
Legal Stress:	No

Protective:

Strong Therapeutic Alliance:	Yes
Positive Coping Skills:	Yes
Responsible to/for Family:	No
Responsible to/for Pet:	
Frustration Tolerance	Limited
Resilience:	Yes
Good Reality Testing:	Yes
Amenable to Treatment:	Yes
Social Support:	No
Religious Beliefs Contrary to Suicide:	

History of Harm to Others: No history of harm to others.

Medical Record

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High

Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

TREATMENT PLAN

Patient was educated about and stated understanding of the dx. Patient collaborated on and agreed to the following tx plan:

Setting: **(X) Outpatient** () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Date last updated: 15 November 2016

Reviewed with patient on: 15 November 2016

Does patient agree with plan? Yes

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Progress:**Problem #2** Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

Measure: GAD-7

Progress: Patient gaining insight on maladaptive behaviors.

Follow-up's scheduled: 2-weeks

Referrals made today:

Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.

2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 08 Dec 2016 1427 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Consult(s): -Referred To: PSY DIAGNOSTIC TESTING MTF BE (Routine) Specialty: PSYCHOLOGY Clinic:
PSYCHOLOGY ASSESSMENT BE Provisional Diagnosis: Generalized anxiety disorder Order Date:
12/08/2016 14:26

Disposition Written by PAUL, SHERIN @ 08 Dec 2016 1427 EST

Released w/o Limitations

Follow up: 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Administrative Options: Consultation requested

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 08 Dec 2016 1427

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

05 Dec 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26690229 Primary Dx: Major depressive disorder, recurrent, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **05 Dec 2016 1000 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 05 Dec 2016 1040 EST

Allergies

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Appointment Comments:

ett/phq9/gad7

Note Written by TOBAR,EDEN @ 05 Dec 2016 1557 EST

Followup Note

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #4

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male

Military Data:

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes Work Colleague Problems: No
 Anger Problems: Yes Spouse/Sig Other Problems: No
 Legal Problems: No Financial Problems: Yes
 Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Medical Record

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Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his third follow-up with this provider. At our last meeting we increased his Lexapro to 20 mg po daily to target anxiety/irritability. Today he states he has not had suicidal thoughts since our last meeting. He has felt more tired since increasing the Lexapro. Two days ago he switched it to night time dosing. He started taking unisom last night for sleep as he was waking up frequently, and slept well on it. He just returned from visiting his family (grandmother, mother and sister) in California. He found out GM and mother have bipolar disorder and sister has depression> they all take Wellbutrin and find it helpful. He started seeing Dr Paul and has a follow up with her tomorrow. He is drinking 3 drinks (beers) around 3-4 nights per week. He plans to stop drinking during the week now. He continues to have ongoing abdominal pain and is seeing GI about this.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score

Merwin, Daniel Dennis

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SLEEP ISSUES:

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

05DEC16 phq9= 13 (#9=0); gad7= 8

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 20 mg po daily, unisom OTC**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

Merwin, Daniel Dennis

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PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly dysphoric

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o GAD; r/o PTSD; Unspecified depressive disorder, r/o MDE; r/o persistent depressive disorder; Alcohol Use Disorder; Trichotillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Goal:pt will experience decrease in anxiety and improvement in mood

Objective: pt will engage in pharmacotherapy, psychotherapy

Intervention: will add Wellbutrin xl 150 mg po qam x 1 week, then increase to 300 mg po qam if tolerated/efficacious. Continue Lexapro 20 mg po daily. Consider taper down on dose due to side effects if Wellbutrin tolerated/effective. Discussed possible interaction with unisom and Lexapro. Counseled pt on risks/benefits and he consented to treatment.

Measure:gad7, pcl, phq9

Problem #2: safety

Goal:pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure: self report

Problem #3: alcohol use

Goal:pt will minimize alcohol use

Objective: pt will minimize alcohol use

Intervention: discussed adverse effects of alcohol on mood and sleep. Pt insists he is cutting back.

Continue to monitor. Consider ats referral.

Measure:self-report

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one month

Referrals:pt has therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

Lab Result Cited by TOBAR,EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyrotropin	SERUM	2.500 <i>	mIU/mL	(0.27-4.2)
Thyroxine Free	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyroxine Free	SERUM	1.28 <i>	ng/dL	(0.93-1.7)

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Written by TOBAR,EDEN @ 05 Dec 2016 1558 EST

1. Major depressive disorder, recurrent, unspecified

Procedure(s): -Psych Ther Indiv Approx 60 Min W/ Medical Evaluation & Management x 1
Medication(s): -buPROpion XL--PO 150MG TBER 24H - TAKE ONE TABLET BY MOUTH EVERY MORNING FOR 1
WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY MORNIN #60 RF1 Ordered By:
TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR,EDEN @ 05 Dec 2016 1558 EST

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 05 Dec 2016 1559

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Nov 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26612374 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **28 Nov 2016 1243 EST**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **COPSEY, HELEN C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 28 Nov 2016 1243 EST

Pt email

S/O Note Written by COPSEY, HELEN C. @ 28 Nov 2016 1243 EST**Subjective**

Hi Daniel, Great insight- there is certainly a relationship between IBS and mental health. That's why we call your gut your "second brain". It sounds like you've started to make some progress and I'm more than happy to meet with you again to talk about next steps in your care. Please let me know if you need any assistance setting up another appointment. In the meantime, if you've already stopped dairy and Splenda and are looking for more ways to modify your diet, you may consider choosing low fodmap foods (see attached sheet). It may give you a bit more flexibility than just meat/potatoes. -Helen-----Original Message-----From: daniel.d.merwin [mailto:daniel.d.merwin@gmail.com] Sent: Friday, November 25, 2016 2:09 PM To: Copsey, Helen C CTR (US) Subject: [Non-DoD Source] RE: Follow-Up - Pain I probably will schedule a follow up soon. I have more food log completed. I also wanted to bring up important information I learned more extensively about recently. I am being treated for mental disorders. My family mom, grandma, great grandma, sister have mental health issues and IBS-D/C. Which made me look for association between mental health and IBS and see some papers have been written on it. Anyways I have been eating mostly meat and potatoes for now because it's really the only safe food so far and really needed a break from the pain and diarrhea. I still have diarrhea half the week but no pain on meat and potato diet. - Daniel Merwin

A/P Last Updated by COPSEY, HELEN C @ 28 Nov 2016 1243 EST**1. Irritable bowel syndrome with diarrhea****Disposition** Last Updated by COPSEY, HELEN C @ 28 Nov 2016 1243 EST**Follow up:** in the GI CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 28 Nov 2016 1243

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

15 Nov 2016 at WRNMMC, Psychiatry Be by PAUL, SHERIN

Encounter ID: BETH-26519450 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **15 Nov 2016 1300 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **SPEC**
 Provider: **PAUL, SHERIN**

Reason for Appointment:
 spec

Note Written by PAUL, SHERIN @ 16 Nov 2016 1451 EST

WR ADULT BEHAVIORAL HEALTH CLINIC INTAKE NOTE

Patient Name: Daniel Merwin

Patient last 4: 0538

Appt type: ☒ **Initial Eval** ☐ Command-Directed ☐ Special Duty Screen ☐ Admin Eval

Referred by: Dr. Tobar

Limits of Confidentiality and clinic no-show policy reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

IDENTIFYING DATA: 31-year-old, Single, Caucasian, Male**MILITARY DATA:**

Branch:	USN	
Rank:	PO1	
MOS:	CTN	
TIS:	11-years	
Deployments:	N/A	
Deployment Related:		N/A
Trauma:	N/A	
WTU:	N/A	
MEB in progress:	N/A	
AdmSep in progress:		N/A
Special Clearance:	Yes	

CHIEF COMPLAINT: The patient reports the following problems/difficulties:

Patient presents for follow up care related to symptoms of depression and anxiety. Patient reports dealing with depression and anxiety since childhood. He has a documented diagnosis of Generalized Anxiety Disorder. He endorses the current anxious symptoms: nervousness, uncontrollable worry, difficulty relaxing, restlessness, irritability, feeling something awful might happen, and excessive worry about multiple areas of his life. Further, patient identified a bald spot on the top of his head where he has been picking at his scalp due to anxiety. Patient also endorses the following mild depressive symptoms: low mood, anhedonia, fatigue, feelings of worthlessness/guilt (each rated at few or several days). Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

Current stressors include: workplace stress, financial debt, and interactions with his girlfriend.

Additionally, patient described considerable detachment from others. He stated that he does not care about other people and finds it difficult to interact with them. He described switching from apathy to anger

Medical Record

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towards others quickly. Patient noted that while he was inpatient for alcohol abuse rehab at Ft. Belvoir he was also diagnosed with Reactive Attachment Disorder and Borderline Personality Traits. Patient stated that this wasn't documented in his records to protect his career opportunities. However, patient now wants to access best possible care options related to all of his diagnoses.

Pt reports the following additional issues:

Work Performance Issues: Yes	Spouse/Sig Other Problems: No
Work Colleague Problems: No	Legal Problems: No
Anger Problems: Yes	Financial Problems: Yes
Overall level of difficulty in work, home, social functioning: Very difficult	

Behavioral Health Vitals (patient reported):

Overall health reported as: Good
Pain Level (0-10): 0
Is pain currently treated: not answered
Difficulty in work, home, social functioning: Very difficult

Patient **IS NOT** currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

HISTORY OF PRESENT ILLNESS:

Patient identified that depressive and anxiety symptoms originated in childhood. Patient stated that because of an abusive home environment, patient was always anxious about getting in trouble with his father. Patient revealed that he attempted suicide 2 x during his adolescence by attempting to over dose on Aspirin once and drinking a significant quantity of alcohol on another occasion. He did not suffer any significant consequences from these attempts and never reported it to others.

PSYCHIATRIC ROS:

SM reports the following self-reported items on screening before appt:

9/6/2016	BASIS-24	GENERAL DISTRESS	2.19	Moderate to High level of general distress reported
9/6/2016	PHQ2	DEPRESSION SCREENER	2	Depressive Syndrome Unlikely
9/6/2016	PHQ9	DEPRESSION	13	Minor depressive symptoms reported. Evaluation indicated.
9/6/2016	GAD2	ANXIETY SCREENER	5	Anxiety Syndrome Possible, see GAD7
9/6/2016	GAD7	ANXIETY	15	Moderate anxiety symptoms reported. Evaluation indicated.

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Created: 16 Aug 2017

9/6/2016	4QPTSD	PTSD SCREENER	3	PTSD possible, see PCL. Evaluation indicated
9/6/2016	PCL-5	PTSD	37	Some PTSD symptoms reported
9/6/2016	AUDIT-C	ALCOHOL SCREENER	6	Hazardous drinking possible, see full AUDIT when available
9/6/2016	AUDIT	ALCOHOL	13	Harmful or Hazardous Alcohol Consumption likely
9/6/2016	CSI	RELATIONSHIP ISSUES	N/A	Pt reports no significant other - no score

TBI/CONCUSSION SCREEN (Negative Screen): 9/6/2016**SLEEP ISSUES:** ISI ()

Hours of sleep per night: 6-7	Snores: No
Sleep latency: 0-15min	Daytime Somnolence: Yes

C-SSRS BASELINE (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?	Yes
Over lifetime, Suicidal Thoughts?	Yes
Over lifetime, Suicidal Thoughts with Method?	Yes
Over lifetime, Suicidal Intent?	Yes
Over lifetime, Suicide Intent with Specific Plan?	Yes
Over lifetime, Suicide Behavior?	Yes
Number of events?	3
<i>Most recent Suicidal Thoughts/Behaviors?</i>	<i>1-3 months ago</i>
<i>Suicidal Thoughts Duration?</i>	<i>Less than 1 hour</i>
<i>Suicidal Thought Frequency?</i>	<i>Less than once a week</i>

RISK ASSESSMENT:**Non-Modifiable Factors:**

Gender (risk factor if male):	Yes
H/O Suicide Attempts:	Yes – twice in adolescence
Organized Plan:	No
Chronic Psychiatric Disorder:	Yes
Recent Psychiatric Hospitalization:	No
H/O Abuse or Trauma:	Yes – sexual abuse as a child
Chronic Physical Illness:	No
Family H/O Suicide/Attempts:	Yes – both sisters have attempted
Other Recent Loss:	No
Chronic Pain:	No

Medical Record

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DoD ID: 1286180538

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Age (risk factor if <25 or >60): No

Modifiable:

Suicidal Ideation/Plans/Intent:		Yes- intermittent fleeting thoughts
Suicide Preparatory Behavior:	No	
Access to Lethal Means:	No	
Poor Treatment Compliance:		No
Hopelessness:	Yes	
Psychic Pain/Anxiety:	Yes	
Acute Event:	No	
Insomnia:	No	
Low Self-Worth:	No	
Impulsivity:	Yes	
Substance Abuse:		Yes, previously
Financial Stress:		Yes
Legal Stress:	No	

Protective:

Strong Therapeutic Alliance:		TBD
Positive Coping Skills:	Yes	
Responsible to/for Family:	No	
Responsible to/for Pet:		
Frustration Tolerance	Limited	
Resilience:	Yes	
Good Reality Testing:	Yes	
Amenable to Treatment:	Yes	
Social Support:	No	
Religious Beliefs Contrary to Suicide:		

History of Harm to Others: No history of harm to others.

This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: () Not Elevated () Low **(X) Intermediate** () High
 Harm to Others: **(X) Not Elevated** () Low () Intermediate () High

DEVELOPMENTAL/SOCIAL HISTORY:

Patient was born in California. He is the oldest of 3 children born to his parents. He has 2 younger sisters. Patient stated that his parents separated when he was 3 years-of-age. His father was awarded primary custody of the children, which patient feels was done through his father's manipulations. Notably, patient reports both parents were physical in managing his younger sister's behavioral outburst and often left bruises on her. His father re-married when he was 8-years old and then remarried again when patient was 18. Patient had visitation with his mother as a child but noted that these visitations were often disrupted by his younger sister's behavioral outbursts. Patient stated that he was frequently scared as a child. He stated that his dad was always angry and yelling at someone. Patient stated that he tried hard to do everything correctly to avoid his dad's attention. He recalled trying to stay in his room as much as possible to avoid the overall family environment. Patient also reported that his father kept pets in the house despite significant exacerbation of his asthma that required medical intervention frequently. The patient and his family participated in intermittent family counseling but patient did not find it to be beneficial as they frequently changed therapists when his dad was displeased. Patient has had limited contact with his mother since leaving the home at 18. He recalls 6/7 visits in the past 15-years. However, he is working on rebuilding the relationship. Patient is currently estranged from his father and has not

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interacted with him in the past 2-years. Prior to that, they saw each other 4 times in the past 15-years. Patient feels closest with his youngest sister because they have more shared experiences. However, he does not describe a strong relationship with her either. Notably, patient stated that he recently started recalling memories of sexual molestation by a paternal cousin in his early childhood (ages 6-12). He stated that the abuse stopped after the family moved from California to New Jersey.

The patient reported that he was teased by his peers for being underweight and because his clothes smelled like mildew as his parent's didn't properly do laundry. However, he was an excellent runner and gained positive experiences by participating in track and cross country. He stated that he struggled academically because he had difficulty learning and keeping focus. He acknowledged that he day dreamed a lot through school and didn't do his homework. However, patient graduated with a 2.2 GPA on time. After graduation, patient moved to Pennsylvania to get away from his home environment. He attempted 1 and ½ semesters at Allentown Business School (now closed) prior to dropping out. Patient worked at McDonald's and T-Mobile for 2 years prior to enlisting. Patient stated that he liked the Navy initially but finds the structure constricting at this point. Patient acknowledged that he likes what he does and is hoping to eventually build his own company developing video games.

Patient stated that he is currently in a romantic relationship but is dissatisfied. He stated that he does not ever feel close or connected to other people stating "I don't care about anyone except maybe my little sister". He described having significant difficulty experiencing empathy for others and described himself as selfish. He acknowledged that even the kind things he does for others is motivated by self-interest. He stated that he has tried to end the relationship with his current partner but she continues to dissuade him.

PAST PSYCHIATRIC HISTORY:

- August – October 2014: Individual Therapy w. Linda Nielsen
- March-April 2015: Inpatient Substance Abuse treatment at Ft. Belvoir
- April 2015- February 2016: Medication Management w. Dr. Zembruska
- September 2016- Present: Medication Management w. Dr. Tobar

FAMILY PSYCHIATRIC HISTORY:

- Maternal Grandmother: Bipolar
- Sister: Bipolar, Substance Abuse

SUBSTANCE USE:

Caffeine Use: Yes	Cups/Date Equivalent: 4
Tobacco/e-cigs: none	Packs/Date Equivalent: N/A
Alcohol: 2-3 glasses 2-3 x weekly	
Illicit drug use: denied	

Previous substance abuse tx: 30-days Inpatient program at Ft. Belvoir in 2014

MEDICAL/SURGICAL HISTORY:

Taken from Dr. Tobar's AHLTA Note Dated 24 October 2016

- Penile warts (HPV)
- Neurotic excoriation (scalp picking when anxious)
- Asthma during childhood
- Allergic response to pets
- Recurrent intestinal pain (possibly lactose intolerance)
- PRK (2011)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

CURRENT MEDICATIONS:

- Lexapro 20mg po daily

MENTAL STATUS EXAM:

Patient was alert and oriented to person, place, and time. He appeared to be his stated age. He is of average build and height walked with a normal gait. Patient was groomed appropriately and dressed in military uniform. He was cooperative and polite and engaged in session. He reported his mood as anxious and affect was mood and context congruent. Speech was coherent and normal in rate, tone, rhythm, and volume. Thought processes were logical and goal directed. Hallucinations or delusions were not endorsed or evidenced in session. Patient's judgment and insight are good. No homicidal thought/intent/plan reported. Patient reports fleeting intermittent suicidal ideation 1-2 times a month with no plan or intent.

DIAGNOSTIC IMPRESSION DISCUSSION:

Axis I: Generalized Anxiety Disorder

Alcohol Abuse Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: Deferred

Axis IV: Financial stress, lack of social support

Axis V: 65

Prognosis: () Excellent (X) Good () Fair () Guarded () Poor

Patient's capacity to participate in and benefit from therapy is evidenced by:

(X) good insight/judgment, (X) a desire to resolve their disorder, (X) verbal agreement to the treatment plan

TREATMENT PLAN:

Setting: (X) Outpatient () Inpatient () IOP () Other: _____

Safety Plan:

() Pt released without limitations, verbally commits to plan below and current safety to self/others.

() Pt released to Chain of Command with the following limitations: _____

(X) Pt is NOT deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Treatment Team:

Therapy: Dr. Paul

Medication Management: Dr. Tobar

Groups:

Problem #1 Suicidal Ideation

Goal: Extinguish suicidal ideation

Objective: Extinguish suicidal ideation

Intervention: CBT, Supportive therapy

Measure: PHQ-9

Problem #2 Anxiety/Depressive symptoms

Goal: "Handle stress better"

Objective: Increase positive coping skills to manage life stressors

Intervention: CBT, Supportive therapy

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Created: 16 Aug 2017

Measure: GAD-7

Patient Strengths: Motivated for treatment, insight, positive coping skills**Intervention Types planned:**

Interpersonal Therapy ()

Cognitive Behavioral Therapy (X)

Acceptance & Commitment Therapy ()

Behavioral Therapy ()

Problem-Solving Therapy ()

Cognitive Processing Therapy ()

Prolonged Exposure ()

Group Psychotherapy ()

Family/Couples Therapy ()

Medication Management ()

Follow-up's scheduled: 1-week**Referrals made today:**Patient would **NOT** like information on the following at this appointment:

Alpha Stim, TMS, Group Psychotherapy, Nutrition Referral, Spiritual Interests, Medications

Military Specific Interventions:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Pt **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **S1**. Pt meets the retention standards of MANMED for fitness and suitability for continued service. Pt remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is SM able to carry and fire weapon, from a BH perspective (safety)? No

Is SM able to have access to sensitive information (to the level of current clearance)? Yes

Is SM able to deploy? Yes

Can SM perform currently assigned MOS duties? Yes

A/P Written by PAUL, SHERIN @ 16 Nov 2016 1452 EST**1. Generalized anxiety disorder**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

2. Alcohol dependence, uncomplicatedDisposition Written by PAUL, SHERIN @ 16 Nov 2016 1453 EST**Released w/o Limitations****Follow up:** 2 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

90 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By PAUL, SHERIN (Clinical Psychologist) @ 16 Nov 2016 1453

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Oct 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-26237328 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **24 Oct 2016 1100 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 24 Oct 2016 1122 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by HAWKINS,DEREKSHEA J @ 24 Oct 2016 0956 EDT

BP: 133/85, HR: 78, RR: 16, T: 97.3 °F, Pain Scale: 0 Pain Free

Appointment Comments:

swk

Vitals**Vitals** Written by HAWKINS,DEREKSHEA J @ 24 Oct 2016 0956 EDT

BP: 133/85, HR: 78, RR: 16, T: 97.3 °F, Pain Scale: 0 Pain Free

Note Written by TOBAR,EDEN @ 24 Oct 2016 1254 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #3

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

Notes from current session:

Pt presents for his second follow-up with this provider. At our last meeting started Lexapro 5 mg po daily tapered up to 10 mg po daily after a week to target anxiety/irritability. . Today he states he has not had suicidal thoughts since our last meeting. He does feel less urge to drink alcohol. He is drinking 3 drinks (beers) around 304 nights per week. He continues to feel mood lability in the mornings. We reviewed his phq9 and gad7 scores, noting they both decreased from last visit. He is picking at his scalp less. When he took Lexapro at night he found it hard to sleep so he takes it in the morning now. We discussed how conversely he had felt fatigued on Zoloft. Pt says he was on leave last week and spent the week building a computer and playing video games, which he enjoyed. He still wonders sometimes 'what's the point' and continues to date a young woman even though he is not so interested in her, because he wants to company and she is pursuing him. He is taking 15 days of leave next month to visit his grandparents in California as they are elderly and he has not seen them in almost twenty years. He continues to have ongoing abdominal pain and is seeing GI about this. He was diagnosed with irritable bowel syndrome.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people , and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

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Merwin, Daniel Dennis

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Created: 16 Aug 2017

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

24OCT16 phq9= 8 (#9=0); gad7= 12

Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Lexapro 10 mg po daily.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost

Merwin, Daniel Dennis

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custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, friendly, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight:wnl

Impulsivity: none at time of interview

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Cognition: grossly intact

Fund of Knowledge: wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM 14.8	mg/dL	(6-20)	
Carbon Dioxide	SERUM 28	mmol/L	(22-29)	
Chloride	SERUM 98	mmol/L	(98-107)	
Creatinine	SERUM 1.00	mg/dL	(0.7-1.2)	
Glucose	SERUM 89	mg/dL	(74-106)	
Potassium	SERUM 4.5	mmol/L	(3.5-5.1)	
Sodium	SERUM 139	mmol/L	(136-145)	
Calcium	SERUM 10.1	mg/dL	(8.6-10.2)	
Anion Gap	SERUM 13	mmol/L	(7-16)	
GFR Calculated Non-Black	SERUM 99.8	mL/min	(60->=60)	
GFR Calculated Black	SERUM 115.4	mL/min	(60->=60)	

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD 5.6	x10(3)/mcL	(3.6-10.6)	
RBC	BLOOD 4.86	x10(6)/mcL	(4.21-5.92)	
Hemoglobin	BLOOD 15.1	g/dL	(12.8-17.7)	
Hematocrit	BLOOD 44.4	%	(37.5-50.9)	
MCV	BLOOD 91.4	fL	(79.5-96.8)	
MCH	BLOOD 31.1	pg	(26.2-33.1)	
MCHC	BLOOD 34.1	g/dL	(32.6-35.0)	
RDW CV	BLOOD 12.9	%	(12.0-16.2)	
Platelets	BLOOD 272	x10(3)/mcL	(162-427)	
MPV	BLOOD 9.0	fL	(7.0-10.9)	
Neutrophils	BLOOD 59.4	%	(40.7-76.4)	
Lymphocytes	BLOOD 29.8	%	(15.9-47.8)	
Monocytes	BLOOD 8.9	%	(4.5-11.8)	
Eosinophils	BLOOD 1.5	%	(0.3-7.1)	
Basophils	BLOOD 0.4	%	(0.2-1.2)	
ABS Neutrophils	BLOOD 3.3	x10(3)/mcL	(1.8-7.5)	
ABS Lymphocytes	BLOOD 1.7	x10(3)/mcL	(1.0-3.1)	
ABS Monocytes	BLOOD 0.5	x10(3)/mcL	(0.2-0.8)	
ABS Eosinophils	BLOOD 0.1	x10(3)/mcL	(0.0-0.5)	
ABS Basophils	BLOOD 0.0	x10(3)/mcL	(0.0-0.4)	
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED		

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM Negative <i>		(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM Negative <i>		(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM 170	nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM Negative <r>			

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM 293 <i>	pg/mL	(211-946)	

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng

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Created: 16 Aug 2017

Homocysteine SERUM 8.9 <i> mcmol/L (4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin SERUM 4.7	g/dL	(3.5-5.2)		
Alkaline Phosphatase SERUM 53	U/L	(40-129)		
Alanine Aminotransferase SERUM 17	U/L	(0-41)		
Bilirubin SERUM 0.4	mg/dL	(0.15-1.2)		
Urea Nitrogen SERUM 13.8	mg/dL	(6-20)		
Calcium SERUM 9.7	mg/dL	(8.6-10.2)		
Carbon Dioxide SERUM 29	mmol/L	(22-29)		
Chloride SERUM 98	mmol/L	(98-107)		
Creatinine SERUM 0.96	mg/dL	(0.7-1.2)		
Glucose SERUM 89	mg/dL	(74-106)		
Potassium SERUM 4.4	mmol/L	(3.5-5.1)		
Protein SERUM 7.6	g/dL	(6.6-8.7)		
Sodium SERUM 141	mmol/L	(136-145)		
Anion Gap SERUM 14	mmol/L	(7-16)		
GFR Calculated Non-Black SERUM 105.6	mL/min	(60->=60)		
GFR Calculated Black SERUM 122.1 <i>	mL/min	(60->=60)		
Aspartate Aminotransferase SERUM 20	U/L	(0-40)		

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide URINE	Negative <i>	ng/mL	Cutoff=250	

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines URINE	NEGATIVE <i>		(Negative)	
Barbiturates URINE	NEGATIVE <i>		(Negative)	
Benzodiazepines URINE	NEGATIVE <i>		(Negative)	
Cocaine URINE	NEGATIVE <i>		(Negative)	
Opiates URINE	NEGATIVE <i>		(Negative)	
Phencyclidine, UA URINE	NEGATIVE <i>		(Negative)	
Cannabinoids URINE	NEGATIVE <i>		(Negative)	
Methadone URINE	NEGATIVE <i>		(Not-Detected)	
Oxycodone URINE	NEGATIVE <i>	ng/mL	(Negative)	

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High
 Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder; Alcohol Use Disorder; Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.
☐ Patient released to Chain of Command with the following limitations: _____

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will consider pharmacotherapy, psychotherapy

Intervention: increase Lexapro to 20 mg po daily. Counseled pt on risks/benefits and he consented to treatment. Monitor alcohol use.

Measure: gad7, pcl

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: one month

Referrals: pt has therapy intake with Dr Paul on 18NOV

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

Lab Result Cited by TOBAR, EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone

Thyrotropin

Site/Specimen

SERUM

06 Sep 2016 0923

2.500 <i>

Units

mIU/mL

Ref Rng

(0.27-4.2)

Thyroxine Free

Thyroxine Free

Site/Specimen

SERUM

06 Sep 2016 0923

1.28 <i>

Units

ng/dL

Ref Rng

(0.93-1.7)

Follow up: 1 month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Written by TOBAR,EDEN @ 24 Oct 2016 1255 EDT

1. Anxiety disorder, unspecified

Procedure(s): -Psych Ther Indiv Approx 45 Min W/ Medical Evaluation & Management x 1
Medication(s): -ESCITALOPRAM--PO 20MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF3 Ordered
By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR,EDEN @ 24 Oct 2016 1256 EDT

Released w/o Limitations

Follow up: month(s) or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TOBAR,EDEN @ 24 Oct 2016 1136 EDT

Additional A/P Information:

Discontinued ESCITALOPRAM--PO 5MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY DAY IF TOLERATED

Signed By TOBAR, EDEN (Physician/Workstation) @ 24 Oct 2016 1256

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

11 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26078538 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **11 Oct 2016 1145 EDT**
Clinic: **GI CL BE**

Appt Type: **T-CON***
Provider: **COPSEY, HELEN C.**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 11 Oct 2016 1145 EDT
Pt email

Note Written by COPSEY, HELEN C @ 11 Oct 2016 1146 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

October 11th, 2016

To Whom It May Concern,

PO1 Daniel Merwin ([REDACTED] 1985) is followed in our clinic for a chronic medical condition that can impact his day to day functioning. Please take this under consideration if/when PO1 Merwin requests reasonable accomodations to his work schedule.

Please feel free to contact me directly with any questions or concerns.

Sincerely,

COPSEY.HELE
N.CHRISTINA.
1393890351

Digitally signed by
COPSEY.HELEN.CHRISTINA.13938903
51
DN: c=US, o=U.S. Government,
ou=DoD, ou=PKI, ou=CONTRACTOR,
cn=COPSEY.HELEN.CHRISTINA.13938
90351
Date: 2016.10.11 11:43:25 -04'00'

Helen Copsey, PA-C

301-400-0552

Helen.C.Copsey.ctr@mail.mil

A/P Last Updated by COPSEY,HELEN C @ 11 Oct 2016 1146 EDT

1. Irritable bowel syndrome with diarrhea

Disposition Last Updated by COPSEY,HELEN C @ 11 Oct 2016 1146 EDT

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 11 Oct 2016 1146

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Oct 2016 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-26016255 Primary Dx: Irritable bowel syndrome with diarrhea

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Oct 2016 1500 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **COPSEY, HELEN C.**

Reason for Appointment:

F/U FOR Helicobacter pylori [H. pylori] as the cause of diseases cla

Appointment Comments:

ame.cc

Vitals**Vitals** Written by THOMPSON,DEREK J @ 04 Oct 2016 1454 EDT

BP: 145/86, HR: 65, RR: 18, T: 98.1 °F, HT: 69 in, WT: 158 lbs, BMI: 23.33, BSA: 1.869 square meters,
 Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 4/10 Moderate, Pain Scale Comments: abd

S/O Note Written by COPSEY,HELEN C. @ 04 Oct 2016 1617 EDT**Reason for Visit**

Visit for: Abdominal pain.

History of present illness

The Patient is a 31 year old male.

31 yo M here for abdominal pain. Reports a long history of GI symptoms, dating back to childhood. Symptoms have been more disruptive over the past few years. Notes generalized sharp abdominal pain about every other day, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft-liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. Reports he has never been formally diagnosed and has not been on treatment for these symptoms. Does consume cheese several times per week, and splenda on a daily basis.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal colitis at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He saw GI earlier this year after he was noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in June.

Allergies

NKDA.

Past medical/surgical history**Reported:**

Past medical history
 Anxiety/depression

Surgical / Procedural: Prior surgery
 Tonsillectomy
 PRK

Medications: Medication history
 Lexapro

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

• Pre-op ASA class 1

Previous therapy

• History of possible limitations and risks do not include complications from anesthesia

Personal history

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

Family history

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

No malignant neoplasm of large intestine

No malignant neoplasm of the gastrointestinal tract.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Otolaryngeal:** No mouth sores.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea.**Gastrointestinal:** No heartburn and no regurgitation. No early satiety, no nausea, no vomiting, no abdominal swelling, no tenesmus, no melena, no hematochezia, and no nocturnal diarrhea.**Musculoskeletal:** No arthralgias, new. No nonspecific pain, swelling, and stiffness.**Skin:** No rash, new.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

Standard Measurements:

° Patient was not observed to be obese.

General Appearance:

° Awake. ° Alert. ° Well developed. ° Well nourished. ° In no acute distress. ° Patient did not appear uncomfortable. ° Not acutely ill. ° Not chronically ill.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Sclera: ° Showed no icterus.

Oral Cavity:

° Normal OP clear, Mallampati score = 1.

Chest:

° Visual inspection revealed no abnormalities.

Lungs:

° Normal CTA B.

Cardiovascular:

° System: normal RRR, no M or G.

Abdomen:

° Normal soft, NT/ND, +BS.

Neurological:

° Level of consciousness was normal. ° Oriented to time, place, and person.

Speech: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Thought Processes: ° Not impaired.

Skin:

° General appearance was normal. ° No jaundice. ° No skin lesions.

Therapy

• Medical regimen review -- medication reconciliation performed.

Lab Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1454 EDT**Comprehensive Metabolic Panel****Site/Specimen****16 Feb 2016 1430**

Aspartate Aminotransferase

SERUM

20

Helicobacter pylori Ag EIA

Order #	160511-04658 (NNMC Bethesda)
Filler #	160606 NBL 374 (NNMC Bethesda)
Status:	Final
Ordering Provider:	SHAH, NISHA AMISH
Priority:	ROUTINE
Date Ordered:	11 May 2016 0843
Date Resulted:	10 Jun 2016 0857
COLLECT_SAMPLE:	STOOL
Order Comment:	to be done two weeks after stopping protonix

BACTERIOLOGY RESULT: OBSERVATION: Negative

Specimen:	Feces
Collected:	06 Jun 2016 1312

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Results:

Final report

Tissue Exam

Date Collected: 12 Oct 2012 0001
 POC Enc: E4520771
 Enc Fac: WRNMMC
 Clinician: COX, TIFFANY CANDACE
 Status: Certify
 Procedure: TISSUE EXAM
 Order #: 121028-01374
 Provider: COX, TIFFANY CANDACE
 Ordered Date: 28 Oct 2012 1038
 Priority: ROUTINE
 Specimen: TISSUE
 Resulted Date: 28 Oct 2012 1038.1-0500
 121018 NSP 23631 Col: 12Oct12 TISSUE(TISSUE)
 Hcp: COX, TIFFANY CANDACE Req Loc: 5 EAST
 TISSUE E C: RB28Oct12@1038
 CoPath Report
 Patient: MERWIN, DANIEL DENNIS Specimen #: NS12-23631
 Accessioned: 10/18/12
 Pathologist: Ross Barner, COL MC USA
 SPECIMEN:
 A: ascending colon B: sigmoid colon

=====

FINAL DIAGNOSIS:
 A. ASCENDING COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATE.

B. SIGMOID COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATES.
 Comment: There is no evidence of acute cryptitis, architectural distortion, or dysplasia.
 rxb/10/19/12 ** Report Electronically Signed Out **
 Ross Barner, COL MC USA

=====

CLINICAL DIAGNOSIS AND HISTORY:

with

thickening of ascending colon on ct with no stranding, presented

PRE-OPERATIVE DIAGNOSIS:

obstructive symptoms, rule out mass vs. inflamm.

POST-OPERATIVE DIAGNOSIS:

ascending colon thickening

GROSS DESCRIPTION:

Operative Findings: sigmoid thickening
 Post-operative Diagnosis: sigmoid thickening

name

A: The specimen is received in formalin, labeled with the patient's

white

Merwin, Daniel designated, "Ascending Colon" consists of two tan-

name

irregular soft tissue fragments measuring 0.4 and 0.6 cm in greatest dimension. Submitted entirely. 2/1/ng

irregular

B: The specimen is received in formalin, labeled with the patient's

Merwin, Daniel designated, "Sigmoid" consists of four tan-white

soft tissue fragments measuring 0.2 to 0.5 cm in greatest dimension.
 Submitted entirely. 4/1/ng NW/JAP/DVC
 HLS/meh

Lab Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1454 EDT**Thyroid Stimulating Hormone****Site/Specimen****06 Sep 2016 0923**

Thyrotropin

SERUM

2.500 <i>

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CBC W/Diff	Site/Specimen	22 Jun 2016 1240
WBC	BLOOD	5.6
RBC	BLOOD	4.86
Hemoglobin	BLOOD	15.1
Hematocrit	BLOOD	44.4
MCV	BLOOD	91.4
MCH	BLOOD	31.1
MCHC	BLOOD	34.1
RDW CV	BLOOD	12.9
Platelets	BLOOD	272
MPV	BLOOD	9.0
Neutrophils	BLOOD	59.4
Lymphocytes	BLOOD	29.8
Monocytes	BLOOD	8.9
Eosinophils	BLOOD	1.5
Basophils	BLOOD	0.4
ABS Neutrophils	BLOOD	3.3
ABS Lymphocytes	BLOOD	1.7
ABS Monocytes	BLOOD	0.5
ABS Eosinophils	BLOOD	0.1
ABS Basophils	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430
Albumin	SERUM	4.7
Alkaline Phosphatase	SERUM	53
Alanine Aminotransferase	SERUM	17
Bilirubin	SERUM	0.4
Urea Nitrogen	SERUM	13.8
Calcium	SERUM	9.7
Carbon Dioxide	SERUM	29
Chloride	SERUM	98
Creatinine	SERUM	0.96
Glucose	SERUM	89
Potassium	SERUM	4.4
Protein	SERUM	7.6
Sodium	SERUM	141
Anion Gap	SERUM	14
GFR Calculated Non-Black	SERUM	105.6
GFR Calculated Black	SERUM	122.1 <i>
Aspartate Aminotransferase	SERUM	20

Rad Result Cited by COPSEY,HELEN C @ 04 Oct 2016 1453 EDT**MERWIN, DANIEL DENNIS** 20/ [REDACTED] **DoD ID: 1286180538 31yo** [REDACTED] **1985 M**

***** MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)
 Event Date: 23-Oct-2012 15:54:00
 Exam #: 12359730
 Exam Date/Time: 02-Nov-2012 07:18:00
 Transcription Date/Time: 05-Nov-2012 09:56:00
 Provider: COPSEY, HELEN C
 Requesting Location:
 GSURG GI APU BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Supervised By: MARCIA JAVITT, MD

Approved By: JAVITT, MARCIA C

Approved Date: 05-Nov-2012 09:48:00

Supervised By: 115455 MARCIA JAVITT, MD

Supervised By Date: 05-Nov-2012 09:48:00

Amended Report Text:

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening and equalization of small bowel. Recent colonoscopy and without lesion the terminal ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer, coronal FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal FIESTA fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing, or luminal narrowing. There is normal bowel peristalsis and motion observed on the cinematic images. Minimal mural thickening of the mid jejunum observed at the left upper quadrant without corresponding abnormal mucosal enhancement, stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary ductal dilatation. The spleen, pancreas, adrenals, and kidneys are normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or pelvic lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the gastrointestinal system, specifically evidence of active inflammation at the site of previously observed colitis on CT examination 10/11/12. Correlate with patient's symptomatology.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)

Event Date: 11-Oct-2012 01:30:00

Exam #: 12343907

Exam Date/Time: 11-Oct-2012 00:30:00

Transcription Date/Time: 12-Oct-2012 07:00:00

Provider: HARDWARE, LESLIE

Requesting Location:

EMERGENCY RM BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Approved By: BERNARD, JACQUELINE M

Approved Date: 11-Oct-2012 08:16:00

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Supervised By Date: 11-Oct-2012 08:16:00

Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra- or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12. _____

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12
Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12 Time:08:16

A/P Written by COPSEY,HELEN C @ 04 Oct 2016 1623 EDT

1. Irritable bowel syndrome with diarrhea: Clinical history is consistent with IBS-D. This diagnosis was discussed with the patient in detail and all questions were answered. Goals of management were reviewed including options such as natural interventions/ dietary change/ stress management, all the way to low dose TCA therapy. He v/u and opts to proceed as detailed below.

PLAN:

1. Celiac panel.
2. Strict dairy free trial x 2 weeks.
3. Stop Splenda.
4. Pending progress, consider 2 week course of Xifaxan.
5. F/u with me directly via phone/email/relay health with updates.

Disposition Written by COPSEY,HELEN C @ 04 Oct 2016 1623 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 04 Oct 2016 1623

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25944739 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **28 Sep 2016 0930 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 28 Sep 2016 1003 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by HAWKINS,DEREKSHEA J @ 28 Sep 2016 0923 EDT

BP: 139/91, HR: 74, RR: 16, T: 97.6 °F, Pain Scale: 3/10 Mild, Pain Scale Comments: intestinal pain

Appointment Comments:

djs

Vitals**Vitals** Written by HAWKINS,DEREKSHEA J @ 28 Sep 2016 0923 EDT

BP: 139/91, HR: 74, RR: 16, T: 97.6 °F, Pain Scale: 3/10 Mild, Pain Scale Comments: intestinal pain

Note Written by TOBAR,EDEN @ 28 Sep 2016 2152 EDT**Followup Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment #2

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

History of Present Illness:

Pt presents for his first follow-up with this provider. At our last meeting we discussed another trial of SSRI for mood and anxiety as he didn't tolerate Zoloft previously; he wanted to think about it. Today he states he continues to feel guilt about how he functions in interpersonal relationships which leads him to feel suicidal. He continues to feel mood lability in the mornings. He is drinking around two glasses of wine per night. He last felt suicidal about two days ago without intent or plan. He continues to have ongoing abdominal pain and is seeing GI about this.

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembruzska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported

Depression - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen**Rating scales:**

28SEP16 phq9= 11 (#9=1); gad7= 16

Risk Assessment:C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead? Yes

Over lifetime, Suicidal Thoughts? Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent? Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes Number of events: 3

Most recent Suicidal Thoughts/Behaviors? 1-3 months ago

Suicidal Thoughts Duration? Less than 1 hour

Suicidal Thought Frequency? Less than once a week

C-SSRS Current: not taken**RISK FACTORS (Weaknesses):** (also see patient reported issues above in vitals)☒ Male ☐ History of family/friend suicide☐ Chronic medical conditions ☒ Impulsivity☒ History of abuse ☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children ☒ Active treatment engagement☐ Good coping/problem solving skills ☒ Hopefulness present☐ Faith/religion commitment ☐ Positive future orientation**Allergies:** nkda**Medications:** Patient denies taking medications/OTC meds/supplements.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

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Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, friendly, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:normal tone and kinetics

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)
Carbon Dioxide	SERUM	28	mmol/L	(22-29)

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Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	<i>mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170	nmol/L	0-378

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)

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Created: 16 Aug 2017

Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1	<i>mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative <i>	ng/mL	Cutoff=250

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Alcohol Use Disorder; r/o Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: anxiety, depressed mood

Goal: pt will experience decrease in anxiety and improvement in mood

Objective: pt will consider pharmacotherapy, psychotherapy

Merwin, Daniel Dennis

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Intervention: Start Lexapro 5 mg po daily x 1 week, then increase to 10 mg po daily. Counseled pt on risks/benefits and he consented to treatment. Monitor alcohol use.

Measure: gad7, pcl

Problem #2: safety

Goal: pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: two weeks with this provider

Referrals: referred to therapist

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**

Can Service Member perform MOS duties? **Yes**

Lab Result Cited by TOBAR,EDEN @ 28 Sep 2016 2152 EDT

Thyroid Stimulating Hormone	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyrotropin	SERUM	2.500 <i>	mIU/mL	(0.27-4.2)
Thyroxine Free	Site/Specimen	06 Sep 2016 0923	Units	Ref Rng
Thyroxine Free	SERUM	1.28 <i>	ng/dL	(0.93-1.7)

A/P Written by TOBAR,EDEN @ 28 Sep 2016 2153 EDT

1. Anxiety disorder, unspecified

Procedure(s): -Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1
 Medication(s): -ESCITALOPRAM--PO 5MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO TWO TABLETS BY MOUTH EVERY DAY IF TO #60 RF1 Ordered By: TOBAR,EDEN
 Ordering Provider: TOBAR, EDEN T

Disposition Written by TOBAR,EDEN @ 28 Sep 2016 2154 EDT

Released w/o Limitations

Follow up: 1 month(s) or sooner if there are problems.

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Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By TOBAR, EDEN (Physician/Workstation) @ 28 Sep 2016 2154

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

08 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25742054 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2016 1517 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 09 Sep 2016 0839 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Reason for Appointment: Written by TOBAR,EDEN @ 08 Sep 2016 1517 EDT
 prolonged non face-to-face services

S/O Note Written by TOBAR,EDEN T @ 09 Sep 2016 0842 EDT**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: Reviewed pt's previous medical records in AHLTA and HAIMS to assist with diagnostic clarification and for treatment planning.

A/P Written by TOBAR,EDEN @ 09 Sep 2016 0843 EDT**1. Anxiety disorder, unspecified****Disposition** Written by TOBAR,EDEN @ 09 Sep 2016 0844 EDT**Released w/o Limitations**

Signed By TOBAR, EDEN (Physician/Workstation) @ 09 Sep 2016 0844

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Sep 2016 at WRNMMC, Psychiatry Be by TOBAR, EDEN

Encounter ID: BETH-25701481 Primary Dx: Anxiety disorder, unspecified

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **06 Sep 2016 0800 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **SPEC**
 Provider: **TOBAR, EDEN T**

AutoCites Refreshed by TOBAR,EDEN @ 06 Sep 2016 0905 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Vitals

No Vitals Found.

Reason for Appointment:

Spec

Appointment Comments:

ssb

Note Written by TOBAR,EDEN @ 08 Sep 2016 1443 EDT**Intake Note**

Patient: Daniel Merwin Gender: M
 DOB: [REDACTED] 1985 Patient DODID: 1286180538

Limits of Confidentiality reviewed with Patient, Patient verbally acknowledged understanding, and signature was obtained.

Appointment type: ☒ Initial evaluation ☐ Command-Directed ☐ Special Duty Screen ☐

Administrative evaluation

Referral by: I decided on my own to come to the clinic

Identifying data: Patient is an unmarried 31 y/o white Active Duty male**Military Data:**

Branch: Navy Rank: MOS: CTN TIS: 11 yrs
 UIC: Commander: NIOC Maryland Unit Phone: 3016770217
 Deployment Related? No # Deployments: 1 Months Deployed: 36
 WTU: No MEB: No AdmSep: No
 Special Clearance: Yes Current PULHES: UNK

CC/Background: The patient reports the following problems/difficulties: previous documented and undocument issues. anxiety, stress, bpd traits and reactive attachment disorder

Patient reports the following additional issues:

Work Performance Issues: Yes

Work Colleague Problems: No

Anger Problems: Yes

Spouse/Sig Other Problems: No

Legal Problems: No

Financial Problems: Yes

Overall level of difficulty in work, home, social functioning: Very difficult

Behavioral Health Vitals (patient reported):

Overall health reported as: Good

Pain Level (0-10): 0

Currently treated: not answered

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Suicidal Ideation Risk - C-SSRS score: 5 Past/Prep Behavior: Yes

past attempts: 3 (as of 09/06/2016)

Harm Others Risk over next week as of 9/6/2016 - None

Active Plan: N/A

Patient with access to weapons: No

History of Present Illness:

Pt presents to establish care with new psychiatrist. Pt completed BHDP after appt. He was previously seen by Dr Zembrukska, most recently in Nov 2015, for medication management of Generalized anxiety disorder, at which time he wanted help tapering off of Zoloft as he felt excessively sleepy on it. Pt returns to treatment today because he has been experiencing increased stress and mood swings. He also states he was diagnosed with Reactive Attachment Disorder and Borderline Personality Traits while in dual diagnosis treatment in Ft Belvoir and wants this documented in his record as he believes he has these diagnoses and doesn't think they made it into his record. Regarding anxiety, pt states he finds in the morning on his way to work he experiences physical tension, increased heart rate, nausea. He likes his job with NIOC but finds it stressful juggling his collateral duties. He has also been picking at his crown since 2008 so that he has a half-dollar size patch of no hair where he has picked it out. He reports struggling with irritability and says when he was stationed on a ship he often felt angry due to being in close proximity to other people, and got into three fights and broke his hand while on the ship. He is concerned about being like his father, whom he states was often angry and physically disciplined pt when he was growing up so that he had bruises at times. He doesn't like being touched. He finds when he dates someone he experiences no empathy for them, or becomes easily irritable. He states he has been dating someone for three months and would like to break up with them. He has poor sleep maintenance, often waking up between 0200-0400. Nevertheless, he states he 'loves sleeping.' He doesn't recall dreaming. He enjoys painting, making bread, and cooking. He also loves programming and says he can say up for days working on this as he has a side business doing this. He admits to \$36,000 in credit card debt which he says is due to buying his stepbrother a car as well as furniture for his home. Pt says he owns a home in Florida that he could sell to pay this off. His appetite is normal. He has trouble focusing at work. He feels guilty when he gets angry. He has had suicidal thoughts throughout his life. The last time this happened was three-four weeks ago, when he had thoughts about jumping off of a roof related to juggling multiple work responsibilities.

Psychiatric ROS:

Service Member reports the following self-reported items on screening AFTER appointment:

General Distress - BASIS-24: 2.19 - Moderate to High level of general distress reported**Depression** - PHQ2: 2 - Depressive Syndrome Unlikely

PHQ9: 13 - Minor depressive symptoms reported. Evaluation indicated.

Thoughts that you would be better off dead, or of hurting yourself in some way

Few or several days

Anxiety - GAD 2: 5 - Anxiety Syndrome Possible, see GAD7

GAD 7: 15 - Moderate anxiety symptoms reported. Evaluation indicated.

PTSD - 4QPTSD: 3 - PTSD possible, see PCL. Evaluation indicated

PCL-5: 37 - Some PTSD symptoms reported

ALCOHOL - AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT

AUDIT: 13 - Harmful or Hazardous Alcohol Consumption likely

RELATIONSHIP ISSUES - CSI - Pt reports no significant other - no score**SLEEP ISSUES:**

Average hours of sleep per night: 6-7 Snore: No

Average sleep latency: 0-15min

Daytime Somnolence: Yes

OTHER - BAM: Risk/Protection/Use (subscales):**TBI/CONCUSSION SCREEN:** Negative Screen

Clinician notes for ROS:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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Risk Assessment:

C-SSRS Baseline (9/6/2016): 5 - Lifetime thoughts of suicide with plan or actual behavior endorsed.

Over lifetime, Wish to be Dead?

Yes

Over lifetime, Suicidal Thoughts?

Yes

Over lifetime, Suicidal Thoughts with Method? Yes

Over lifetime, Suicidal Intent?

Yes

Over lifetime, Suicide Intent with Specific Plan? Yes

Over lifetime, Suicide Behavior? Yes

Number of events: 3

Most recent Suicidal Thoughts/Behaviors?

1-3 months ago

Suicidal Thoughts Duration?

Less than 1 hour

Suicidal Thought Frequency?

Less than once a week

C-SSRS Current: not taken

RISK FACTORS (Weaknesses): (also see patient reported issues above in vitals)☒ Male☐ History of family/friend suicide☐ Chronic medical conditions☒ Impulsivity☒ History of abuse☐ Chronic pain**PROTECTIVE FACTORS (Strengths):**☐ Married, children☒ Active treatment engagement☐ Good coping/problem solving skills☒ Hopefulness present☐ Faith/religion commitment☐ Positive future orientation**Allergies:** nkda**Medications:** Patient denies taking medications/OTC meds/supplements.**Past Behavioral Health History:**

Past counseling/therapy: Yes, saw Ms Nilsen previously, didn't find it helpful.

Past Meds for Behavioral Health reasons: Yes, Zoloft 50 mg, felt tired and 'tranquilized' on it.

Past Behavioral Health hospitalizations: Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Past problems treated: Confirmed from Dr Z's note that "Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior."

Family Behavioral Health History:

Grandmother and sister have bipolar disorder. Says sister is frequently hospitalized and uses drugs. Lost custody of her children. Thinks grandmother and other sister are on Wellbutrin.

Medical History: as per Dr Z's notes: Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

Patient denies significant nutrition concerns.

Substance Use:

Caffeine Use: Yes

Cups/Day Equivalent: 4

Tobacco/e-cigs: none

PPD Equivalent:

Alcohol: AUDIT-C: 6 - Hazardous drinking possible, see full AUDIT. States he drinks two glasses of wine per night Friday-Sunday. Cut back two months ago. Denies drinking alcohol during the week.

Illicit drug use: denied

Developmental/Social History:

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Patient was primarily raised by Biological parents and that childhood was generally Poor. Parents were divorced or separated when patient was 3 yrs old.

Patient admits ever being physically, sexually or emotionally abused. Pt believes he was molested by his 'uncle's son' when pt was between the age of five and ten. Uncle's son was in his teens. Pt can't remember exactly; started having this memory while at Ft Belvoir. Doesn't know where uncle's son is now.

Highest level of education achieved is: High School graduate.

Patient is currently single and currently lives with Roommate. Housing is currently Off-Post.

Patient reports religion, faith or spirituality DO NOT play an important role in life.

Social support reported as satisfactory.

Patient reports the following history of legal issues: Drug/Alcohol Issues.

Past Family/Medical History:

Family Medical Illnesses: Diabetes, Heart Disease or Stroke, High Blood Pressure

Family Behavioral Health Illnesses: Depression, Anxiety Problems, Bipolar Disorder (Manic Depressive)

Family Substance Use History: Alcohol, Prescription Drugs, Street Drugs

Learning / Needs Assessment:

Community Resources Used: None

Patient denies treatment team needs to be aware of specific ethnic/cultural issues.

Learns best by: Pictures. Learning is adversely affected by: None.

Patient would not like family members involved in care.

Patient would like the following information at this appointment: Diagnosis, Medications, Follow-up Care

Mental Status Exam:

Appearance: Neatly groomed in uniform.

Behavior/Orientation: Polite, friendly, and cooperative.

Abnormal Movements:normal gait. No abnormal movements apparent.

Rapport:easy to establish

Speech:mildly pressured

Mood:mildly anxious

Affect:full

Thought Process: circumstantial

Thought Content: no current SI/HI/AVH

Judgment: wnl

Insight:wnl

Impulsivity: none at time of interview

Cognition:grossly intact

Fund of Knowledge:wnl

Lab/Imaging/Other Objective Data

Basic Metabolic Panel	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
Urea Nitrogen	SERUM	14.8	mg/dL	(6-20)
Carbon Dioxide	SERUM	28	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	1.00	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.5	mmol/L	(3.5-5.1)
Sodium	SERUM	139	mmol/L	(136-145)
Calcium	SERUM	10.1	mg/dL	(8.6-10.2)
Anion Gap	SERUM	13	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	99.8	mL/min	(60->=60)
GFR Calculated Black	SERUM	115.4	mL/min	(60->=60)

CBC W/Diff	Site/Specimen	22 Jun 2016 1240	Units	Ref Rng
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WBC	BLOOD	5.6	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.86	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	15.1	g/dL	(12.8-17.7)
Hematocrit	BLOOD	44.4	%	(37.5-50.9)
MCV	BLOOD	91.4	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	34.1	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.9	%	(12.0-16.2)
Platelets	BLOOD	272	x10(3)/mcL	(162-427)
MPV	BLOOD	9.0	fL	(7.0-10.9)
Neutrophils	BLOOD	59.4	%	(40.7-76.4)
Lymphocytes	BLOOD	29.8	%	(15.9-47.8)
Monocytes	BLOOD	8.9	%	(4.5-11.8)
Eosinophils	BLOOD	1.5	%	(0.3-7.1)
Basophils	BLOOD	0.4	%	(0.2-1.2)
ABS Neutrophils	BLOOD	3.3	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	MANUAL	DIFF NOT PERFORMED	

Lyme Disease Ab Total Screen	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Borrelia burgdorferi Ab	SERUM	Negative <i>	(See-Below)	

Treponema pallidum Ab	Site/Specimen	11 Apr 2016 1043	Units	Ref Rng
Treponema pallidum Ab	SERUM	Negative <i>	(Negative)	
Methylmalonic Acid	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Methylmalonate	SERUM	170 nmol/L	0-378	

HIV-1/O/2 Ab	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Vitamin B12 (Cyanocobalamin)	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Vitamin B12 (Cobalamins)	SERUM	293 <i>	pg/mL	(211-946)

Homocysteine	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Homocysteine	SERUM	8.9 <i>	mcmol/L	(4.0-15.4)

Comprehensive Metabolic Panel	Site/Specimen	16 Feb 2016 1430	Units	Ref Rng
Albumin	SERUM	4.7	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	53	U/L	(40-129)
Alanine Aminotransferase	SERUM	17	U/L	(0-41)
Bilirubin	SERUM	0.4	mg/dL	(0.15-1.2)
Urea Nitrogen	SERUM	13.8	mg/dL	(6-20)
Calcium	SERUM	9.7	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)

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Created: 16 Aug 2017

GFR Calculated Black SERUM 122.1 <i> mL/min (60->=60)
 Aspartate Aminotransferase SERUM 20 U/L (0-40)

ETG/ETS, UA (250 Cut-Off) Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Ethyl Glucuronide URINE Negative <i> ng/mL Cutoff=250

Drug Abuse Screen Site/Specimen 02 Feb 2016 1406 Units Ref Rng
 Amphetamines URINE NEGATIVE <i> (Negative)
 Barbiturates URINE NEGATIVE <i> (Negative)
 Benzodiazepines URINE NEGATIVE <i> (Negative)
 Cocaine URINE NEGATIVE <i> (Negative)
 Opiates URINE NEGATIVE <i> (Negative)
 Phencyclidine, UA URINE NEGATIVE <i> (Negative)
 Cannabinoids URINE NEGATIVE <i> (Negative)
 Methadone URINE NEGATIVE <i> (Not-Detected)
 Oxycodone URINE NEGATIVE <i> ng/mL (Negative)

Assessment:

Safety Risk: This provider considered all of the risk/protective factors, both acute/chronic for harm to self or others and has determined the following overall risk level:

Harm to Self: ☐ Not Elevated ☒ Low ☒ Intermediate ☐ High

Harm to Others: ☐ Not Elevated ☒ Low ☐ Intermediate ☐ High

Diagnosis:

Unspecified Anxiety Disorder, r/o PTSD; Alcohol Use Disorder; r/o Trichitillomania

PLAN:

Patient was educated about and stated understanding of the diagnosis. Patient collaborated on and agreed to the following treatment plan:

Setting: ☒ Outpatient ☐ Inpatient ☐ IOP ☐ Other: _____

Labs: ☐ CBC ☐ LFTs ☒ TSH ☐ Chem 8 ☐ Lipids
☐ Fasting Glucose ☐ HCG ☐ UDS ☐ Vit B12 ☐ _____

Safety Plan:

☒ Patient released without limitations, verbally commits to plan below and current safety to self/others.

☐ Patient released to Chain of Command with the following limitations: _____

Patient is **NOT** deemed an imminent threat to self or others. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

Problem #1: diagnostic clarification

Goal: clarify diagnosis

Objective: pt will return for follow-up

Intervention: serial evaluations, chart review, lab evaluation

Measure: pt self-report, rating scales

Problem #2: anxiety

Goal: pt will experience decrease in anxiety

Objective: pt will consider pharmacotherapy, psychotherapy

Intervention: discussed considering alternative SSRI to Zoloft which he didn't tolerate. Will further discuss pharmacotherapy at next visit after eliciting further history. Monitor alcohol use.

Measure: gad7, pcl

Problem #3: safety

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Goal:pt will refrain from acts of self-harm

Objective: pt will refrain from acts of self-harm

Intervention: pt agrees to call 911, return to clinic, or go to ED if he becomes actively suicidal with plan.

Measure:

Therapy Type:

Not Set

Planned Frequency: None

Patient's capacity to participate in and benefit from therapy is evidenced by:

[] good insight/judgment, [x] a desire to resolve their disorder, [x] verbal agreement to the treatment plan

Medication: Medication reconciliation completed. Reviewed risks, benefits, major/common side effects, and alternatives of below medication plan with patient who stated understanding and agreement with plan. Patient told to abstain from ETOH, drugs of abuse, and OTC remedies. If experiencing sedative effects from meds, patient told not to drive or operate vehicles, including heavy machinery.

Prognosis: [] Excellent [] Good [] Fair [] Guarded [] Poor

Follow-up: two weeks with this provider

Referrals:refer to therapist at next visit.

Occupational:

1. The Command **WAS NOT** directly notified of the current condition of the patient.
2. Patient **HAS NOT** granted permission to discuss HIPAA-protected information to the Command.
3. A new/revised profile **HAS NOT** been written for patient by this writer today.

Profile: **SM has no duty restrictions necessitating a profile.** Patient meets the retention standards of Chap 3, AR 40-501 and AR 635-200 for fitness and suitability for continued service. Patient remains world-wide qualified and cleared for any TDY or deployments. No alterations to duty status or security clearance recommended at this time.

Is Service Member able to have access to sensitive information (to the level of current clearance)? **Yes**Can Service Member perform MOS duties? **Yes**A/P Last Updated by TOBAR,EDEN @ 08 Sep 2016 1428 EDT**1. Anxiety disorder, unspecified**

Procedure(s): -Psych Ther Indiv Approx 60 Min W/ Medical Evaluation & Management x 1

Laboratory(ies): -T4 FREE (Routine) Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T; THYROTROPIN (Routine) Ordered By: TOBAR,EDEN Ordering Provider: TOBAR, EDEN T

Disposition Last Updated by TOBAR,EDEN @ 08 Sep 2016 1431 EDT**Released w/o Limitations****Follow up:** 2 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.Signed By TOBAR, EDEN (Physician/Workstation) @ 08 Sep 2016 1444CHANGE HISTORYThe following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by TOBAR,EDEN @ 08 Sep 2016 1442 EDT:Signed TOBAR, EDEN T (Physician/Workstation) @ 08 Sep 2016 1432

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Aug 2016 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-25603142 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **25 Aug 2016 1000 EDT** Appt Type: **SPEC**
 Clinic: **INTEGRATIVE HLTH & WELL BE** Provider: **JARRETT, ERICA M.**

Reason for Appointment:

counseling

Appointment Comments:

SKJ

S/O Note Written by HICKEY, LINDSEY S @ 25 Aug 2016 1715 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

History of present illness

The Patient is a 31 year old male.

This is the initial visit to the IBHC clinic.

Source of information was self.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Patient was seen by a trainee under the supervision of a licensed mental health professional. Patient indicated an understanding of this.

....

Feeling tired (fatigue).

Decreased appetite.

Decreased concentrating ability.

Sleep disturbances, loss of pleasure, and frequent thoughts of death / morbid ideation.

Previous history of visit is not deployment-related.

Pain Severity 0 / 10.

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Description of Symptoms: Extreme mood swings with depression and anxiety, irritability, concentration problems, poor sleep, fatigue, racing heart and thoughts, trouble relaxing, and worrying. PT reported dry heaving episodes for the past 2 years and pulling the hair off a spot on his scalp since 2008. Several times a week he has a "tingling sensation" with a mood change where he will suddenly smile or frown. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16.

PT reported having passive SI since he was a child. He reported 2 prior suicide attempts when he was in high school: one by overdosing on OTC medicine and one by overdosing on alcohol. His last plan was to overdose on helium before self-referring to substance abuse treatment last year. He last had passive SI ("why even bother") 3 weeks ago, with no plans or intent. PT denied any current SI, plans, or intent.

Duration of Problem: PT has experienced symptoms since his first ship tour in 2006. Symptoms have worsened since he re-enlisted last October.

Factors correlated with onset: Anxiety started after PT joined the Navy in 2006. He regrets re-enlisting last October, and because he waited so long to re-enlist he had last pick for orders. Subsequently he was stationed in the same same environment with the same work stress.

Frequency of symptoms: Symptoms occur every day.

Severity of symptoms: Depression symptoms from PHQ-9 are in the mild range. Anxiety symptoms from GAD-7 are in the moderate range.

Psychosocial factors: Occupational stress and minimal social support.

Aggravating/alleviating factors: Aggravating factors include occupational stress and feeling disconnected from others. Alleviating factors include cooking and programming.

Current tx: None

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

Past tx: PT began behavioral health treatment in 2012.

Functional impact: Symptoms negatively impact PT's functioning at home and work.

....

Anxiety Intervention:

[x] Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).

[x] Developed Crisis Response plan.

[x] Trained in strategies for increasing balanced thinking.

[x] Provided IBHC handout on unhelpful thinking styles.

....

Current medication

None.

Past medical/surgical history**Reported:**

Medical: Reported medical history Irritable bowl syndrome
Parageusia

.....BHM-20 Life Functioning - Severe distress.....

....

Personal history

Behavioral: Caffeine use 4 cups of coffee per day. No tobacco use history.

Alcohol: Alcohol use 3 days a week, 2 glasses of wine each day.

Review of systems

Neurological: No disorientation.

Psychological: A desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No impulsive behavior.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results:	Value
---------------	-------

.....PHQ-9 Score This Appointment:.....	8
---	---

Test Results:	Value
---------------	-------

.....BHM-20 Global Mental Health Scale -	1.95
--	------

Score:.....	
-------------	--

....

Test Results:	Value
---------------	-------

.....GAD-7 Score This Appointment:.....	14
---	----

Test Results:	Value
---------------	-------

.....BHM-20 Well-being -	1.33
--------------------------	------

Score:.....	
-------------	--

....

Test Results:	Value
---------------	-------

.....BHM-20 Psychological Symptoms -	2.23
--------------------------------------	------

Score:.....	
-------------	--

....

Test Results:	Value
---------------	-------

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.....BHM-20 Psychological Symptoms Anxiety - 1.25
Score:.....

....

Test Results: Value

.....BHM-20 Psychological Symptoms Suicide - 3.00
score:.....

....

Test Results: Value

.....BHM-20 Psychological Symptoms - 2.50
ETOH/Drug Score:.....

....

Test Results: Value

.....BHM-20 Psychological Symptoms - 2.17
Depression Score:.....

....

Tests: Value

.....BHM-20 Psychological Symptoms Harm to - 4.00
Others score:.....

....

BHM-20 Psychological Symptoms Suicide - Low risk

....

.....BHM-20 Life Functioning Score:.....

....

.....BHM-20 Global Mental Health Scale - Severe distress.....

....

.....BHM-20 Well-being - Moderate distress.....

....

• DEPRESSION SCREENING / MONITORING (PHQ-9)

- [1] Little Interest or pleasure in doing things
- [1] Feeling down depressed or hopeless
- [0] Trouble sleeping or sleeping too much
- [1] Feeling tired or little energy
- [0] Poor appetite or overeating
- [0] Feeling bad about self
- [3] Trouble concentrating on things
- [2] Moving or speaking slowly or being restless
- [0] Thoughts that you would be better off dead

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [] Somewhat [x] Very [] Extremely

....

•

Generalized Anxiety Disorder Screening:

- [3] 1. Feeling nervous, anxious, or on edge
- [2] 2. Not being able to stop or control worrying
- [3] 3. Worrying too much about different things
- [2] 4. Trouble relaxing
- [1] 5. Being so restless that its hard to sit still
- [3] 6. Becoming easily annoyed or irritable
- [0] 7. Feeling afraid as if something awful might happen

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [] Somewhat [x] Very [] Extremely

....

Counseling/Education

Anxiety Recommendations for patient:

1. Identify and challenge at least one maladaptive thought per day.
2. Engage in at least one enjoyable activity per week.
3. Follow up with outpatient behavioral health.
4. Use crisis response plan if having SI or crisis.
5. RTC if symptoms persist or worsen.

Anxiety Recommendations for PCM Team:

1. Monitor for safety.
2. Monitor symptoms for improvement.

....

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by HICKEY,LINDSEY S @ 25 Aug 2016 1714 EDT

1. Generalized anxiety disorder: 31yo PT with history of anxiety, depression, and alcohol abuse seen f2f for 30min initial appt. PT presents with sys secondary to occupational stress and limited social support. Sys are consistent with Generalized Anxiety Disorder. PT also has SI history with two previous attempts and one previous plan. PT reported last having passive SI 3 weeks ago with no plan or intent; he denied any current SI, plans, or intent. Developed crisis response plan with PT with triggers, coping skills, and resources for SI or crisis. PT has an appointment with Dr. Tobar in outpatient behavioral health on 06SEP16. PT was encouraged to RTC if symptoms persist or worsen. PT appears to be in the preparation stage of change and agreed to implement the recommendations made during today's appt. RTC as needed.

Anxiety Recommendations for patient:

1. Identify and challenge at least one maladaptive thought per day.
2. Engage in at least one enjoyable activity per week.
3. Follow up with outpatient behavioral health.
4. Use crisis response plan if having SI or crisis.
5. RTC in symptoms persist or worsen.

Anxiety Recommendations for PCM Team:

1. Monitor for safety.
2. Monitor symptoms for improvement.

Discussed with LT Hickey and plan reviewed with PT.

Disposition Last updated by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT**Released w/o Limitations****Follow up:** as needed .**Signed By JARRETT, ERICA M** (Clinical Health Psychologist, NNMC Bethesda, MD) @ 25 Aug 2016 1756**CHANGE HISTORY*****The following Disposition Note Was Overwritten by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT:***

The Disposition section was last updated by JARRETT,ERICA M @ 25 Aug 2016 1756 EDT - see above. Previous Version of Disposition section was entered/updated by HICKEY,LINDSEY S @ 25 Aug 2016 1715 EDT.

Released w/o Limitations**Follow up:** as needed .

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

23 Jun 2016 at WRNMMC, Int Med CL C Medical Home BE by ATCHERSON, KATHY A

Encounter ID: BETH-24977587 Primary Dx: Encounter for other administrative examinations

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **23 Jun 2016 1140 EDT**
Clinic: **INT MED MEDICAL HOME CL C
BE**Appt Type: **T-CON***
Provider: **ATCHERSON, KATHY A**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by ATCHERSON, KATHY A @ 23 Jun 2016 1140 EDT

Emergency room follow up call.

Telephone Consult Comments: Written by ATCHERSON, KATHY A @ 23 Jun 2016 1140 EDT

No answer. Left message for patient to call 301-319-2349 or 301-295-0196 and make an appointment with PCM if further care is needed.

Questionnaire AutoCites Refreshed by ATCHERSON, KATHY A @ 23 Jun 2016 1144 EDT**Questionnaires****A/P** Last Updated by ATCHERSON, KATHY A @ 23 Jun 2016 1145 EDT**1. Encounter for other administrative examinations****Disposition** Last Updated by ATCHERSON, KATHY A @ 23 Jun 2016 1337 EDT**Referred for Appointment****Follow up:** as needed .**Signed By ATCHERSON, KATHY A** (Physician/Workstation) @ 23 Jun 2016 1338

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Jun 2016 at WRNMMC, GI Clinic Bethesda by KWOK, RYAN M

Encounter ID: BETH-24961678 Primary Dx: Other chest pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **22 Jun 2016 1040 EDT**
 Clinic: **GI CL BE**

Appt Type: **FTR**
 Provider: **KWOK,RYAN MITCHELL**

AutoCites Refreshed by SHAH,NISHA A @ 22 Jun 2016 1111 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

f/u

Appointment Comments:

BAR

Vitals**Vitals** Written by THOMPSON,DEREK J @ 22 Jun 2016 1039 EDT

BP: 146/87, HR: 74, RR: 14, T: 98.2 °F, HT: 69 in, WT: 165 lbs, SpO₂: 99%, BMI: 24.37,
 BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 4/10 Moderate,
 Pain Scale Comments: Sharp Pain in Chest when taking deep breaths on inhale.

S/O Note Written by SHAH,NISHA AMISH @ 22 Jun 2016 1349 EDT**Chief complaint**

The Chief Complaint is: F/u.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male to f/u for lab results (confirmed h pylori eradication) but states he is having intense chest pain worsened with coughing and breathing right now. Denies n/v/diaphoresis. Denies pain radiating to back/jaw/arm. He is very anxious and concerned and would like to go to ED. Appointment ended at this time.

A/P Last Updated by SHAH,NISHA A @ 22 Jun 2016 1335 EDT

1. Other chest pain R07.89: Due to lightheadedness/dizziness although stable vital signs and continued chest pain, will send to ED for evaluation. Can f/u in 4 weeks after trial of fodmap as discussed in past. H pylori eradication confirmed.

Disposition Written by KWOK,RYAN M @ 23 Jun 2016 1507 EDT**Immediate Referral** - Referred to: ED

Follow up: 4 week(s) in the GI CL BE clinic or sooner if there are problems. - Comments: Case discussed with GI staff, Dr. Kwok, who agrees with above plan.

Patient was wheelchaired to ED. ED staff was called and case discussed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by KWOK,RYAN M @ 23 Jun 2016 1508 EDT

Pt not seen as triaged to ER prior to my encounter, agree with plan for urgent triage via ER prior to GI evaluation.

Signed By KWOK, RYAN M (Physician, Gastroenterology / Transplant Hepatology Staff, Walter Reed National Military Medical Center) @ 23 Jun 2016 1508

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

15 Jun 2016 at WRNMMC, GI Clinic Bethesda by SHAH, NISHA AMISH

Encounter ID: BETH-24897721 Primary Dx: Encounter for issue of other medical certificate

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **15 Jun 2016 1621 EDT**
Clinic: **GI CL BE**

Appt Type: **T-CON***
Provider: **SHAH,NISHA AMISH**

Call Back Phone: [REDACTED]

AutoCites Refreshed by SHAH,NISHA A @ 15 Jun 2016 1621 EDT

Allergies

•OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by SHAH,NISHA A @ 15 Jun 2016 1621 EDT
Lab results

Questionnaire AutoCites Refreshed by SHAH,NISHA A @ 15 Jun 2016 1621 EDT
Questionnaires

S/O Note Written by SHAH,NISHA AMISH @ 15 Jun 2016 1624 EDT

Subjective

Called and spoke with patient about results and confirmation of eradication; off PPI for two weeks prior to testing.

A/P Last Updated by SHAH,NISHA A @ 15 Jun 2016 1624 EDT

1. Encounter for issue of other medical certificate Z02.79

Disposition Last Updated by SHAH,NISHA A @ 15 Jun 2016 1624 EDT

Follow up: as needed with PCM.

Signed By SHAH, NISHA A (LCDR MC USN, Physician, Gastroenterology Fellow) @ 15 Jun 2016 1624

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jun 2016 at WRNMMC, Otolaryngology Clinic Bethesda by XYDAKIS, MICHAEL S

Encounter ID: BETH-24803403 Primary Dx: Unspecified disturbances of smell and taste

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **07 Jun 2016 1300 EDT**
 Clinic: **OTOLARYNG CL BE**

Appt Type: **SPEC**
 Provider: **XYDAKIS, MICHAEL S**

Reason for Appointment:

Unspecified disturbances of smell and taste

Appointment Comments:

emh

S/O Note Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1341 EDT**Chief complaint**

The Chief Complaint is: 31 active duty navy from Ft Meade referred by colleague (dr David Thompson) for dysgeusia of approximately 8 months duration. Specifically, patient indicates that on 16 Oct 2015, he was making pizza and noticed the alteration in taste. He presented to his nurse practitioner on 9 Nov 2015 and was referred to ENT. Smell is fine. NO tobacco (social smoker about 9 years ago). Patient does have a h/o alcohol dependence requiring counseling (notes in AHLTA indicate that therapy began in Aug 2014). MRI Brain (15 April 2016) = Normal olfactory eloquent structures.

History of present illness

The Patient is a 31 year old male.

He reported: Past medical history reviewed, problem list reviewed, medication list reviewed, family history reviewed, and surgical history reviewed.

Past medical/surgical history**Reported:**

Recent Events: An active illness Longstanding history of irritable bowel syndrome. History of H. Pylori and GERD (followed by GI).

Physical findings**Neck:**

- Neck: No palpable adenopathy.

Nose:

Right Side Of Nose:

- Examined.

Left Side Of Nose:

- Examined Moderate nasal septal deflection to the left with fracture / dislocation at the bony cartilaginous junction. No infectious, inflammatory nor obstructive pathology noted.

Oral Cavity:

- ° General condition was good S/p tonsillectomy. + discoloration and brownish/green film noted on posterior 1/3 of the tongue. Mucosa otherwise pale pink and moist. + discoloration of the teeth.

Tongue: • Mucositis scale.

A/P Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1356 EDT**1. Unspecified disturbances of smell and taste****2. Glossitis**

3. Gastro-esophageal reflux disease without esophagitis: Sniffen extended battery 16 panel odorant test performed. Patient scored 16/16 with rapid, crisp reliable responses. Olfactory threshold testing performed. Patient scored 8/16 which is normal for age. Olfactory discrimination was normal. Burghart taste strips and sprays administered. Patient was able to discern tastes (sweet, salty, sour, bitter) at even the lowest concentrations. Hence, completely normal taste. A/P: Dysgeusia due to mild glossitis which is due to GERD up to the level of the hypopharynx and base of tongue. Patient is scheduled to see GI in the next week or so. Likely his symptomatology will resolve once his acid reflux is under control and the tongue is no longer inflamed. Would consider Nystatin or mycelex oral troches. However, it would be preferable to address the underlying cause of the problem (i.e. Acid reflux) and see if the tongue inflammation resolves. Patient understands and agrees with this approach. He will send me an e-mail to assess interval change.

Disposition Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1357 EDT**Released w/o Limitations****Follow up:** as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Note Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1255 EDT

Consult Order

Referring Provider: THOMPSON, DAVID HERRON

Date of Request: 11 Apr 2016

Priority: Routine

Provisional Diagnosis:

Unspecified disturbances of smell and taste

Reason for Request:

Consult from Dr Thompson to Dr Xydakis: SM with chronic bitter tastes with surgery like foods. Normal ENT exam, Ordered MRI Brain, Please evaluate and treat

Signed By XYDAKIS, MICHAEL S (Physician) @ 07 Jun 2016 1357

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 May 2016 at WRNMMC, GI Clinic Bethesda by LACZEK, JEFFREY T

Encounter ID: BETH-24528671 Primary Dx: Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 May 2016 0800 EDT**
 Clinic: **GI CL BE**

Appt Type: **SPEC**
 Provider: **LACZEK,JEFFREY T**

AutoCites Refreshed by SHAH,NISHA A @ 11 May 2016 0808 EDT

Allergies

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Appointment Comments:

ek/irmac

Vitals

Vitals Written by THOMPSON,DEREK J @ 11 May 2016 0752 EDT

BP: 118/72, HR: 68, RR: 10, T: 98.4 °F, HT: 69 in, WT: 167 lbs, SpO₂: 98%, BMI: 24.66,
 BSA: 1.913 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 6/10 Moderate,
 Pain Scale Comments: Cramping intermittent pain in the Intestines

S/O Note Written by SHAH,NISHA AMISH @ 11 May 2016 1523 EDT

Chief complaint

The Chief Complaint is: + h pylori test.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male referred from ENT when during w/u of dysgeusia was found to + serum H pylori Ab and presents for further management. Patient states he has never been treated for h pylori.

He also states that he has had 'ibs pain' since age 15. The pain is in the upper abdomen described as sharp and does not radiate. The pain can last minutes to longer and resolves once he goes to the bathroom having a soft stool; bristol type 5-6. Episodes occur weekly and are triggered by certain foods (spicy foods/fiber filled foods).

Of note, he went to the ED a few years ago for similar abdominal pain, he was then seen in the GI clinic and found to have a normal MRE after initial colonoscopy was concerning for thickened folds. He was lost to follow up.

Heartburn burning sensation - 2x per month, abdominal pain, and diarrhea.

Allergies

Allergies Verified and Updated

NKDA.

Current medication

Including OTCs, vitamins, herbals, supplements, etc.

Albuterol prn

Denies otc/herbals/supplements.

Past medical/surgical history**Reported:**

Medical: Reported medical history

SAR

He denies any other medical issues.

Surgical / Procedural: Surgical / procedural history None.

Personal history

Social history reviewed Denies tob/etoh.

Family history

Family medical history

No hx of celiac/IBD

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

No hx of GI malignancies

Mom and grandmother with also 'stomach problems'.

Review of systems**Systemic:** Not feeling tired (fatigue). No fever, no chills, and no night sweats.**Eyes:** No eye pain. No red eyes.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Appetite not decreased. No dysphagia and no pain on swallowing. No nausea, no vomiting, no hematemesis, no jaundice, no bright red blood per rectum, and no constipation.**Musculoskeletal:** No localized joint pain.**Skin:** No rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

External: ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

• Pharynx: MC3.

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender Mild ttp in RLQ. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: ° Mobility was not limited.

Neurological:

° Oriented to time, place, and person.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

CBC W/o Diff	Site/Specimen	11 Apr 2016 1043
WBC	BLOOD	4.7
RBC	BLOOD	4.88
Hemoglobin	BLOOD	15.4
Hematocrit	BLOOD	45.0
MCV	BLOOD	92.3
MCH	BLOOD	31.5

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

MCHC	BLOOD	34.1
Platelets	BLOOD	293
RDW CV	BLOOD	13.3
MPV	BLOOD	8.6

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Basic Metabolic Panel	Site/Specimen	11 Apr 2016 1043
Urea Nitrogen	SERUM	9.7
Carbon Dioxide	SERUM	28
Chloride	SERUM	97 (L)
Creatinine	SERUM	0.87
Glucose	SERUM	92
Potassium	SERUM	4.4
Sodium	SERUM	139
Calcium	SERUM	10.2
Anion Gap	SERUM	15
GFR Calculated Non-Black	SERUM	115.0
GFR Calculated Black	SERUM	132.9 <i>

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Helicobacter pylori Ab IgG	Site/Specimen	11 Apr 2016 1043
Helicobacter pylori Ab IgG	SERUM	7.1 (H) <i>

A/P Last Updated by SHAH,NISHA A @ 11 May 2016 1553 EDT

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere B96.81: 31 year old male with incidental finding of h pylori, unlikely related to dysphagia but would be interested at follow up to see if treatment affects symptoms. As it is a carcinogen, would recommend therapy. No exposure to antibiotics in last 6-8 months, will do triple therapy. Patient counseled on importance of compliance as well as confirmation of eradication two weeks after stopping PPI therapy.

Medication(s): -PANTOPRAZOLE--PO 40MG TBDR - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR TWO WEEKS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 -AMOXICILLIN--PO 500MG CAP - TAKE TWO CAPSULE BY MOUTH TWICE A DAY FOR TWO WEEKS #56 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 -CLARITHROMYCIN--PO 500MG TAB - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR FOURTEEN DAYS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH
 Laboratory(ies): -H PYLORI AG, EIA (Routine): to be done two weeks after stopping protonix Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

2. Irritable bowel syndrome with diarrhea K58.0: No red flags and triggers seem to be primarily food/stress. Will first focus on understanding triggers with food diary and assess if high fodmap (sheet given), After two week of observation, asked that he eliminate one food a week from his triggers. Plan to see back in 6-8 weeks and decide next step in management.

Disposition Last Updated by SHAH,NISHA A @ 11 May 2016 1612 EDT**Released w/o Limitations**

Follow up: 6 to 8 week(s) in the GI CL BE clinic or sooner if there are problems. - Comments: Case discussed with GI staff, Dr. Laczek, who agrees with above plan.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by MCPHERSON,CARL E @ 11 May 2016 0721 EDT**Consult Order**

Referring Provider: THOMPSON, DAVID HERRON

Date of Request: 13 Apr 2016

Priority: Routine

Provisional Diagnosis:

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Reason for Request:

SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.

Note Written by LACZEK,JEFFREY T @ 17 May 2016 1432 EDT**GI Staff**

I saw PO1 Merwin with Dr. Shah. I agree with Dr. Shah's assesment that his dysphagia is unlikely related to his H. pylori infection. I also agree with the plan to treat his H. pylori infection.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By LACZEK, JEFFREY T (Staff Gastroenterologist, WRNMMC Bethesda, MD) @ 17 May 2016 1434

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Apr 2016 at WRNMMC, Medical Readiness Clinic Bethesda by TACKIE, DIANE A

Encounter ID: BETH-24331899 Primary Dx:

EXAM/ASSESSMENT,
OCCUPATIONAL, SERVICE MEMBER
PERIODIC HEALTH ASSESSMENT
(PHA)Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **22 Apr 2016 0830 EDT**
Clinic: **MEDICAL READINESS CL BE**Appt Type: **WELL**
Provider: **TACKIE, DIANE A****AutoCites** Refreshed by TACKIE, DIANE A @ 22 Apr 2016 0942 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

pha/navy

Appointment Comments:

ass4105625345

Vitals**Vitals** Written by WOOTEN, LORI A @ 22 Apr 2016 0911 EDT

BP: 114/73, HR: 72, RR: 14, T: 98.1 °F, HT: 69 in, WT: 170.4 lbs, Uncorr OD: 20/40, Uncorr OS: 20/40, Uncorr OU: 20/40, BMI: 25.16,

BSA: 1.93 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 2 or 3 drinks 2 or 3 times a week, Pain Scale: 0 Pain Free

Comments: PRK 2011

Epworth Study 15 Pt went to Sleep Clinic and was told he didn't meet the threshold to have a sleep study.

Questionnaire AutoCites Refreshed by TACKIE, DIANE A @ 22 Apr 2016 0942 EDT**Questionnaires**

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 22 Apr 2016

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis(i.e. with persistent cough, weight loss, night sweats, and/or fever)? No

2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations?: No

3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: N/A

4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No

5. Have you had a prior history of TB or prior treatment for Latent TB?: No

6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No

7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade?: No

8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use?: No

EPWORTH Sleepiness Scale Version: 1 Completed On: 22 Apr 2016

Questionnaire Notes: 15

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Epworth 15: SM has already been seen by PCM and appropriate specialty care for sleep disturbances.

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3
2. How likely are you to doze off or fall asleep while WATCHING TV?: 2
3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 0
4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3
5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 3
6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 0
7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 2
8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 2

S/O Note Written by TACKIE, DIANE A @ 22 Apr 2016 0952 EDT

Chief complaint

The Chief Complaint is: PHA.

Reason for Visit

Visit for: FACE TO FACE PHA, U.S. NAVY AND HRA REVIEW.

History of present illness

The Patient is a 31 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Past medical history reviewed and problem list reviewed. Medication reconciliation performed. Medication list reviewed, family history reviewed, and surgical history reviewed.

Military service [] Y [X] N Deployed since previous PHA
 [] Y [X] N Post-Deployment Health Assessment completed
 [] Y [X] N Post-Deployment Health Reassessment completed
 [] Y [X] N Post-Deployment labs/tests completed
 [] Y [X] N Deployment/Shipboard limiting conditions identified.

Patient identified by first and last name as well as DOB. 31yo Male U.S. Navy Active Duty Service Member presents for Face to Face PHA. SM states he is not on Limited Duty or Light Duty Status at the current time. Refer to the A/P section of this SF 600 for HRA documentation.

Past medical/surgical history

PMH DISCUSSED WITH SM

- Unspecified disturbances of smell and taste, Parageusia: under the care of Otolaryngeal Clinic, last seen 19 April 2016, MRI wnl.
- Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere: referred to GI per ENT Clinic.
- Pain in left ankle and joints of left foot: under the care of Physical Therapy Clinic, last seen 05 April 2016.
- Alcohol dependence, uncomplicated: SM states he has completed treatment. Last seen by BH Clinic last in Feb 2016.

Reported:

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No [X] N/A. No allergies -- NKDA.

Surgical / Procedural: Surgical / procedural history -- PRK OD/OS 2011.

Medications: Medication history -- SM states he is not taking any medications at the current time.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No [X] N/A.

Personal history

Behavioral: No tobacco use.

Alcohol: Alcohol SM reports consuming alcohol 3 times per week with 2-3 drinks per occasion.

Work: Occupation Computer Network Intelligence Analyst, Fort Meade.

Marital: Marital history Single, no children.

Review of systems

Otolaryngeal symptoms-- parageusia, taste and smell disturbances

Gastroenterology symptoms-- H. pylori positive, heart burn, stomach discomfort

Musculoskeletal symptoms-- left foot and ankle pain

Skin symptoms-- Anogenital (venereal) warts, being managed by Derm Clinic, last seen 24 Feb 2016

Behavioral Health symptoms-- alcohol dependence previous history, resolved.

Systemic: No systemic symptoms.

Head: No head symptoms.

Neck: No neck symptoms.

Eyes: No eye symptoms.

Breasts: No breast symptoms.

Cardiovascular: No cardiovascular symptoms.

Pulmonary: No pulmonary symptoms.

Genitourinary: No genitourinary symptoms.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Endocrine: No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Neurological:** No neurological symptoms.**Allergic and Immunologic:** No allergic/immunologic symptoms.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing ? Not tired. ? Clothing was appropriate. ? Grooming was within normal limits.

Head:

Appearance: ° Head normocephalic.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.

Neurological:

° Level of consciousness was normal.

Speech: ° Normal.

Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Affect: ° Normal o Full-ranging. ? Not inappropriate. ? Not labile. ? Congruent with the mood.

Thought Processes: ° Not impaired ? No thought disorder was noted. ? Evaluation of connectedness showed no deficiency. ?

Rate of thought was normal. ? Attention demonstrated no abnormalities.

Thought Content: ° Revealed no impairment ? Insight was intact. ? No suicidal tendency. ? No preoccupation with violent thoughts was observed. ? No homicidal tendencies.

Objective

REVIEWED AHLTA SF 600 PREVIOUS ENCOUNTERS. PAPER/ HARD COPY MEDICAL RECORDS NOT AVAILABLE.

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunizations and Labs [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminate ()

Comments:

Lab Result Cited by TACKIE,DIANE A @ 22 Apr 2016 0946 EDT**HIV-1/O/2 Ab****Site/Specimen****16 Feb 2016 1430**

Units

Ref Rng

HIV-1/O/2 Ab

SERUM

Negative <r>

Lab Result Cited by WOOTEN,LORI A @ 22 Apr 2016 0918 EDT**Varicella Virus Ab****Site/Specimen****03 Nov 2005 1849**

Varicella Zoster Virus Ab

SERUM

IMMUNE

Lab Result Cited by WOOTEN,LORI A @ 22 Apr 2016 0918 EDT**Chlamydia+Gonococcus DNA Panel NAAT****Site/Specimen****28 Jan 2013 1110**

Neisseria gonorrhoeae DNA

URINE

NEGATIVE FOR N.GONORRHOEAE <i>

Chlamydia trachomatis DNA

URINE

NEGATIVE FOR C.TRACHOMATIS <i>

Lab Result Cited by WOOTEN,LORI A @ 22 Apr 2016 0917 EDT**Lipid Panel****Site/Specimen****10 Apr 2014 0951**

Cholesterol

SERUM

208 (H) <i>

Triglyceride

SERUM

158 (H) <i>

HDL Cholesterol

SERUM

64.0 (H)

LDL Cholesterol

SERUM

112 <i>

VLDL Cholesterol

SERUM

32

Cholesterol/HDL Cholesterol

SERUM

3.25

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lab Result Cited by WOOTEN,LORI A @ 22 Apr 2016 0917 EDT**Varicella Zoster Virus DFA**

Varicella Zoster Virus Ag

Site/Specimen

SKIN

29 Sep 2015 1730

NO VZ ANTIGEN DETECTED <i>

Lab Result Cited by WOOTEN,LORI A @ 22 Apr 2016 0917 EDT**Basic Metabolic Panel**

Urea Nitrogen

Carbon Dioxide

Chloride

Creatinine

Glucose

Potassium

Sodium

Calcium

Anion Gap

GFR Calculated Non-Black

GFR Calculated Black

Site/Specimen

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

SERUM

11 Apr 2016 1043

9.7

28

97 (L)

0.87

92

4.4

139

10.2

15

115.0

132.9 <i>

Lab Result Cited by TACKIE,DIANE A @ 22 Apr 2016 0859 EDT**HIV-1/O/2 Ab**

HIV-1/O/2 Ab

Site/Specimen

SERUM

16 Feb 2016 1430

Negative <r>

Units

Ref Rng

A/P Last updated by TACKIE,DIANE A @ 22 Apr 2016 1153 EDT**1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225:**

Face to Face PHA completed and updated in MRRS.

TB Exposure Risk Assessment Questionnaire complete. Medications reconciled.

Copy of IMR given to SM. Next PHA one year.

MEDICAL READINESS STATUS: Fully Medically Ready.

Reviewed Immunization Records in AHLTA and on IMR, Tdap and Influenza vaccines up to date.

Procedure(s): -(99173) Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S):
WOOTEN,LORI A

2. Counseling, unspecified Z71.9: SM educated to the PHA visit. Reviewed HRA survey results, discussed, education provided. Epworth Sleepiness Scale review and discussed.

SM educated to Skin Cancer Prevention. To lower your skin cancer risk, protect your skin from the sun and avoid indoor tanning. CDC recommends these easy options:

- Stay in the shade, especially during midday hours.
- Wear clothing that covers your arms and legs.
- Wear sunglasses that block both UVA and UVB rays.
- Use sunscreen with SPF 15 or higher and both UVA and UVB protection.
- Avoid indoor tanning.
- Consider your Skin cancer risk factors: Personal history of skin cancer or precancerous skin lesions, tendency to freckle or burn easily, lots of sun exposure throughout your life, family history of skin cancer
- Perform a thorough skin check regularly, preferably once a month. Do this in a brightly lit room in front of a full-length mirror.

Procedure(s): -(G8420) BMI IS DOC W/IN NORMAL PARAMETERS &NO FOLLOW-UP PLAN IS REQD x 1
ADDITIONAL PROVIDER(S): WOOTEN,LORI A

Patient Instruction(s): -Guidance: Concerns About Stress Management
-Inquiry And Counseling: Contraceptive Practices
-Inquiry And Counseling: Family Planning
-Patient Education - Nutrition
-Anticipatory Guidance: Food Groups
-Anticipatory Guidance: Maintaining Healthy Weight
-Maintain Healthy Diet
-Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure
-Parent Education: Avoiding Direct Sun Exposure
-Avoid Exposure Bright Sunlight

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Disposition Written by TACKIE,DIANE A @ 22 Apr 2016 1153 EDT**Released w/o Limitations****Follow up:** as needed with PCM. - Comments: SM to continue to fu with the appropriate specialists for continuity of care.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** TACKIE, DIANE A (Physician Assitant) @ 22 Apr 2016 1154**CHANGE HISTORY****The following A/P Note Was Overwritten by TACKIE,DIANE A @ 22 Apr 2016 0948 EDT:**

The A/P section was last updated by TACKIE,DIANE A @ 22 Apr 2016 0948 EDT - see above.Previous Version of A/P section was entered/updated by WOOTEN,LORI A @ 22 Apr 2016 0920 EDT.

1. EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA)

Procedure(s):

-Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S): WOOTEN,LORI A

The following Lab Note Was Deleted by TACKIE,DIANE A @ 22 Apr 2016 0946 EDT:

Note Written by WOOTEN,LORI A @ 22 Apr 2016 0917 EDT

Lab Result

HIV-1/O/2 Ab

Site/Specimen

16 Feb 2016 1430

HIV-1/O/2 Ab

SERUM

The following S/O Note Was Overwritten by TACKIE,DIANE A @ 22 Apr 2016 0945 EDT:**S/O Note** Written by WOOTEN,LORI A @ 22 Apr 2016 0918 EDT**History of present illness**

The Patient is a 31 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

[] Y [X] N Deployment/Shipboard limiting conditions identified

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [] No. An allergy Feathers, Cats.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [] Yes [X] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [] No.

Physical findings**Vital Signs:**

* Current vital signs reviewed.

Objective

Health Record [X] Reviewed [] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

* Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Therapy

* Electronic medical alert pendant in possession as indicated.

The following Text Note Was Deleted by WOOTEN,LORI A @ 22 Apr 2016 0923 EDT:

Note Written by WOOTEN,LORI A @ 22 Apr 2016 0923 EDT

You rated your health as **Good**. Personal perception about how healthy you are is usually quite accurate. ;Your Personal Health Risk Appraisal Report identified **3 risk categories** from the answers you provided that relate to overall health, which places you in a **MEDIUM** risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the "low risk" category by reducing the number of behavioral risks, and for those already at low risk, to avoid increasing the number of risk factors over time.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

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1985

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DoD ID: 1286180538

Created: 16 Aug 2017

High Risk	= 5 or more risk categories	You reported 3 categories, which places you at MEDIUM risk. The categories you scored "unhealthy" on included: <ul style="list-style-type: none"> • Stress Management • Sexual Health • Nutrition
Medium Risk	= 3-4 risk categories	
Low Risk	= 0-2 risk categories	

Body Mass Index (Note the limitations of BMI**below) ; *Normal Weight* ;;;;**
http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

YOUR BODY MASS INDEX = 24.4.

Both being overweight or being underweight are related to increased risk of disease and death. Among most Americans, BMI is a reliable indicator of total body fat. It is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. Limitations of BMI are that it may overestimate body fat in athletes and others who have a muscular build or underestimate body fat in individuals who lack lean muscles mass.

TOBACCO USE; *Never used tobacco* ;;;;
<http://www.ucanquit2.org> ; ; ;
<http://betobaccofree.hhs.gov/>

You are doing the single most important thing to stay healthy! Not smoking saves you money (over \$2000/year for one pack per day), helps you avoid many tobacco related diseases, and adds to your fitness level and overall health.

TOBACCO USE; *Never used tobacco* ;;;;
<http://www.ucanquit2.org> ; ; ;
<http://betobaccofree.hhs.gov/>

Not using smokeless tobacco is a great choice. You can avoid oral cancer, tooth and gum disease, and maintain a fresh and clean mouth.

ALCOHOL USE; *No* ;;;;
<http://www.nlm.nih.gov/medlineplus/alcoholconsumption.html>
¿¿ALCOHOL USE; *Once or twice per year* ;;;;
<http://www.rethinkingdrinking.niaaa.nih.gov/>

Many Sailors and Marines occasionally drink more heavily than usual during celebrations or special events. Plan ahead to avoid alcohol-related incidents. DUIs will put your career in danger.

¿ALCOHOL USE; *Never (i.e. not during the past year)* ;;;;
<http://www.rethinkingdrinking.niaaa.nih.gov/>

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol related incidents by looking out for those who try to drink and drive - and help them get home safely.

INJURY PREVENTION; *Always* ;;;; <http://www.nhtsa.gov/Driving+Safety>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

INJURY PREVENTION; *Does not apply to me / None recommended* ;;;; <http://www.nhtsa.gov/Driving+Safety>

<http://www.nhtsa.gov/Driving+Safety>

If you ride these vehicles in the future, a helmet will provide significant protection against head injury and death. A large portion of medical, disability, and rehabilitation costs from these head injuries are paid for by the general public.

INJURY PREVENTION; *Does not apply to me / None recommended* ;;;; <http://www.cdc.gov/niosh/topics/safety.html>

<http://www.cdc.gov/niosh/topics/safety.html>

If you visit work sites, encounter an environmental hazard, or work at home, use appropriate safety equipment

STRESS MANAGEMENT; *Somewhat satisfied* ;;;; <http://www.nlm.nih.gov/medlineplus/stress.html> ;;;; <http://afterdeployment.dcoe.mil>

<http://www.nlm.nih.gov/medlineplus/stress.html> ;;;; <http://afterdeployment.dcoe.mil>

You are only somewhat satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationships and social activities can all contribute to life satisfaction. Look to these sources for improving your level of satisfaction.

STRESS MANAGEMENT; *Most of the time* ;;;; <http://www.med.navy.mil/sites/nmcscd/nccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx> ;;;; <http://startmovingforward.dcoe.mil>

<http://www.med.navy.mil/sites/nmcscd/nccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx> ;;;; <http://startmovingforward.dcoe.mil>

Long-term and short-term stress in your work or at home may increase your risk of cardiovascular disease and impact on your personal and professional relationships. Problem-solving or discussing possible solutions with someone else may help reduce or eliminate some of your stress.

STRESS MANAGEMENT; *Most of the time* ;;;; <http://www.helpguide.org/topics/relationships.htm> ;;;; <http://afterdeployment.dcoe.mil>

<http://www.helpguide.org/topics/relationships.htm> ;;;; <http://afterdeployment.dcoe.mil>

Expressing your feelings can help you see that you are not alone in how you feel.

Talking with others can also provide you with strategies to successfully manage your concerns.

SEXUAL HEALTH; *Most of the time* ;;;; http://nationalcoalitionforsexualhealth.org/tools/communicating-to-the-public/document/SexualHealthGuide_national.pdf

http://nationalcoalitionforsexualhealth.org/tools/communicating-to-the-public/document/SexualHealthGuide_national.pdf

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection

Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

PHYSICAL ACTIVITY; 3 weeks per month ;;;;<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

To promote and maintain health, all healthy adults aged 18-64 years need moderate-intensity aerobic activity for a minimum of 150 minutes each week or vigorous-intensity aerobic activity for 75 minutes each week. Combinations of moderate- and vigorous-intensity activity can be performed to meet this recommendation. Exercise sessions can be broken up into as little as 10 minutes at a time.

PHYSICAL ACTIVITY; 2 days per week ;;;;<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

Muscle-strengthening activities should work all the major muscle groups of your body (legs, hips, back, chest, abdomen, shoulders, and arms). To gain health benefits, muscle-strengthening activities need to be done to the point where it is hard for you to do another repetition without help. Adding muscle allows you to do more activities, improves appearance, and reduces the risk of several chronic diseases.

NUTRITION; At least 3-5 times per week or more ;;;;<http://www.cdc.gov/nutrition/everyone/basics/fat/index.html>

Some dietary fat is needed for good health, but high levels of fat in your diet may lead to excessive weight gain and increase your risk of certain cancers. Eating foods high in saturated and trans-fats also increases your risk of heart disease. Select foods low in saturated fats, trans fats, and cholesterol; eat plenty of whole grains, fruits and vegetables; and choose low fat milk products and lean meats.

NUTRITION; Less than one ;;;;<http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is to consume at least two servings of fruits per day. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SUPPLEMENTS; Seldom ;;;; <http://humanperformancecenter.org/dietary-supplements>

People choosing to supplement their diets with herbals, vitamins, minerals, or other substances need to know about the products they choose so that they can make informed decisions about them. The choice to use a dietary supplement can be a wise decision that provides health benefits. However, under certain circumstances, these products may be unnecessary for good health or they may even create unexpected risks or interact with medications. It is wise to ask your physician or pharmacist before taking supplements.

DENTAL; Daily ;;;; <http://www.ada.org/public.aspx>

You are to be commended for flossing your teeth daily. Daily flossing is recommended

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

to remove plaque and food particles from between the teeth and under the gum line, which prevents gum disease, tooth loss, decay, and bad breath. In addition to flossing, the American Dental Association recommends brushing your teeth twice a day with fluoride toothpaste to achieve good dental health.

NUTRITION; *Two* ;;;; <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is three servings of vegetables per day, with at least one being a dark green or orange vegetable. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SLEEP; *Most of the time* ;;;; <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/sleep.aspx>

People who get enough restful sleep are able to concentrate on their activities, have more energy, and generally feel better.

PREGNANCY; *My partner or I are correctly and consistently using birth control ALL the time* ;;;; <http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/contraception.aspx>

There is a wide range of new, safe and effective contraception options available, some that work for years after you have started them. Some are permanent and others are easily and quickly reversible when you are ready to have a baby. But not all forms of contraception are equally effective. It makes sense to carefully consider your parenting plans and get informed about contraception so you and your partner can select the option that works best for you. Be well informed about contraception, and talk with your partner and doctor.

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24277977 Primary Dx: Parageusia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **18 Apr 2016 1344 EDT**
 Clinic: **OTOLARYNG CL BE**

Appt Type: **T-CON***
 Provider: **THOMPSON, DAVID HERRON**

Call Back Phone: [REDACTED]

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 18 Apr 2016 1344 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Note Written by THOMPSON,DAVID HERRON @ 19 Apr 2016 1237 EDT**A/P** Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1032 EDT**1. Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS , ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvc mobile no edema arytoids

-- b12 neg

-- HIV neg, 16 Feb 16

-- MRI Brain 15 april 16 = normal olfactory nerves and brain

-- Trep, lyme, cbc normal

A: ddx olfactory nerve issue, H pylori

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet

2. H pylori

O: positive IGG

A: possible cause of abnormal taste

P: Referred to GI medicine on 13 april

Rad Result Cited by THOMPSON,DAVID HERRON @ 19 Apr 2016 1233 EDT**MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M**

***** MRI, BRAIN W W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, BRAIN W W/O CON

Event Date: 11-Apr-2016 10:19:00

Exam #: 16131283

Exam Date/Time: 15-Apr-2016 04:48:00

Transcription Date/Time: 15-Apr-2016 08:18:00

Provider: THOMPSON, DAVID HERRON

Requesting Location:

OTOLARYNG CL BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: DEMARCO, JAMES K

Supervised By: James Demarco K, MD Dept of Radiology

Approved By: DEMARCO, JAMES K

Approved Date: 15-Apr-2016 08:18:00

Supervised By:

318118 James Demarco K, MD Dept of Radiology

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Supervised By Date: 15-Apr-2016 08:18:00

Amended Report Text:

Brain MRI without and with gadolinium: 04/15/16 04:48:00.

History: 31 y/o M with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad.

Technique: Sagittal T1, axial and coronal T2, axial T2 FLAIR, axial DWI, axial GRE, axial T1, axial post T1 FS, coronal post 3D SPGR of the brain. A total of 16 mL of ProHance was given intravenously as part of the study.

FINDINGS: No focal mass lesion or abnormal enhancement along the expected course of either olfactory bulb or groove is seen. There is normal appearance of both olfactory bulb and nerves.

Acute: No hemorrhage, herniation, or hydrocephalus. No evidence of acute ischemia.

Brain: Brain parenchyma is within normal limits in signal and volume for age.

Vessels: No abnormal intravascular signal to suggest thrombosis. There is note of a tubular enhancing structure posteriorly in the left cerebellar hemisphere compatible with an incidental developmental venous anomaly

Bones: No suspicious lesion in the calvarium or skull base.

Other: Extracranial soft tissues are unremarkable.

IMPRESSION:

1. No enhancing mass lesions along the expected course of either olfactory bulb or groove is seen. Both olfactory bulbs and nerves appear to be normally developed.

2. No intracranial pathology. No abnormal enhancement.

Electronically signed by: Demarco Department of Radiology Walter Reed National Military Medical Center

Date: 04/15/16 Time: 08:18

A/P Written by THOMPSON, DAVID HERRON @ 19 Apr 2016 1251 EDT

1. Parageusia: Spoke to patient, no change taste

1. Told MRI brain normal
2. Has appt with GI
3. Will get appt with Dr xydakis

Disposition Written by THOMPSON, DAVID HERRON @ 19 Apr 2016 1252 EDT

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 19 Apr 2016 1252

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24217382 Primary Dx: Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **12 Apr 2016 1309 EDT**
 Clinic: **OTOLARYNG CL BE**

Appt Type: **T-CON***
 Provider: **THOMPSON, DAVID HERRON**

Call Back Phone: [REDACTED]

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 12 Apr 2016 1309 EDT

Problems

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Note Written by THOMPSON,DAVID HERRON @ 13 Apr 2016 0933 EDT**A/P** Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1032 EDT**1. Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS , ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvc mobile no edema arytoids

-- b12 neg

-- HIV neg, 16 Feb 16

-- H pylori positive

A: ddx olfactory nerve issue, brain pathology, h pylori, zinc, b12

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet / Refer to Gastroenterology for H pylori Rx

Disposition Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1034 EDT**Released w/o Limitations****Follow up:** 2 month(s) or sooner if there are problems. - Comments: follow up with Dr Xydakis, c 410 562 5345 w 443 654 5847**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Lab Result** Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT

CBC W/o Diff	Site/Specimen	11 Apr 2016 1043
WBC	BLOOD	4.7
RBC	BLOOD	4.88
Hemoglobin	BLOOD	15.4
Hematocrit	BLOOD	45.0
MCV	BLOOD	92.3
MCH	BLOOD	31.5
MCHC	BLOOD	34.1
Platelets	BLOOD	293
RDW CV	BLOOD	13.3
MPV	BLOOD	8.6

Lab Result Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT

Basic Metabolic Panel	Site/Specimen	11 Apr 2016 1043
Urea Nitrogen	SERUM	9.7
Carbon Dioxide	SERUM	28
Chloride	SERUM	97 (L)
Creatinine	SERUM	0.87
Glucose	SERUM	92
Potassium	SERUM	4.4
Sodium	SERUM	139
Calcium	SERUM	10.2
Anion Gap	SERUM	15
GFR Calculated Non-Black	SERUM	115.0
GFR Calculated Black	SERUM	132.9 <i>

Lab Result Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT

ESR	Site/Specimen	11 Apr 2016 1043
ESR	BLOOD	5

Lab Result Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT

Helicobacter pylori Ab IgG	Site/Specimen	11 Apr 2016 1043
Helicobacter pylori Ab IgG	SERUM	7.1 (H) <i>

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lab Result Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT**Treponema pallidum Ab**
Treponema pallidum Ab**Site/Specimen**
SERUM**11 Apr 2016 1043**
Negative <i>**Lab Result** Cited by THOMPSON,DAVID HERRON @ 13 Apr 2016 0935 EDT**Lyme Disease Ab Total Screen**
Borrelia burgdorferi Ab**Site/Specimen**
SERUM**11 Apr 2016 1043**
Negative <i>**Lab Result** Cited by THOMPSON,DAVID HERRON @ 12 Apr 2016 1309 EDT**Helicobacter pylori Ab IgG**
Helicobacter pylori Ab IgG**Site/Specimen**
SERUM**11 Apr 2016 1043**
7.1 (H) <i>**A/P** Written by THOMPSON,DAVID HERRON @ 13 Apr 2016 0941 EDT**1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere:** Spoke to patient: has had stomach discomfort and heart burn

1. Told H. Pylori was positive and can cause reflux and throat problems

2. Told to call 301 295 navy for GI consult at WR

3. Told all rest labs are normal

Consult(s):

-Referred To: GASTROENTEROLOGY MTF BE (Routine) Specialty: GASTROENTEROLOGY Clinic: GI
CL BE Provisional Diagnosis: Helicobacter pylori [H. pylori] as the cause of diseases classified
elsewhere Order Date: 04/13/2016 09:34**Disposition** Written by THOMPSON,DAVID HERRON @ 13 Apr 2016 0942 EDT**Administrative Options:** Consultation requested**Signed By THOMPSON, DAVID HERRON** (Physician/Workstation) @ 13 Apr 2016 0942

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Apr 2016 at WRNMMC, Otolaryngology Clinic Bethesda by THOMPSON, DAVID HERRON

Encounter ID: BETH-24134555 Primary Dx: Unspecified disturbances of smell and taste

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 Apr 2016 0830 EDT**
 Clinic: **OTOLARYNG CL BE**

Appt Type: **SPEC**
 Provider: **THOMPSON, DAVID HERRON**

AutoCites Refreshed by THOMPSON, DAVID HERRON @ 05 Apr 2016 1011 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of test conclusions [Use for free text] (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of heart disease (General FHx)
- family history of mental illness (not retardation) (General FHx)
- no family history of cancer (General FHx)
- family history of the options include referral (General FHx)
- family history of patient counseling (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Reason for Appointment:

change in taste

Appointment Comments:

pb/irmac

Vitals**Vitals** Written by KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

BP: 121/79, HR: 70, RR: 16, T: 98.5 °F, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: 4105625345

nkda

A/P Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1032 EDT**1. Unspecified disturbances of smell and taste:** S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS , ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvc mobile no edema arytoids

-- b12 neg

-- HIV neg, 16 Feb 16

A: ddx olfactory nerve issue, brain pathology, h pylori, zinc, b12

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet

Procedure(s):

-Fiberoptic Laryngoscopy Flexible (diagnostic) x 1 - After verbal informed consent, topical 4% lidocaine/ afrin mixture was sprayed into the nose bilaterally. The flexible scope was passed through bilateral nares and into hypopharynx with findings as described in above exam. The patient tolerated well without complications.

Note: Reviewed AHLTA record, and Reviewed with patient: past treatments, laboratory, and Radiological Studies, DDX symptoms, and Planned Management

Laboratory(ies):

-H PYLORI IGG (Routine); ZINC (Routine); BASIC METABOLIC PANEL (Routine); LYME DISEASE AB, TOTAL (Routine); CBC W/O DIFFERENTIAL (Routine); ESR (Routine); TREPONEMA PALLIDUM AB (Routine)

Radiology(ies):-MRI, BRAIN W W/O CON (Routine) Impression: SM with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad
Comment: Please use gad**Consult(s):**

-Referred To: OTOLARYNGOLOGY NCR (Routine) Specialty: OTORHINOLARYNGOLOGY Clinic: RM OTOLARYNGOLOGY IR Provisional Diagnosis: Unspecified disturbances of smell and taste

Disposition Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1034 EDT**Released w/o Limitations****Follow up:** 2 month(s) or sooner if there are problems. - Comments: follow up with Dr Xydakis, c 410 562 5345 w 443 654 5847**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Note** Written by KIPTOO,ALEX @ 11 Apr 2016 0907 EDT**Consult Order****Referring Provider:** AUSTIN, MARIE R**Date of Request:** 01 Mar 2016**Priority:** Routine**Provisional Diagnosis:**

change in taste

Reason for Request:

Pt is reporting that all sweet things taste bitter except for artificial sweeteners please eval and treat

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 11 Apr 2016 1035

CHANGE HISTORY

The following Vitals Entry Was Overwritten by KIPTOO,ALEX @ 11 Apr 2016 0909 EDT:

Vitals Written by KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 Apr 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-24131043 Primary Dx: Pain in left ankle and joints of left foot

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **05 Apr 2016 0830 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **FTR**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J @ 05 Apr 2016 0835 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAHR, ROBERT J. @ 05 Apr 2016 0858 EDT**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Pain decreases with foot into the neutral position. He states he uses no meds--see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, evertors, invertors 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain is now gone. He is training for a marathon and is up to running 25 miles per week. Pt does not want his foot examined today. Plan: discharge PT. F/U prn.

A/P Written by BAH,ROBERT J @ 05 Apr 2016 0900 EDT

1. Pain in left ankle and joints of left foot

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAH,ROBERT J @ 05 Apr 2016 0900 EDT

Released w/o Limitations

Signed By BAH, ROBERT J (Physical Therapist, wrnmmc) @ 05 Apr 2016 0900

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Mar 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-23804906 Primary Dx: Pain in left ankle and joints of left foot

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **07 Mar 2016 0830 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **FTR**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J @ 07 Mar 2016 0823 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAHR, ROBERT J. @ 07 Mar 2016 0909 EDT**History of present illness**

The Patient is a 31 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs. Pain decreases with foot into the neutral position. He states he uses no meds--see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, evertors, invertors 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain has decreased and his strength is good. Exercise causes pain laterally while doing the exercises but he feels better afterwards. He rates his pain at 1/10 at rest and 3/10 with activity. Pt to do saphenous and peroneal nerve glides throughout the day and to return in two to three weeks for followup.

A/P Written by BAHR,ROBERT J @ 07 Mar 2016 0912 EDT**1. Pain in left ankle and joints of left foot**

Procedure(s):

-Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

-Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAHR,ROBERT J @ 07 Mar 2016 0912 EDT**Released w/o Limitations**

Signed By BAHR, ROBERT J (Physician) @ 07 Mar 2016 0913

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-23726066 Primary Dx: Parageusia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Feb 2016 0849 EST**
 Clinic: **INT MED MEDICAL HOME CL C
 BE**

Appt Type: **T-CON***
 Provider: **AUSTIN, MARIE**

Call Back Phone: [REDACTED]

AutoCites Refreshed by AUSTIN, MARIE @ 29 Feb 2016 1704 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Other PMHs

No Other PMHs Found.

Social History

No Social History Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
PODOFILOX, 0.5 %, SOLUTION, TOPICAL	Active	APPLY TWICE A DAY FOR 3 2 of 2 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2		24 Feb 2016
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	24 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015- 16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Labs**16 Feb 2016 1430****Methylmalonic Acid**

Methylmalonate

Site Specimen

SERUM

Result

170

Units

nmol/L

Ref Range

0-378

16 Feb 2016 1430**HIV-1/O/2 Ab**

HIV-1/O/2 Ab

Site Specimen

SERUM

Result

Units

Ref Range

16 Feb 2016 1430**Vitamin B12 (Cyanocobalamin)**

Vitamin B12 (Cobalamins)

Site Specimen

SERUM

Result

293 <i>

Units

pg/mL

Ref Range

(211-946)

16 Feb 2016 1430**Homocysteine**

Homocysteine

Site Specimen

SERUM

Result

8.9 <i>

Units

mcmol/L

Ref Range

(4.0-15.4)

16 Feb 2016 1430**Comprehensive Metabolic Panel**

Albumin

Site Specimen

SERUM

Result

4.7

Units

g/dL

Ref Range

(3.5-5.2)

Alkaline Phosphatase

SERUM

53

U/L

(40-129)

Alanine Aminotransferase

SERUM

17

U/L

(0-41)

Bilirubin

SERUM

0.4

mg/dL

(0.15-1.2)

Urea Nitrogen

SERUM

13.8

mg/dL

(6-20)

Calcium

SERUM

9.7

mg/dL

(8.6-10.2)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Carbon Dioxide	SERUM	29	mmol/L	(22-29)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.96	mg/dL	(0.7-1.2)
Glucose	SERUM	89	mg/dL	(74-106)
Potassium	SERUM	4.4	mmol/L	(3.5-5.1)
Protein	SERUM	7.6	g/dL	(6.6-8.7)
Sodium	SERUM	141	mmol/L	(136-145)
Anion Gap	SERUM	14	mmol/L	(7-16)
GFR Calculated Non-Black	SERUM	105.6	mL/min	(60->=60)
GFR Calculated Black	SERUM	122.1 <i>	mL/min	(60->=60)
Aspartate Aminotransferase	SERUM	20	U/L	(0-40)

02 Feb 2016 1406**ETG/ETS, UA (250 Cut-Off)**

Ethyl Glucuronide

Site Specimen

URINE

Result

negative <i>

Units

ng/mL

Ref Range

Cutoff=250

02 Feb 2016 1406**Drug Abuse Screen**

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Opiates

Phencyclidine, UA

Cannabinoids

Methadone

Oxycodone

Site Specimen

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

Result

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

Units

ng/mL

Ref Range

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Not-Detected)

(Negative)

Rads**MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985 M**

***** ANKLE, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: ANKLE, LT 3 VIEWS

Event Date: 16-Feb-2016 14:07:00

Exam #: 16054521

Exam Date/Time: 16-Feb-2016 14:10:00

Transcription Date/Time: 16-Feb-2016 14:55:00

Provider: WILSON, BRYAN JAMES

Requesting Location:

INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: FISHER, ZACHARY ETHAN

Supervised By:

ZACHARY E FISHER, MAJ, MC, Dept of Radiology

Approved By: FISHER, ZACHARY ETHAN

Approved Date: 16-Feb-2016 14:54:00

Supervised By:

92925 ZACHARY E FISHER, MAJ, MC, Dept of Radiology

Supervised By Date: 16-Feb-2016 14:54:00

Amended Report Text:

Comparison: MRI October 5, 2014 and prior radiographs May 6, 2014

Findings: Routine radiographs of the ankle were obtained. Normal alignment is present without evidence for acute fracture or dislocation. There is mild lateral soft tissue swelling present. The ankle mortise and talar dome are intact. The joint spaces are preserved without significant degenerative changes.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Impression: Lateral soft tissue swelling without evidence for acute bony abnormality

Electronically signed by: Dr. ZACHARY ETHAN FISHER Department of Radiology Walter Reed National Military Medical Center

Date: 02/16/16 Time: 14:54

Reason for Telephone Consult: Written by CONRAD, ALLEN C @ 29 Feb 2016 0849 EST

Call pt with test results

Telephone Consult Comments: Written by CONRAD, ALLEN C @ 29 Feb 2016 0849 EST

Pt called this morning requesting Ms. Austin give him a call to discuss test results. Direct number at work is 443-654-5847

Questionnaire AutoCites Refreshed by AUSTIN, MARIE @ 29 Feb 2016 1704 EST

Questionnaires

A/P Written by AUSTIN, MARIE @ 01 Mar 2016 1234 EST

1. Parageusia R43.2

Consult(s):

-Referred To: OTOLARYNGOLOGY NCR (Routine) Specialty: OTORHINOLARYNGOLOGY Clinic: RM
OTOLARYNGOLOGY IR Provisional Diagnosis: change in taste Order Date: 03/01/2016 12:34

Disposition Written by AUSTIN, MARIE @ 01 Mar 2016 1234 EST

Follow up: as needed . - Comments: pt to f/u as discussed with ENT

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 01 Mar 2016 1234

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 476
AR 2463

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Feb 2016 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL

Encounter ID: BETH-23687169 Primary Dx: Anogenital (venereal) warts

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **24 Feb 2016 1300 EST**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **MARQUART, JASON DANIEL**

Reason for Appointment:

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

Note Written by LAM, THOMAS KIN @ 24 Feb 2016 1329 EST

CC: Genital warts

HPI: 31 yo man who was referred here by PCM for further evaluation and/or management of warts on penis not responsive to topical Aldara.

Hx of skin cancer: None ☒ BCC ☐ SCC ☐ MM ☐

Family Hx of melanoma: None

Drug Allergies: None

Medication list reviewed ☒

Pain (10-pt scale): 0

Tobacco Use: Y ☐ N ☐Alcohol Use: Y ☐ N ☐**OBJECTIVE:**Fitzpatrick Type: I ☐ II ☒ III ☐ IV ☐ V ☐ VI ☐

Standby: N/A

A focused skin exam was notable for the following:

1. Scattered (~10) skin-colored, verrucous papules on the dorsal penis.

A/P Last Updated by LAM, THOMAS KIN @ 24 Feb 2016 1330 EST

1. Anogenital (venereal) warts: Lesions on exam c/w warts. Treated today with LN2. Will give Condyllox for continued Tx at home. Also counseled Pt on wart clinic on Thursday mornings. Pt voiced understanding and agreement.

Procedure(s):

-Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent was received and cryo applied to lesions in standard fashion. Tx was applied in a pulsed fashion to minimize collateral tissue injury. Pt was instructed to use Vaseline ointment to the area(s) until healed. Pt tolerated the procedure well and left in stable condition.

Medication(s):

Locations: DORSAL PENIS x8

-PODOFILOX--TOP 0.5% SOLN - APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #1 RF2

Disposition Last Updated by LAM, THOMAS KIN @ 24 Feb 2016 1330 EST**Released w/o Limitations****Note** Written by LAM, THOMAS KIN @ 24 Feb 2016 1324 EST**Consult Order**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Referring Provider: WILSON, BRYAN J
Date of Request: 16 Feb 2016
Priority: Routine

Provisional Diagnosis:

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

1mm x 1mm papules at base of penis previously treated empirically for genital warts, did not respond to Imiquimod. Skin changes are very limited, may be physiologic. Please evaluate and treat.

Note Written by MARQUART, JASON DANIEL @ 24 Feb 2016 1404 EST

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service) @ 24 Feb 2016 1404

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Feb 2016 at WRNMMC, Phys Therapy CL BE by BAHR, ROBERT J

Encounter ID: BETH-23626266 Primary Dx: Acquired absence of right leg below knee

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **19 Feb 2016 0645 EST**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **SPEC**
 Provider: **BAHR, ROBERT J.**

AutoCites Refreshed by BAHR, ROBERT J @ 19 Feb 2016 0928 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	17 Feb 2016
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment:

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

S/O Note Written by BAHR, ROBERT J. @ 19 Feb 2016 0912 EST**History of present illness**

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo WM who injured his left ankle 1.5 years ago while springing. The MRI showed a thickening of his ligament. He was treated in PT here. His pain has been off and on until two

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

months ago when his foot was plantarflexed. He has had no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with activity. Mild swelling noted laterally. Pain increases with walking and the pushing off of his foot and going up and down stairs. Pain decreases with foot into the neutral position. He states he uses no meds--see AHLTA for medication reconciliation. He works with computers, exercises moderately running/walking 3-11 miles. He had new xrays three days ago which appear WNL. He learns without preference. His goal is to have a pain free ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle dorsiflexors, plantarflexors, evertors, invertors 5/5. negative drawer. Mild tenderness along lateral malleolus on left. Mild swelling noted. No heat or warmth or discoloration noted. Gait WNL, heel and toe walk within normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will benefit from skilled physical therapy program. ~PLAN: Home program of eccentric heel lowering and calf stretches for three weeks and then followup. ~GOAL: Decrease pain 75% in three weeks STG. Increase running without pain to four miles in 2 months. Pt educated on exercises and given handouts. ~PROGNOSIS: good.

A/P Written by BAHR,ROBERT J @ 19 Feb 2016 0930 EST**1. Acquired absence of right leg below knee**

Procedure(s):

-Physical Therapy Service Evaluation x 1

-Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

Disposition Written by BAHR,ROBERT J @ 19 Feb 2016 0930 EST**Released w/o Limitations****Note** Written by HARMON,DAVID JR @ 19 Feb 2016 0703 EST**Consult Order****Referring Provider:** WILSON, BRYAN J**Date of Request:** 16 Feb 2016**Priority:** Routine**Provisional Diagnosis:**

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On light duty 30 days. Needs eval and likely graduated exercise.

Signed By BAHR, ROBERT J (Physical Therapist, wrnmmc) @ 19 Feb 2016 0931

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Feb 2016 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-23591652 Primary Dx: Encounter for issue of repeat prescription

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **16 Feb 2016 1438 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **T-CON***
 Provider: **ZEMBRZUSKA, HANNA DOMINIKA**
 Call Back Phone: [REDACTED]

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1438 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

02 Feb 2016 1406
ETG/ETS, UA (250 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative <i>

Units
 ng/mL

Ref Range
 Cutoff=250

02 Feb 2016 1406
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>

Units

ng/mL

Ref Range

(Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Not-Detected)
 (Negative)

Rads

No Rads Found.

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST**Subjective**

Contacted pt for checkup; has not been seen in clinic for a few months. Left VM at [REDACTED] number. Other number - cell 850 410 1041 has been disconnected.

A/P Last Updated by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST**1. Encounter for issue of repeat prescription Z76.0****Disposition** Last Updated by ZEMBRZUSKA, HANNA DOMINIKA @ 16 Feb 2016 1440 EST

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 16 Feb 2016 1440

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Feb 2016 at WRNMMC, Int Med CL C Medical Home BE by WILSON, BRYAN J

Encounter ID: BETH-23581847

Primary Dx:

Sprain of other ligament of left ankle,
subsequent encounterPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **16 Feb 2016 0950 EST**
Clinic: **INT MED MEDICAL HOME CL C**
BEAppt Type: **FTR**
Provider: **WILSON, BRYAN JAMES****Reason for Appointment:**

Ankle - Extreme pain from previous injury location

Appointment Comments:

Appt self-booked via TOL

Injury/Accident Written by WILSON, BRYAN J @ 16 Feb 2016 1926 EST**Injury Cause/Activity:** W01.0XXD Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter**Date of Injury/Accident:** 16 Feb 2014**Place of Occurrence:** Y92.9 Unspecified place or not applicable**Injury Category for Compensation Code(s):** OA-Other Accident**Vitals****Vitals** Written by WOODS, CHARLENE N @ 16 Feb 2016 1018 ESTBP: 129/80, HR: 78, RR: 20, T: 98.1 °F Oral, HT: 69 in, WT: 175 lbs, SpO₂: 97%, BMI: 25.84,
BSA: 1.952 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 3/10 Mild, Pain Scale Comments: LEFT ANKLE**S/O Note** Written by WILSON, BRYAN JAMES @ 16 Feb 2016 1911 EST**Chief complaint**

The Chief Complaint is: Ankle pain.

History of present illness

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31M PMH s/f L ankle sprain and GAD in clinic for multiple c/o. 1.) Last 1 mo developed L ankle pain same distribution as ankle sprain 2 yr ago. Initially tripped in hole when playing softball, extensive swelling, bleeding into foot. Underwent physical therapy, fitted for brace. Plain films X2 negative for fx. MRI demonstrates thickening at anterior talofibular joint. Pt subsequently passed multiple PRTs. Now, getting back into shape for upcoming PRT, has developed pain at same site, mild swelling, crepitus. No known reinjury. Currently 2/10 pain, max 4/10. Exacerbated by rolling the ankle and walking. Has not taken any medications for it.

2.) C/o genital warts. Last seen by Marie Austin 9/2015. Was prescribed Imiquimod then 2nd course but no resolution of skin changes. Pt states he has had at least 150 lifetime sexual partners, decreased number of partners recently but using condoms only about 90% of the time. No other lesions. Did not have the Gardasil vaccine. 3.) Saw Marie Austin for dysgeusia 10/2015. At this time he had come off his Zolof rapidly, did not taper, and his sx were attributed to w/d. He was sent to psychiatry, and restarted on low-dose 25 then tapered to 12.5 and off. The medication changes have not affected his taste, sx persist. In general what used to taste sweet now tastes bitter. Some savory foods also taste bitter. Of note: has low-normal B12. No nasal congestion. Has intact olfaction. No GERD. No change to urine output/appearance. No abdominal pain.

Current medication

Including OTC meds, vitamins, herbals, etc.

Sertraline 25mg daily followed by weaning to 12.5mg daily then off

Melatonin qhs prn

ALL

NKDA.

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

H/o childhood asthma.

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Personal history

Social history reviewed

Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Physical findings**General:**

• Physical examination GEN: WNWD, no acute distress

HEENT: MMM, no scleral icterus

HEART: RRR, no m/g/r

LUNGS: CTAB

ABD: NABS, soft, NTND, no HSM

EXT: Mild swelling, pain on extreme inversion, plantar flexion and dorsiflexion L ankle; no joint laxity

GENITAL: 1x1mm papules vs. nodule maximum 3-5 at base of penis, no inflammatory changes, no discharge

NEURO: No focal neurologic deficits appreciated.

Practice Management

Preventive medicine services.

A/P Last Updated by WILSON,BRYAN J @ 16 Feb 2016 1940 EST

1. Sprain of other ligament of left ankle, subsequent encounter: Reinjury vs. subtalar OA 2/2 original sprain. Repeat plain films today and restart physical therapy. 30 days light duty until eval by physical therapy. O/w Motrin and graduated exercise. Continue brace. No role for MRI or ortho referral at this time.

Medication(s): -IBUPROFEN--PO 800MG TAB - TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN #60 RF0 Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Radiology(ies): -ANKLE, LT 3 VIEWS (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES Impression: H/o anterior talofibular ligament sprain, conservative manag

Consult(s): -Referred To: PHYSICAL THERAPY MTF BE (Routine) Specialty: THERAPY, PHYSICAL Clinic: PHYS THERAPY CL BE Provisional Diagnosis: Sprain of other ligament of left ankle, subsequent encounter Ordered By: WILSON,BRYAN J Ordering Provider: WILSON,BRYAN JAMES

Injury -W01.0XXD Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter

Cause(s)/Activity(ies): **2. Other skin changes:** Skin changes very limited, and the tiny papules may be physiologic. Did not respond to Imiquimod. Referral to derm for possible bx vs. reassurance vs. tew tx.

Consult(s): -Referred To: DERMATOLOGY MTF BE (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL BE Provisional Diagnosis: Sprain of other ligament of left ankle, subsequent encounter Ordered By: WILSON,BRYAN J Ordering Provider: WILSON,BRYAN JAMES

3. Parageusia: Did not respond to change in SSRI. Ddx is broad. Given his sexual hx, will draw CMP for possible hepatitis, HIV. Consider electrolyte abnormalities. Also has low-nl B12. Change may be manifestation of tongue enlargement. B12, MMA, homocysteine today.

Laboratory(ies): -HIV-1/O/2 (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; VITAMIN B12 (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; METHYLMALONATE, SERUM (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; HOMOCYSTEINE (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES; COMPREHENSIVE METABOLIC PANEL (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES

Radiology(ies): -ANKLE, LT 3 VIEWS (Routine) Ordered By: WILSON,BRYAN J Ordering Provider: WILSON, BRYAN JAMES Impression: H/o anterior talofibular ligament sprain, conservative manag

Disposition Last Updated by WILSON,BRYAN J @ 16 Feb 2016 1941 EST**Released w/ Work/Duty Limitations****Administrative Options:** Consultation requested**Note** Written by RITTER,JOAN B @ 21 Feb 2016 2305 EST**Co-signer Note**

Case discussed with resident. Agree with assessment and plan as above.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

Signed By **WILSON, BRYAN JAMES** (Physician) @ 16 Feb 2016 1941
Co-Signed By **RITTER, JOAN B** (Physician) @ 21 Feb 2016 2305

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Feb 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23502474 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **04 Feb 2016 1345 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 05 Feb 2016 1521 EST

Drug Abuse Screen	Site/Specimen	02 Feb 2016 1406	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site/Specimen

URINE

02 Feb 2016 1406

Negative <i>

Units

ng/mL

Ref Rng

Cutoff=250

A/P Written by AILOR, LYNNE P @ 05 Feb 2016 1523 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative, Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 05 Feb 2016 1523 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 05 Feb 2016 1524

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

02 Feb 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23453438 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **02 Feb 2016 1208 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 03 Feb 2016 1448 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES,MICHAEL J @ 02 Feb 2016 1208 EST
 CC GROUP/ CLOSE OUT

Screening Written by MAPLES,MICHAEL J @ 02 Feb 2016 1237 EST

Reason For Appointment: Notes Entered by: MAPLES,MICHAEL J 02 Feb 2016 1208

 CC GROUP/ CLOSE OUT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES,MICHAEL J @ 02 Feb 2016 1237 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Comments: LAUNGUAGE: ENGLISH
NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by BROWN,CYNTHIA E @ 03 Feb 2016 1448 EST

Reason for Visit

CC Group/Individual.

A/P Last Updated by MAPLES,MICHAEL J @ 02 Feb 2016 1238 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN,CYNTHIA E @ 03 Feb 2016 1457 EST

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP
Daniel arrived on time for group. Daniel is at session #26 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No one in group admitted to drinking or abusing drugs since we last saw them. The facility was closed down last week due to weather so it was 2 weeks since we had seen any of them. The group shared the stress and struggles they have had over the past 2 weeks focusing on if there was a trigger to drink or if they would have in the past. Group closed with a group member sharing one constructive thing the person can do for a better sober lifestyle. Daniel stated that his snow days were on the mountain snowboarding. He stated that he is working to be more social. He shared that he really did not have triggers to drink. He shared with an angry that he was given the tool to see he also makes mistakes. He does not get as angry or for as long if he just can bring to mind the times he has done the thing he is getting mad at. He closed with the group hearing he appears to have made positive changes in his life and his behavior reflects it. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has completed his ITP. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is not scheduled to return and this record is CLOSED.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by BROWN,CYNTHIA E @ 03 Feb 2016 1448 EST

INDIVIDUAL SESSION CC

Daniel arrived Daniel is at session 26 of the 26 scheduled sessions of the Continuing Care treatment program attending from 1400 to 1500, total of 1 hour. Daniel reported the Continuing Care group was helpful in keeping him from drinking. He did state that his has learned the CBT to be the best therapy for him. He shared how he dealing with life better now that he has stopped drinking. He stated that he continues to use his CBT on situations that baffle him. He stated that he will be getting a new roommate. He does see that drinking will be an issue with either of them because they have both been through this program. We reviewed his treatment plan. He cancelled Problem #1 Objectives#7 and 8 because he knows what to do and has heard enough that he could have a sponsor if he wanted one, but he does not. He stated an understanding that he would not be allowed to abuse alcohol again while on active duty and the Navy would like for him to have an alcohol abstinent lifestyle. He does not see where that is a problem for him. Daniel closed his entire open treatment plan Objectives in preparation of closing with this program. Daniel is staying for group today.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 03 Feb 2016 1457

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23336071 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
 Patient Status: **Outpatient**

Date: **19 Jan 2016 1208 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment:Written by BROWN,CYNTHIA E @ 19 Jan 2016 1208 EST
 CC Group/Individual

Screening Written by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST**Reason For Appointment:** Notes Entered by: BROWN,CYNTHIA E 19 Jan 2016 1208

CC Group/Individual

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by BROWN,CYNTHIA E @ 19 Jan 2016 1443 EST

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact Number: [REDACTED]

No vitals taken at SARP treatment

S/O Note Written by BROWN,CYNTHIA E @ 19 Jan 2016 1445 EST**Reason for Visit**

CC Group/Individual.

A/P Last Updated by BROWN,CYNTHIA E @ 19 Jan 2016 1449 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - Patient attended group from 1230 to 1400 today.

-BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 1100 to 1200 to review and update his treatment plan.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 28 Jan 2016 1325 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD NOTE SECTION FOR THE INFORMATION ON THIS ENCOUNTER.**Note** Written by BROWN,CYNTHIA E @ 28 Jan 2016 1325 EST**INDIVIDUAL SESSION CC Urine test**

Daniel arrived on time to his individual session. He is at session 25 of the 26 scheduled sessions of the Continuing Care treatment program attending from 1100 to 1210, total of 1 hour. He shared how stressful it has been having 4 people in his apartment. He described needing his down time and would go into his walk-in closet to be by himself. He began to describe at length how he was delegating these duties as all 4 of them are partners in his business. When asked if this made him want to drink he responded that the thoughts were there but he would not call them cravings. He shared that drinking would not be the answer for him. He did state that he met a woman not on line. She is a professor and he believes she is interested in having sex with him. He stated that they have not had sex yet. He believes this is a huge step in the right direction for him but he does not see them having a long term relationship. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the day. Daniel extended Problem #1, Objectives #1-4, 6, 7, and 9 to 26 January 2016 and he cancelled Objective #8 as he knows how to get a sponsor already

Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #1-4, 6, 7, and 9 due 26 January 2016. Daniel is schedule to stay for group today.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

CC GROUP

Daniel stayed for group after his individual session. Daniel is at session # 25 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Foul weather and base closure guidelines were discussed. The infections illness of this season was also discussed. Each member was encouraged that if they were contagious they should call their sponsors and let them know why they will not be in group. They were instructed to not come to group if contagious. The group conducted check in process describing if they any thoughts to drink or triggers for

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

relapse. Three members of the group admitted to having fleeting thoughts of drinking during their time from the last group they attended. All group members denied drinking or abusing drugs. Daniel shared that he went snowboarding with some men from work. He met them on the mountain and did the slopes for about half of the day. He shared that it was different because he was not in his own zone with just music in his ears. He shared with the group that he has 4 people in his 1 bedroom apartment right now and they have been for the past 2 weeks. He stated that they are connected to his business. He has found that it was over stimulation for him and he would retreat to closet. He shared they are dirty people but admitted that he was a clean person and will take 2 showers a day. He said that they were flying back to their own homes tomorrow and he just couldn't wait. He stated to the group that he bought a house because he has orders to the same duty station. Daniel did appear to stay on point for most of group today which shows respect for group members and progress for him. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel updated his treatment plan before group. See ADD NOTE section of this encounter for that information. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #1, 2, 3, 4, 6, 7, and 9 due 26 January 2016. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 26 January 2016 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 28 Jan 2016 1327

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

13 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23294815 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**
Patient Status: **Outpatient**Date: **13 Jan 2016 1445 EST**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **AILOR,LYNNE P****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR,LYNNE P @ 13 Jan 2016 1533 EST**ETG/ETS, UA (250 Cut-Off)**

Ethyl Glucuronide

Site/Specimen

URINE

05 Jan 2016 1402

Negative <i>

Units

ng/mL

Ref Rng

Cutoff=250

A/P Written by AILOR,LYNNE P @ 13 Jan 2016 1535 EST**1. Alcohol dependence, uncomplicated:** Labs were reviewed by undersigned provider per SARP protocol. Result of ETG/ETS was negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR,LYNNE P @ 13 Jan 2016 1535 EST**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By** AILOR, LYNNE P (Physician) @ 13 Jan 2016 1535

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23235227 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **08 Jan 2016 0830 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 08 Jan 2016 0848 EST

Drug Abuse Screen	Site/Specimen	05 Jan 2016 1402	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

A/P Written by AILOR, LYNNE P @ 08 Jan 2016 0849 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 08 Jan 2016 0850 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up in SARP.

Signed By AILOR, LYNNE P (Physician) @ 08 Jan 2016 0850

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Jan 2016 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23202652 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **06 Jan 2016 1500 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 06 Jan 2016 0731 EST

Drug Abuse Screen	Site/Specimen	29 Dec 2015 1405	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

A/P Written by AILOR, LYNNE P @ 06 Jan 2016 0733 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 06 Jan 2016 0733 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up in SARP.

Signed By AILOR, LYNNE P (Physician) @ 06 Jan 2016 0733

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 Jan 2016 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-23195319 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
 Patient Status: **Outpatient**

Date: **05 Jan 2016 1230 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 06 Jan 2016 0755 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Loading...

Reason for Appointment: Written by MAPLES,MICHAEL J @ 05 Jan 2016 1230 EST
 CC GROUP

Screening Written by MAPLES,MICHAEL J @ 05 Jan 2016 1239 EST**Reason For Appointment:** Notes Entered by: MAPLES,MICHAEL J 05 Jan 2016 1230-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by MAPLES,MICHAEL J @ 05 Jan 2016 1239 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by BROWN,CYNTHIA E @ 06 Jan 2016 0755 EST**Reason for Visit**

CC Group.

A/P Last updated by BROWN,CYNTHIA E @ 06 Jan 2016 0927 EST

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

1. Alcohol dependence, uncomplicated

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies):

-DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN, CYNTHIA E @ 06 Jan 2016 0929 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.**Note** Written by BROWN, CYNTHIA E @ 06 Jan 2016 0928 EST**CC GROUP (URINE TEST)**

Daniel arrived 45 minutes early to group. Daniel is at session # 24 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group discussed one member's unwillingness to follow through with what he promised to group. The point of trust and making changes is what treatment is about was made. Group debriefed their activities during Christmas and New Year's. No group member admitted to drinking or using drugs. A discussion of euphoria and how childhood experiences with video games was like drinking in losing track of time, food, and human interaction.

Daniel shared that he kept one of his dating sites open for 2 extra days because he had already started a conversation with someone and wanted to complete it. He shared this woman he was having the "conversation" with became his date for New Year's. He stated that it was "lack luster". This was the reason he was taking himself off the dating sites in the first place. He was confronted with lying to the group. He stated that he sees as changing his mind. He failed to see the promise as binding or a commitment. He stated that doing he wanted and necessarily the next right thing gets him trouble. He was able to relate to his production at work being discussed as poor. He stated that he just does not work as hard as he could and senior paygrades are starting to notice. He stated that he wants to do better and will his CBT to make better decisions. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has several treatment plan problem objectives out of date on his treatment plan. He will not be in group next week due to a class he is taking but agreed to an individual session when he returns. Daniel will continue with Continuing Care treatment and has an outdated treatment plan. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 19 January 2016 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 06 Jan 2016 0933**CHANGE HISTORY****The following A/P Note Was Overwritten by** BROWN, CYNTHIA E @ 06 Jan 2016 0927 EST:

The A/P section was last updated by BROWN, CYNTHIA E @ 06 Jan 2016 0927 EST - see above. Previous Version of A/P section was entered/updated by MAPLES, MICHAEL J @ 06 Jan 2016 0755 EST.

1. Alcohol dependence, uncomplicated

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Laboratory(ies):

SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.
-DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-23146597 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **29 Dec 2015 1223 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1332 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 29 Dec 2015 1223 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 29 Dec 2015 1224 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 29 Dec 2015 1223

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 29 Dec 2015 1224 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Comments: LAUNGUAGE: ENGLISH
 CONTACT NUMBER [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES,MICHAEL J @ 29 Dec 2015 1227 EST

1. Alcohol dependence, uncomplicated

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 30 Dec 2015 1356 EST

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: See ADD/NOTE section for more information on this encounter.

Note Written by GONZALEZZARAZUA,JORGE A @ 30 Dec 2015 1356 EST

Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ½ hours. Group went over their recent holiday weekend and how they were able to handle any urges or cravings to drink. Members also shared their plans for the upcoming New Year's weekend and how they plan to deal with possible triggers or urges to drink. All members denied consuming alcohol or abusing illegal drugs since their last visit.

Daniel shared that he spent his Christmas holiday working on his computer based game, but at times throughout the night he would check his social media and notice that plenty of his online friends would post pictures of themselves out with family and friends, opening presents or just hanging out celebrating the holiday. He states that he felt envious and lonely and had a craving to want to drink, but instead continued to work on his game and the feeling would pass. He also reports that later in the weekend he became upset because a female friend who he states he was interested in canceled on their date. He states that he was mad about it because he thought they had a good time during their previous date. Daniel states that online dating is taking a lot of his time as he does it often and after receiving feedback from the group states that he will likely delete his online dating profiles and would share with the group during the next session.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel has Problem #5, Objective # 3 overdue 18 December 2015. He will schedule his individual appointment after the New Year's holiday to update his treatment plan with this counselor. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return 05 January 2016 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 30 Dec 2015 1357

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 31 Dec 2015 0747

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CHANGE HISTORY**The following Disposition Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST:**

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: See ADD/NOTE section for more information on this encounter.**The following Disposition Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST:**

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1356 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1332 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. Group went over their recent holiday weekend and how they were able to handle any urges or cravings to drink. Members also shared their plans for the upcoming New Year's weekend and how they plan to deal with possible triggers or urges to drink. All members denied consuming alcohol or abusing illegal drugs since their last visit.

Daniel shared that he spent his Christmas holiday working on his computer based game, but at times throughout the night he would check his social media and notice that plenty of his online friends would post pictures of themselves out with family and friends, opening presents or just hanging out celebrating the holiday. He states that he felt envious and lonely and had a craving to want to drink, but instead continued to work on his game and the feeling would pass. He also reports that later in the weekend he became upset because a female friend who he states he was interested in canceled on their date. He states that he was mad about it because he thought they had a good time during their previous date. Daniel states that online dating is taking a lot of his time as he does it often and after receiving feedback from the group states that he will likely delete his online dating profiles and would share with the group during the next session.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel has Problem #5, Objective # 3 overdue 18 December 2015. He will schedule his individual appointment after the New Year's holiday to update his treatment plan with this counselor. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Da

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 30 Dec 2015 1355 EST:**Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 30 Dec 2015 1333**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Dec 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-23111240 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **22 Dec 2015 1243 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **HILL, LARRY D**

AutoCites Refreshed by HILL, LARRY D @ 23 Dec 2015 1211 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 22 Dec 2015 1243 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 22 Dec 2015 1317 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 22 Dec 2015 1243

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 22 Dec 2015 1317 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by HILL, LARRY D @ 23 Dec 2015 1213 EST**History of present illness**

The Patient is a 30 year old male.

The patient was in attendance for the Continuing Care Support Group.

A/P Last Updated by MAPLES, MICHAEL J @ 22 Dec 2015 1320 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL, LARRY D @ 23 Dec 2015 1211 EST**Released w/o Limitations****Discussed:** Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session 22 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group shared their holiday plans and how Christmas will look through sober eyes, for some the first time in years. No group member admitted to drinking alcohol or abusing drugs since last seen at SARP.

Daniel sat relaxed for the majority of the group, but did provide minimal feedback to others and was observed probing as usual.

Daniel was eventually drawn into the group and shared his holiday plans saying "I plan on spending Christmas alone this year and catch up on a lot of work I have to get done in my business. I have to step back and look at myself and identify that I'm choosing to be alone during the holidays due to my business and not because I have nowhere to go. I find myself drinking more when I'm around others for example, last year I was at my mom's house and I drank a lot there more than usual." Daniel wrote that he has not attended any required AA meetings, has no sponsor and is working steps 3&4. Daniels progress reports are contradictory as to his sponsor status and meeting attendance, where some he has a sponsor and others he does not.

Daniel appeared engaged and interested in the treatment process and was appropriate and less active throughout the session.

Daniel has several objectives that are overdue and his ITP is out dated. Daniels ITP will be updated during his next individual session 28 December 2015. Daniel will continue with Continuing Care treatment and his record will be updated at his next individual session as stated above. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return at 1230 28 December 2015. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard.

Signed By HILL, LARRY D (Physician) @ 23 Dec 2015 1217**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 23 Dec 2015 1415

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

15 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-23038866 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **15 Dec 2015 1223 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 18 Dec 2015 1124 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 15 Dec 2015 1223 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 15 Dec 2015 1227 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 15 Dec 2015 1223

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 15 Dec 2015 1227 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 15 Dec 2015 1228 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 18 Dec 2015 1245 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #19 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. Group opened today by doing their weekly check-in, recapping their week and identifying any possible triggers or cravings. Group also said good bye to a group member by doing a group closing exercise.

Daniel shared that over the past 2 weeks he rekindled an old relationship with one of his ex-girlfriends. He states that she contacted him and invited him to a game and he accepted. While at the game, Daniel reports to have experienced a craving for beer as a lot of people around him were drinking while everyone seemed to be having fun. Daniel states that he was able to control his craving and the rest of the day went on just fine without him drinking. He also states to having had a serious talk with his friend and they were able to shared feelings that they had kept bottled up for over a year since they stopped talking. Daniel states that although nothing serious seems to be coming out from meeting up with her, he liked the fact that they were able to shared insight about each other.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel completed Problem #5, Objectives #1 and 2 of his ITP. He will continue with Continuing Care treatment and has Problem #5, Objective # 3 due 18 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 22 December 2015 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 18 Dec 2015 1245**Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 18 Dec 2015 1254**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

14 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-23012235 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **14 Dec 2015 0800 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 14 Dec 2015 0727 EST

Drug Abuse Screen	Site/Specimen	08 Dec 2015 1408	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site/Specimen

URINE

08 Dec 2015 1408

Negative

Units

ng/mL

Ref Rng

Cutoff=250

A/P Written by AILOR, LYNNE P @ 14 Dec 2015 0729 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative, Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 14 Dec 2015 0729 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up in SARP.

Signed By AILOR, LYNNE P (Physician) @ 14 Dec 2015 0729

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Dec 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-22965935 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **08 Dec 2015 1515 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 08 Dec 2015 1545 EST**Drug Abuse Screen**

Drug Abuse Screen	Site/Specimen	01 Dec 2015 1413	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)

ETG/ETS, UA (250 Cut-Off)	Site/Specimen	01 Dec 2015 1413	Units	Ref Rng
Ethyl Glucuronide	URINE	Negative	ng/mL	Cutoff=250

A/P Written by AILOR, LYNNE P @ 08 Dec 2015 1546 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 08 Dec 2015 1547 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 08 Dec 2015 1547

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Dec 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22959749 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **08 Dec 2015 1155 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 11 Dec 2015 1309 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 08 Dec 2015 1155 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 08 Dec 2015 1236 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 08 Dec 2015 1155

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES, MICHAEL J @ 08 Dec 2015 1243 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 08 Dec 2015 1246 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group session from 1230 - 1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 11 Dec 2015 1310 EST**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #20 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group performed their check-in reporting changes since last group and thoughts, cravings or triggers; no group member admitted to drinking alcohol or abusing drugs since last seen at SARP. The group shared about challenging family relationship and the newness of holidays without alcohol.

Daniel shared that he believes he is making progress as he is slowly being able to communicate with others and is actually enjoying having others company. He states he continues to work on his personal projects developing software and at this point that continues to be his main priority. Daniel provided feedback to another member, stating he could relate to some of the issues he is confronting as he also faces similar circumstances when he thinks about his past with his father and how hard it is to let go and move forward.

Daniel appeared engaged and interested in the treatment process. He appeared engaged and was appropriate and active throughout the session. Daniel appeared quite for most of the group, but seemed to relate to another group member when talking about things that have happened in the past and how hard it is to let go at times. Daniel has no objective due from his ITP. He will continue with Continuing Care treatment and has Problem #5, Objective # 1 and 2 due 11 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 15 December 2015 at 1230 for group.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 11 Dec 2015 1311**Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 11 Dec 2015 1519**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Dec 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-22878128 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
 Patient Status: **Outpatient**

Date: **01 Dec 2015 1226 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 04 Dec 2015 0645 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment:Written by MAPLES,MICHAEL J @ 01 Dec 2015 1226 EST
 CC GROUP

Screening Written by MAPLES,MICHAEL J @ 01 Dec 2015 1253 EST

Reason For Appointment: Notes Entered by: MAPLES,MICHAEL J 01 Dec 2015 1226

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by MAPLES,MICHAEL J @ 01 Dec 2015 1253 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Comments: VITALS: LAUNGUAGE: ENGLISH
 CONTACT NUMBER: [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES,MICHAEL J @ 01 Dec 2015 1254 EST

1. Alcohol dependence, uncomplicated

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES,MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS,JAMES @ 04 Dec 2015 0645 EST

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: SEE ADD NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.

Note Written by REGIS,JAMES @ 04 Dec 2015 0647 EST

Continuing Care Group - Tuesday, 01 December 2015

Daniel arrived on time to his Continuing Care Group which was held on Tuesday the 1st of December 2015, from 1230-1400. This is Daniel's 19th of 26 scheduled sessions. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Daniel performed his check-in with the group members going over any triggers or cravings he may have had during the past week and holiday. Afterwards, Daniel said goodbye to a group member who was closing out of group today.

During Daniel's check-in, Daniel shared that he didn't do anything for Thanksgiving. Daniel said that he relaxed all weekend and was able to do a lot of programing on his new computer game. He stated that he was able to go out on a date with one of his female friends but that it was strictly platonic and amicable. He wrote that he was able to become "independent from romantic relationships" a something that he did this week as a positive step towards his recovery. He also wrote how he was able to relate in todays group with the act "revenge seeking" and it's importance at times.

Daniel seemed thoughtful and indifferent about his holiday weekend and up and coming week and events. He wrote that he attended only 1 AA meeting and that he still doesn't have an AA sponsor but that he is working on steps #3 & #4 of the AA 12 Step program while abstaining from alcohol. See "CCG PATIENT ATTENDANCE NOTE" in SARP Patient file for complete information. Daniel has Problem #5 Objectives #1 and #2 of his ITP due next week on the 11th of December 2015. Daniel will return for his next CC treatment group on the 8th of December 2015.

Daniel had no evidence of SI/HI/ATV during this encounter.

Secondary record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 04 Dec 2015 0648

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 04 Dec 2015 0809

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22825470 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **24 Nov 2015 1218 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 25 Nov 2015 1048 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 24 Nov 2015 1218 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 24 Nov 2015 1300 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 24 Nov 2015 1218

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 24 Nov 2015 1300 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LANGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

A/P Last Updated by MAPLES, MICHAEL J @ 24 Nov 2015 1304 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PROGRESS AND OVERALL SERVICE DELIVERED.

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 25 Nov 2015 1049 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group session. He is at session #16 of the scheduled 26 sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. All group members denied drinking or abusing drugs. Group members performed their check-in exercise and identified possible triggers or cravings for the upcoming long holiday weekend. Group also filled out "Types of Relapses Before Chemical Relapse" worksheet and shared their individual answers with the rest of the group.

Daniel shared that he had a trigger yesterday because his friend who he had planned on visiting over the Thanksgiving weekend cancelled on him at the last minute. He states that normally he would just get mad and start drinking, but instead used what he has learned in CBT and was able to fight off the urge to want to drink on impulse. He states that instead he went on a local date and pretty much forgot about the craving and focused on his game developing; reminding himself that staying local is a better option for him because he can get so much more done then going out of town.

Daniel appeared comfortable throughout today's session. He seemed active and willing to engage in discussion with group, sharing and providing feedback. Daniel has no objective due today. He will continue with Continuing Care treatment and has Problem #5, Objectives #1 and 2 from ITP due 11 December 2015. See Daniel "'Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 01 December 2015 for her next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 25 Nov 2015 1050**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 25 Nov 2015 1237

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

20 Nov 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-22796451 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **20 Nov 2015 1545 EST**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by AILOR, LYNNE P @ 23 Nov 2015 0720 EST

Drug Abuse Screen	Site/Specimen	17 Nov 2015 1405	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site/Specimen

URINE

17 Nov 2015 1405

Negative

Units

ng/mL

Ref Rng

Cutoff=250

A/P Written by AILOR, LYNNE P @ 23 Nov 2015 0722 EST

1. Alcohol dependence, uncomplicated: Labs were reviewed by undersigned provider per SARP protocol. Result of ETG/ETS was negative. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by AILOR, LYNNE P @ 23 Nov 2015 0723 EST**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 23 Nov 2015 0723

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22743789 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **17 Nov 2015 1326 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 20 Nov 2015 1251 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 17 Nov 2015 1326 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 17 Nov 2015 1344 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 17 Nov 2015 1326

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 17 Nov 2015 1344 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LANGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 17 Nov 2015 1345 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 17 Nov 2015 1348 EST**1. Alcohol abuse, uncomplicated**

Procedure(s): -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PROGRESS AND OVERALL SERVICE DELIVERED.

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF) NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 20 Nov 2015 1252 EST**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group session. He is at session #15 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 ? hours. The group shared updates since last group regarding triggers and cravings during their check-in exercise. Group completed "Positive Influence List" and "Negative Influence List" worksheets and shared their answers with the group. No group member admitted to drinking alcohol or abusing drugs since last seen at SARP. Each group member submitted a sample for testing.

Daniel shared that he has had a good week since his last visit to SARP. He states that he spent some time with friends from work and is looking forward to continue that trend. He also shared that this upcoming weekend he plans to visit a female friend that lives a couple hours from here and might spend the weekend with her. He states that she is also in recovery so drinking while out with her will not be an issue. Daniel identified both his mother and step dad as positive influences toward his recovery. He listed his dad as a positive influence and also had his step mom listed being both, positive and negative depending on what they talk about or her mood.

Daniel appeared appropriate and interested in the treatment process. He seemed active and appropriate throughout today's session. Daniel has no objective due today. Daniel will continue with Continuing Care treatment and has Problem #5, Objective #1 and 2 due 11 December 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return 24 November 2015 at 1230 for group.

No evidence of SI/Hi during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 20 Nov 2015 1252**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 20 Nov 2015 1520

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22680652 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **12 Nov 2015 0756 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **FTR**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 12 Nov 2015 0759 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)(PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 12 Nov 2015 0756 EST
 INDIVIDUAL SESSION

Screening Written by MAPLES, MICHAEL J @ 12 Nov 2015 0757 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 12 Nov 2015 0756

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

INDIVIDUAL SESSION**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by MAPLES,MICHAEL J @ 12 Nov 2015 0757 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LAUNGUAGE: ENGLISH

CONTACT NUMBER: [REDACTED]

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES,MICHAEL J @ 12 Nov 2015 0757 EST**History of present illness**

The Patient is a 30 year old male.

THE PATIENT ATTENDED AN INDIVIDUAL SESSION FROM 0800-0900.

A/P Last Updated by MAPLES,MICHAEL J @ 12 Nov 2015 0759 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - THE PATIENT ATTENDED GROUP SESSION FROM 0800-0900

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 13 Nov 2015 1411 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his monthly individual appointment with this counselor, dressed appropriately in casual civilian attire. Daniel opened by stating that he is doing well and feeling more comfortable in the group setting than he did a few months ago prior to him having to go TAD for school. He also reports that he is seeing his therapist is putting an honest effort on working on his issues, rather than overlooking them.

Daniel shared that he is feeling good and accomplished after having accepted an invite from a male co-worker to attend a BBQ gathering this week. He states that he actually had a good time at the gathering and even met new people who he had conversations with. Daniel admits that it was not easy and at certain points he would wonder if he was being appropriate or too weird, but would then forget about it and just enjoyed most of the evening.

Daniel update his treatment plan by adding 4 more problems to his Master Problems List. He also states that at this time he is unable to complete Problem 1, Objective 7 as he is not comfortable approaching men and being open with them, something he states he is currently working on with his therapist. Daniel and this counselor have agreed to delay Problem 1, Objective 7 until 04 January 2016 and will revisit at that time. Daniel is scheduled to return for his next group session on 17 November 2015 @ 1230Hrs. He has Problem 5, Objectives 1 and 2 due 11 December 2015.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1412**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 13 Nov 2015 1445

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22671984 Primary Dx: Alcohol abuse, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **10 Nov 2015 1300 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1356 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 10 Nov 2015 1300 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 10 Nov 2015 1302 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 10 Nov 2015 1300

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 10 Nov 2015 1302 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LAUNGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 10 Nov 2015 1303 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 10 Nov 2015 1326 EST**1. Alcohol abuse, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #14 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group opened today by welcoming one new member to the group, performing individual introductions and going over group rules. Group also performed their weekly check-in exercise, reporting any current struggles, cravings or triggers that they might have suffered since their last visit.

Daniel shared that he is attending AA again and is currently working on steps 3 and 4 with his home group. He states that he is also trying to overcome his inability to hang-out with other males and will try to attend a BBQ gathering with guys from work. He states that he is often invited to gatherings by his male peers, but normally does not attend as he has always preferred to spend time with women, rather than with men.

Daniel appeared active and comfortable throughout today's group session. He seemed at ease sharing what his goals are and what he is trying to do, without hesitating if anyone was judging him or bothering himself about what anyone else was thinking of him. Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015 and has scheduled an individual appointment on 12 November 2015 with this counselor to update his treatment plan. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 17 November 2015 for his next scheduled group session.

No evidence of SI/Hi during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1401**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 13 Nov 2015 1410**CHANGE HISTORY****The following Disposition Note Was Overwritten by** GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST:

The Disposition section was last updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1357 EST.

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Tiffany arrived on time and is at session #13 of the 40 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group opened today by welcoming one new member to the group, performing individual introductions and going over group rules. Group also performed their weekly check-in exercise, reporting any current struggles, cravings or triggers that they might have suffered since their last visit.

Tiffany shared that she continues to battle her struggles and is doing all the things that are asked of her by her sponsor and other AA members to help her stay sober each day. She reports that this coming weekend she has signed up along with a few of her acquaintances to attend a "Gratitude breakfast" and also a "Step study" group. She also engaged with another member who is having family issues and offered her support, stating she was proud of him for handling his current situation without resorting to drinking. Tiffany report she is feeling better overall and although still feeling lonely at times, it is not as intense as it has been in the past.

Tiffany appeared comfortable and active throughout today's group session. She seemed to care about another group member's current struggles with family issues and offered

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

her support and wished well.

Tiffany has no objective due today. She has Problem #1, Objectives 5, 7 and 8 due 18 December 2015. See Tiffany "Continuing Care Progress Report" for more information on this encounter. Tiffany is scheduled to return on 17 November 2015 for her next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 13 Nov 2015 1400 EST:

Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 13 Nov 2015 1357

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

09 Nov 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-22649915 Primary Dx: Parageusia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **09 Nov 2015 1045 EST**
 Clinic: **INT MED MEDICAL HOME CL C**
BE

Appt Type: **FTR**
 Provider: **AUSTIN, MARIE**

Reason for Appointment:

lost taste

Appointment Comments:

clm

Vitals**Vitals** Written by TRAN,CAT D @ 09 Nov 2015 1056 EST

BP: 113/78, HR: 69, RR: 18, T: 97.6 °F, HT: 69 in, WT: 167 lbs, SpO₂: 98%, BMI: 24.66,
 BSA: 1.913 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by TRAN,CAT D @ 09 Nov 2015 1057 EST**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 09 Nov 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN,MARIE @ 09 Nov 2015 1155 EST**Chief complaint**

The Chief Complaint is: Evaluating for ageusia.

History of present illness

The Patient is a 30 year old male.
 Autocited allergies verified.

PO1 is 30 y/o male - pt has weaned himself off the zoloft . Saw the psychiatrist and she is weaning him off more slowly . He had been c/o of insomnia - now no insomnia , and lost weight. He was at 125 of zoloft will on a slower taper .

Pt c/o loss of taste x1 month, particularly in detecting sweetness than any others senses. Pt claims the only current med taking is Zoloft. Since he had so many side effects will wait until he is off the zoloft and re- evaluate the taste issue .

General overall feeling /health - Very Good.

admission diagnosis of HPI [use for free text].

Patient reports that they are compliant with medications.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day- weaning off

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

AHLTA Problem List Updated. Date:11/2015.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** Otolaryngeal symptoms loss of taste for sugar. No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** Decreased appetite sugar taste bitter where as artificial sweeteners

. No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Uvula showed no abnormalities. ° Base of the tongue was normal. ° Tonsils showed no abnormalities.

Hypopharynx: ° Mucous membranes had no abnormalities. ° Had no swelling. ° Had no tenderness.

Test conclusions

Medication list was upated at the beginning of the visit.

A qualified individual compared the medication list against any orders, and resolved any discrepancies (if required).

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

A/P Written by AUSTIN,MARIE @ 09 Nov 2015 1155 EST**1. Parageusia** R43.2: Pt reports sugar is tasting bitter not sweet . Pt is waeing off zoloft with + side effects due to not tapering . In addition pt takes daily fluoride [water does have fluoride} will stop and wait until he is completely off the zoloft before we reassess .**Disposition Written by AUSTIN,MARIE @ 09 Nov 2015 1159 EST****Released w/o Limitations****Follow up:** as needed . - Comments: pt to continue to wean off zoloft nad stop fluroide

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: discussed the side effects of this current meds
 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 09 Nov 2015 1200

CHANGE HISTORY

The following S/O Note Was Overwritten by AUSTIN, MARIE @ 09 Nov 2015 1139 EST:

S/O Note Written by TRAN, CAT D @ 09 Nov 2015 1058 EST

Chief complaint

The Chief Complaint is: Evaluating for ageusia.

History of present illness

The Patient is a 30 year old male.

Pt c/o loss of taste x1 month, particularly in detecting sweetness than any others senses. Pt claims the only current med taking is Zoloft.

General overall feeling /health - Very Good.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History

ANNUAL QUESTIONS

Preferred language (written or spoken): ☒ English ☐ Other:

What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

03 Nov 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22586549 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **03 Nov 2015 1226 EST**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1258 EST**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 25 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY FOR 7 DAYS THEN DECREASE TO ONE HALF TABLET (12.5MG) BY MOUTH EVERY DAY #0 RF0	NR	04 Nov 2015
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 03 Nov 2015 1226 EST
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 03 Nov 2015 1228 EST

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 03 Nov 2015 1226

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by MAPLES,MICHAEL J @ 03 Nov 2015 1228 EST

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: VITALS: LAUNGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES,MICHAEL J @ 03 Nov 2015 1244 EST**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES,MICHAEL J @ 03 Nov 2015 1246 EST**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PRGRESS AND OVERALL SERVICE DELIVERED.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 06 Nov 2015 1419 EST**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments:

Daniel arrived on time and is at session #13 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group performed their weekly check-in, reporting their struggles, triggers and cravings. The group was challenged with a scaling question; on a scale from 1-10, 1 being the lowest, 10 being the highest, how dedicated are you to your recovery? The group shared post group feelings from last group after two members shared they suffered a relapse.

Daniel shared that he has taken positive steps since sharing about his relapse during the previous group. He states he attended AA this past week is trying to be more active in managing his anxiety and working with his psychologist. He admitted that at times he does not do or use all the tools he has learned since starting treatment to help him in his sobriety, but last week was a reminder for him and is looking forward to continue in a positive light.

Daniel appeared relaxed and attentive during today's group session. He seemed to connect with the group and provided feedback. He also seemed receptive to what others shared and feedback that was provided. Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015. Daniel will be asked to setup an individual appointment with his counselor to address treatment planning and updating. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 09 November 2015 for his next scheduled group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 06 Nov 2015 1419**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 06 Nov 2015 1422**CHANGE HISTORY****The following Disposition Note Was Overwritten by** GONZALEZZARAZUA,JORGE A @ 06 Nov 2015 1419 EST:

The Disposition section was last updated by GONZALEZZARAZUA,JORGE A @ 06 Nov 2015 1419 EST - see above. Previous Version of Disposition section was entered/updated by GONZALEZZARAZUA,JORGE A @ 06 Nov 2015 1258 EST.

Released w/o Limitations**Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #13 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ? hours. The group performed their weekly check-in, reporting their struggles, triggers and cravings. The group was challenged with a scaling question; on a scale from 1-10, 1 being the lowest, 10 being the highest, how dedicated are you to your recovery? The group shared post group feelings from last group after two members shared they suffered a relapse.

Daniel shared that he has taken positive steps since sharing about his relapse during the previous group. He states he attended AA this past week is trying to be more active in managing his anxiety and working with his psychologist. He admitted that at times he does not do or use all the tools he has learned since starting treatment to help him in his sobriety, but last week was a reminder for him and is looking forward to continue in a positive light.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Daniel appeared relaxed and attentive during today's group session. He seemed to connect with the group and provided feedback. He also seemed receptive to what others shared and feedback that was provided. Daniel has Problem #1, Objective #7 of his ITP overdue 20 Oct 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel will continue with Continuing Care treatment and is scheduled to return on 09 November 2015 for his next scheduled group session.

No evidence of SI/HI during this encounter.
Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GONZALEZZARAZUA, JORGE A @ 06 Nov 2015 1416 EST:
Signed GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 06 Nov 2015 1259

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

03 Nov 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-22583769 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **03 Nov 2015 1030 EST**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **ZEMBRZUSKA,HANNA**
DOMINIKA

AutoCites Refreshed by ZEMBRZUSKA,HANNA DOMINIKA @ 03 Nov 2015 1620 EST**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

No Labs Found.

Rads

No Rads Found.

Reason for Appointment:

est

Appointment Comments:

ddr

Vitals**Vitals** Written by NEFF,JOANNE S @ 03 Nov 2015 1042 EST

BP: 125/73, HR: 76, RR: 12, T: 97.2 °F, Pain Scale: 0 Pain Free

S/O Note Written by ZEMBRZUSKA,HANNA DOMINIKA @ 06 Nov 2015 1312 EST**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt ran out of Zoloft and so for the past 2 weeks he has been off of it. Since Zoloft was discontinued pt has been struggling with some mild withdrawal symptoms, but hypersomnia has resolved. He no longer needs to naps for 30-45 min about three times per day. He is sleeping 6-7 hours per night with Melatonin. He feels much more productive and has lost weight. He is running 25-30 miles per week and is using CBT skills to combat anxiety. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts. Re-enlistment ceremony was on 16OCT and his family came.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

- limited impact of these visits.
- * MEDS: Denies other medication trials
 - * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
 - * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Alcohol use Drank one glass of wine recently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic Able to smile appropriately. ° Not depressed. ° Not anxious.

Affect: ° Normal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Suicidal ideation/plans/intent:N
 Access to Lethal Means:N
 Poor Treatment Compliance:N
 Hopelessness:?
 Psychic Pain/Anxiety:Y
 Acute Event:N
 Insomnia:N
 Low Self-Worth:Y
 Impulsivity:N
 Substance Abuse:Y
 Financial Stress:Y, PAYING OFF DEBT
 Legal Stress:N

Protective:

Strong Therapeutic Alliance:Y
 Positive Coping Skills:Y
 Responsible to/for Family:Y
 Responsible to/for Pet:N
 Frustration Tolerance:Y
 Resilience:Y
 Good Reality Testing:Y
 Amenable to Treatment:Y
 Social Support:Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

☒ [X] Released without limitations. Advised of emergency procedures.
☐ [] SM released to Chain of Command with the following limitations:
☐ [] SM sent to ER for evaluation for admission to inpatient psychiatry
☐ [] Other:

Therapy

- Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist:TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 11/3/2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u 17DEC at 1400

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, depressed mood, irritability

-

Interventions:

- 1.Restart Zoloft at 25mg daily to help with withdrawal symptoms. After 7-14 days if pt is doing well decrease Zoloft to 12.5mg daily and then taper off. Discussed r/b/se. Obtained informed consent for medication.
2. Continue SARP. Advised pt to attend an AA or SMART-recovery meeting if he experiences cravings for alcohol or begins to have thoughts of using alcohol to cope with anxiety related to work.
3. Referred pt for individual CBT.

Objective 2 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 03 Nov 2015 1621 EST

1. Generalized anxiety disorder F41.1

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 06 Nov 2015 1321 EST

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 17DEC at 1400

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 06 Nov 2015 1322

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Oct 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-22501132 Primary Dx: Alcohol dependence, uncomplicated

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **27 Oct 2015 1245 EDT**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 30 Oct 2015 1104 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE	Active		NR	05 Oct 2015
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015

Reason for Appointment: Written by MAPLES, MICHAEL J @ 27 Oct 2015 1245 EDT
 CC GROUP

Screening Written by MAPLES, MICHAEL J @ 27 Oct 2015 1300 EDT

Reason For Appointment: Notes Entered by: MAPLES, MICHAEL J 27 Oct 2015 1245

 CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug Abuse/Dependence (Follow-Up) ;

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by MAPLES, MICHAEL J @ 27 Oct 2015 1301 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: LANGUAGE: ENGLISH

CONTACT NUMBER: 850-969-7239

NO VITALS TAKEN AT SARP TREATMENT

S/O Note Written by MAPLES, MICHAEL J @ 27 Oct 2015 1303 EDT**History of present illness**

The Patient is a 30 year old male.

THE PT ATTENDED THE OUTPATIENT CONTINUING CARE TREATMENT PROGRAM (CC).

A/P Last Updated by MAPLES, MICHAEL J @ 27 Oct 2015 1304 EDT**1. Alcohol dependence, uncomplicated**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - THE PATIENT ATTENDED GROUP SESSION FROM 1230-1400

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - CONDUCTED CASE MANAGEMENT TO REVIEW AND UPDATE THE OVERALL SARP CLINICAL RECORD. IN ADDITION SERVICES TO HELP ASSIST THE PT AND TO MONITOR TREATMENT PROGRESS AND OVERALL SERVICE DELIVERED.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF)NAVY (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: MAPLES, MICHAEL J Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by GONZALEZZARAZUA, JORGE A @ 30 Oct 2015 1206 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: SEE ADD/NOTE SECTION FOR MORE INFORMATION ON THIS ENCOUNTER.**Note** Written by GONZALEZZARAZUA, JORGE A @ 30 Oct 2015 1206 EDT

Daniel arrived on time and is at session #12 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230-1400, total of 1 ½ hours. The group processed one member's recent relapse, which sparked another member to admit to a relapse. Several group members provided

feedback and reported being envious that the two replaces got to drink and voiced disappointment. No other group members admitted to drinking alcohol or abusing drugs since last seen at SARP. The group was reminded that they are here at SARP for treatment of alcohol/drugs.

Daniel opened group today and revealed that he relapsed. He shared that while out with some friends at a steak house he was offered a glass of wine and he decided to accept without hesitation. He states to have drunk two glasses of red wine with his dinner. Daniel reports that although he knows that he is not allowed to drink while in the program, he chose to do so without real regard to what could happen. When confronted by two counselors as why he decided to drink, Daniel stated he just wanted to and felt as if it should be ok for him to have a couple glasses of wine if he wanted to. Daniel also brought up that he initially self-referred himself for other underlying reasons and not specifically because he thought he had an issue with alcoholism. After hearing from a member who also suffered a relapse in the past week, Daniel shared that there were some underlying reasons as to why he decided to drink. He stated that he was upset because he had family over for his re-enlistment the past week and his father decided to not come. He states that his relationship with his father still affects him to this

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

date and believes that the stress of having everyone around and his father being the one person to not show led him to drink.

Daniel appeared comfortable in today's group, sharing and giving feedback to other members. He seemed to lack any remorse or guilt about why he chose to drink and at points appeared to defend his decision. Daniel seems to not trust the group, stating the dynamics have changed since he first started and not feeling comfortable. A SARP staffing will be scheduled for Daniel and his case will be re-evaluated for treatment update. Daniel has an outdated treatment plan and will be scheduled for an individual appointment following the findings of his SARP staffing for treatment planning and updating. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is scheduled to return on 03 November 2015 for his next group session.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By **GONZALEZZARAZUA, JORGE A** (PARAPROFESSIONAL) @ 30 Oct 2015 1207

Co-Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 30 Oct 2015 1514

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Oct 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-22215056 Primary Dx: Generalized anxiety disorder

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **01 Oct 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **ZEMBRZUSKA, HANNA
 DOMINIKA**

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 01 Oct 2015 1308 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs**29 Sep 2015 1730****Varicella Zoster Virus DFA**

Varicella Zoster Virus Ag

Site Specimen

SKIN

Result

no vz antigen detected <i>

Units**Ref Range****15 Sep 2015 1400****ETG/ETS, UA (500 Cut-Off)**

Ethyl Glucuronide

Site Specimen

URINE

Result

negative

Units

ng/mL

Ref Range

Cutoff=500

15 Sep 2015 1400**Drug Abuse Screen**

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Opiates

Phencyclidine, UA

Cannabinoids

Methadone

Oxycodone

Site Specimen

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

URINE

Result

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

negative <i>

Units

ng/mL

Ref Range

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Negative)

(Not-Detected)

(Negative)

08 Sep 2015 0817**HSV 1 & 2 Abs Indirect Panel**

Herpes Simplex Virus 1 Ab IgM

Herpes Simplex Virus 2 Ab IgM

Site Specimen

SERUM

SERUM

Result

<1:10

<1:10 <i>

Units

Titer units

Titer units

Ref Range

<1:10

<1:10

08 Sep 2015 0817**Chlamydia+Gonococcus DNA Panel NAAT Site Specimen**

Neisseria gonorrhoeae DNA

Chlamydia trachomatis DNA

URINE

URINE

Result

negative for n.gonorrhoeae <i>

negative for c.trachomatis <i>

Units**Ref Range**

(Negative)

08 Sep 2015 0817**Herpes Simplex Virus 1+2 Ab IgG**

Herpes Simplex Virus 1 Ab IgG

Herpes Simplex Virus 2 Ab IgG

Site Specimen

SERUM

SERUM

Result

<0.91 <i>

<0.91 <i>

Units

Index

Index

Ref Range

0.00-0.90

0.00-0.90

08 Sep 2015 0817**Rapid Plasma Reagin**

Reagin Ab

Site Specimen

SERUM

Result

nonreactive <i>

Units**Ref Range**

(Non-Reactive)

08 Sep 2015 0817**HIV Rapid**

HIV-1 Ab Rapid

Microbiology Results**Herpes Virus DFA****Site Specimen**

BLOOD

Result

Units**Ref Range**

(Negative)

Order #

Filler #

Status:

Ordering Provider:

150929-09137 (NNMC Bethesda)

150929 NVI 2333 (NNMC Bethesda)

Final

CUNNINGHAM, RACHEL ELIZABETH

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Priority: ROUTINE
 Date Ordered: 29 Sep 2015 1032
 Date Resulted: 30 Sep 2015 0954
 COLLECT_SAMPLE: LESION/WOUND

VIROLOGY RESULT: NEGATIVE DIRECT FLUORESCENT ANTIBODY FOR: HSV

Specimen: Wound
 Collected: 29 Sep 2015 1730

Results: Final report

Herpes Virus Culture

Order # 150909-02160 (NNMC Bethesda)
 Filler # 150909 NVI 2193 (NNMC Bethesda)
 Status: Final
 Ordering Provider: FIACCO, NICHOLAS RYAN
 Priority: ROUTINE
 Date Ordered: 09 Sep 2015 0748
 Date Resulted: 14 Sep 2015 1210
 COLLECT_SAMPLE: OTHER SOURCE
 Order Comment: for specimen already in lab

VIROLOGY RESULT: NO HERPES SIMPLEX VIRUS ISOLATED.

Specimen: Groin, Left
 Collected: 08 Sep 2015 0819

Results: Final report

Rads

No Rads Found.

Reason for Appointment:

follow-up

Appointment Comments:

jc

VitalsVitals Written by ERICKSON,NANCY A @ 01 Oct 2015 1340 EDT

BP: 132/76, HR: 70, RR: 16, T: 97.8 °F

S/O Note Written by ZEMBRZUSKA,HANNA DOMINIKA @ 02 Oct 2015 1310 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt has been doing well on Zoloft 100mg daily, but has been experiencing anxiety related to work which causes him to think about using alcohol to cope. He has been struggling with hypersomnia rather than insomnia and attended a Sleep Pathways Group. He naps for 30-45 min about three times per day despite sleeping 5-6 hours per night. His PCM referred him to sleep clinic and he has an appt on 17NOV at 10:30AM. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts. Re-enlistment ceremony will be on 16OCT and his family is coming. Pt will be on leave 12-23OCT in the local area.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Zolof 100mg daily
 Melatonin for insomnia.

Past medical/surgical history**Reported:**

- Recent Events: Medication compliance.
 Medical: Reported medical history Penile warts (HPV)
 Neurotic excoriation (scalp picking when anxious)
 Asthma during childhood
 Allergic response to pets
 Recurrent intestinal pain (possibly lactose intolerance)
 PRK (2011)
 and psychiatric history
- * THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.
 - * MEDS: Denies other medication trials
 - * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
 - * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself unable to experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Alcohol use Has drank a few beers recently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms
 No current cognitive symptoms
 No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Merwin, Daniel Dennis

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Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic Able to smile appropriately. ° Not depressed. ° Not anxious.

Affect: ° Normal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N

Access to Lethal Means: N

Poor Treatment Compliance: N

Hopelessness: ?

Psychic Pain/Anxiety: Y

Acute Event: N

Insomnia: N

Low Self-Worth: Y

Impulsivity: N

Substance Abuse: Y

Financial Stress: Y, PAYING OFF DEBT

Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y

Positive Coping Skills: Y

Responsible to/for Family: Y

Responsible to/for Pet: N

Frustration Tolerance: Y

Resilience: Y

Good Reality Testing: Y

Amenable to Treatment: Y

Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

[X] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other:

Therapy

• Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Treatment Team Members -

Individual Therapist: SARP

Medication Prescriber: ZEMBRZUSKA

Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 10/1/2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 4 weeks

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft to 150mg daily. Discussed r/b/se. Obtained informed consent for medication.

2. Continue SARP. Advised pt to attend an AA or SMART-recovery meeting if he experiences cravings for alcohol or begins to have thoughts of using alcohol to cope with anxiety related to work.

3. Referred pt for individual CBT.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft to 150mg daily. Discussed r/b/se. Obtained informed consent for medication.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia

2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 01 Oct 2015 1309 EDT

1. Generalized anxiety disorder F41.1

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 02 Oct 2015 1319 EDT

Released w/o Limitations

Follow up: 4 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 02 Oct 2015 1320

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by CUNNINGHAM, RACHEL E

Encounter ID: BETH-22196001 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Sep 2015 1027 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **T-CON***
 Provider: **CUNNINGHAM,RACHEL ELIZABETH**
 Call Back Phone: [REDACTED]

AutoCites Refreshed by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1028 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL	Active	APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3	3 of 3	29 Sep 2015
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015
BENZONATATE, 100 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #0 RF0	NR	28 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015

Reason for Telephone Consult: Written by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1027 EDT
 lab

Lab Result Cited by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT**Herpes Virus DFA**

Order # 150929-09137 (NNMC Bethesda)
 Filler # 150929 NVI 2333 (NNMC Bethesda)
 Status: Final
 Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH
 Priority: ROUTINE
 Date Ordered: 29 Sep 2015 1032
 Date Resulted: 30 Sep 2015 0954
 COLLECT_SAMPLE: LESION/WOUND

VIROLOGY RESULT: NEGATIVE DIRECT FLUORESCENT ANTIBODY FOR: HSV

Specimen: Wound
 Collected: 29 Sep 2015 1730

Results: Final report

Lab Result Cited by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT**Varicella Zoster Virus DFA**

Varicella Zoster Virus Ag

Site/Specimen
 SKIN

29 Sep 2015 1730

NO VZ ANTIGEN DETECTED <i>

A/P Written by CUNNINGHAM,RACHEL E @ 30 Sep 2015 1037 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

1. Visit for: administrative purpose: DFA negative for HSV1/2 and VZV, confirming previous testing negative for herpetic infection. STD testing in previous month also negative, at this time etiology for ulcerations does not reveal any infectious etiology. Will recommend patient to stop any topical irritant for treatment of molluscum as not demonstrated on clinical exam. Follow up with PCM for repeat exam in 2-3 weeks if new ulcerations or erosions present. If resolving then continue with gentle skin care recommended today. May be due to irritant from aldera used for HPV condyloma. Consider retesting RPR for false negative as syphilitic chancre may still be in differential. If new primary lesions occurring PCM to send back to derm for potential biopsy.

Disposition Written by CUNNINGHAM, RACHEL E @ 30 Sep 2015 1037 EDT

Follow up: 2 week(s) with PCM or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By CUNNINGHAM, RACHEL E (Physician) @ 30 Sep 2015 1037

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA

Encounter ID: BETH-22183712 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**Date: **29 Sep 2015 1315 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **MANTANONALEE,CHRISTY LIA**Patient Status: **Outpatient****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1530 EDT

Drug Abuse Screen	Site/Specimen	15 Sep 2015 1400
Amphetamines	URINE	NEGATIVE <i>
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine, UA	URINE	NEGATIVE <i>
Cannabinoids	URINE	NEGATIVE <i>
Methadone	URINE	NEGATIVE <i>
Oxycodone	URINE	NEGATIVE <i>

ETG/ETS, UA (500 Cut-Off)	Site/Specimen	15 Sep 2015 1400
Ethyl Glucuronide	URINE	Negative

A/P Written by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1532 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. ETG/ETS was negative. Drug Abuse Screen was negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

Disposition Written by MANTANONALEE,CHRISTY LIA @ 29 Sep 2015 1533 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: FOLLOW UP WITH SARP AS SCHEDULED**Signed By** MANTANONALEE, CHRISTY LIA (Physician) @ 29 Sep 2015 1533

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Sep 2015 at WRNMMC, Dermatology Clinic Bethesda by MARQUART, JASON DANIEL

Encounter ID: BETH-22176596 Primary Dx: SKIN NEOPLASM GROIN

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **29 Sep 2015 1000 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **MARQUART, JASON DANIEL**

AutoCites Refreshed by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1031 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
GUAIFENESIN, 600 MG, TABLET ER, ORAL	Active	TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0	NR	28 Sep 2015
Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA	Active	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3	3 of 3	28 Sep 2015
BENZONATATE, 100 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #0 RF0	NR	28 Sep 2015
Imiquimod 5%, Cream, Topical	Active	APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS #0 RF3	3 of 3	28 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015

Reason for Appointment:

MOLLUSCUM CONTAGIOSUM

Appointment Comments:

LCR

S/O Note Written by CUNNINGHAM, RACHEL ELIZABETH @ 29 Sep 2015 1037 EDT**Chief complaint**

The Chief Complaint is: Rash.

Reason for Visit

Visit for: STAFFED WITH DR. [] HANDFIELD [] GRATRAX [] GREEN [] LACKEY [] KENTOSH [x] MARQUART [] MEYERLE [] STEARNS [] SPERLING [] DARLING

30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, STD workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses alda on them but has not been using it on the areas in question. Partner currently does not have any STD or similar rash. Uses condoms. Has recently had bronchitis with subjective fevers which began before the papules appeared. HIV testing recently negative.

History of present illness

The Patient is a 30 year old male.

He reported: Past medical history reviewed and updated dermatology problem list.

No previous history of skin symptoms. Rash:

Visit is not deployment-related.

Past medical/surgical history

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Reported:

Surgical / Procedural: Surgical / procedural history reviewed and updated in patient's Problem List.

Medications: Medication history was reviewed and updated in patient medication list as needed.

Diagnoses:

- No eczema
- No psoriasis.
- No malignant skin neoplasm
- No basal cell carcinoma of the skin
- No squamous cell carcinoma of the skin.
- No malignant melanoma of the skin

Personal history

Behavioral: No tobacco use.

Alcohol: No consumption of alcohol.

Family history

Family medical history: Reviewed in Problem List.

Review of systems**Systemic:** No systemic symptoms and no night sweats.**Skin:** Skin scaling.**Physical findings****General Appearance:**

- General appearance: ° Alert.

Neurological:

- ° Oriented to time, place, and person.
- Speech: ° Normal.

Skin:

- Multiple skin lesions. • Lesions located. • Lesions on the scalp Vertex scalp with short vellus hairs, mild boggy skin of scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp. • Perineal lesions. • Lesions in the inguinal region Punched out erythematous eroded papules on L and R groin without papules on the penis or scrotum on exam.
- Lesions on the right side of the groin. • Lesions on the left side of the groin. ° General appearance was normal.
- ° Mobile. ° Texture was normal. ° Turgor was normal. ° Color and pigmentation were normal. ° Moisture was normal.
- ° Temperature was normal. ° No lesions on the ear. ° No lesions on the face. ° No lesions on the neck. ° No lesions on the upper extremities. ° No lesions on the scrotum. ° No lesions on the penile shaft. ° No lesions on the buttocks. ° No lesions on the lower extremities.

Hair:

- Quantity and distribution were abnormal.

Nails:

- ° Normal.

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**HIV Rapid**

HIV-1 Ab Rapid

Site/Specimen

BLOOD

08 Sep 2015 0817

NEGATIVE-ONBOARD QC ACCEPTED <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**Rapid Plasma Reagin**

Reagin Ab

Site/Specimen

SERUM

08 Sep 2015 0817

NONREACTIVE <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**Chlamydia+Gonococcus DNA Panel NAAT**

Neisseria gonorrhoeae DNA

URINE

08 Sep 2015 0817

NEGATIVE FOR N.GONORRHOEAE <i>

Chlamydia trachomatis DNA

URINE

NEGATIVE FOR C.TRACHOMATIS <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**Herpes Simplex Virus 1+2 Ab IgG**

Herpes Simplex Virus 1 Ab IgG

Site/Specimen

SERUM

08 Sep 2015 0817

<0.91 <i>

Herpes Simplex Virus 2 Ab IgG

SERUM

<0.91 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT**HSV 1 & 2 Abs Indirect Panel**

Herpes Simplex Virus 1 Ab IgM

Site/Specimen

SERUM

08 Sep 2015 0817

<1:10

Herpes Simplex Virus 2 Ab IgM

SERUM

<1:10 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT**Herpes Virus Culture**

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Order # 150909-02160 (NNMC Bethesda)
 Filler # 150909 NVI 2193 (NNMC Bethesda)
 Status: Final
 Ordering Provider: FIACCO, NICHOLAS RYAN
 Priority: ROUTINE
 Date Ordered: 09 Sep 2015 0748
 Date Resulted: 14 Sep 2015 1210
 COLLECT_SAMPLE: OTHER SOURCE
 Order Comment: for specimen already in lab

VIROLOGY RESULT: NO HERPES SIMPLEX VIRUS ISOLATED.

Specimen: Groin, Left
 Collected: 08 Sep 2015 0819

Results: Final report

A/P Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT

1. SKIN NEOPLASM GROIN: Given punched out erosions on groin hx of multiple sexual partners, will get DFA today to rule out HSV infection. Previous tests showed non acute phase of HSV (IgG positive, IgM negative). Has had course of valtrex 500 twice daily for 10 days 1 month ago but did not resolve, may not have been correct treatment or may represent atypical presentation of another herpetic infection. Rest of STD workup negative.

Laboratory(ies): -HERPES DFA ~ (Routine) Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH; VARICELLA DFA (Routine) Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo.

Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

Disposition Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT**Released w/o Limitations****Follow up:** as needed in the DERMATOLO CL BE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by RANDOLPH,CANDICE M @ 29 Sep 2015 0955 EDT**Consult Order****Referring Provider:** AUSTIN, MARIE R**Date of Request:** 28 Sep 2015**Priority:** Routine**Provisional Diagnosis:**

MOLLUSCUM CONTAGIOSUM

Reason for Request:

Pt was worked up for herpes and it was negative suspect active molluscum contagiosum please evla and treat confirm DX I am going to start alidara

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT**Additional A/P Information:**

Discontinued IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT**Additional A/P Information:**

Discontinued IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS

Note Written by MARQUART,JASON DANIEL @ 29 Sep 2015 1132 EDT

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service) @ 29 Sep 2015 1132

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Sep 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-22165018 Primary Dx: MOLLUSCUM CONTAGIOSUM

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **28 Sep 2015 1045 EDT**
 Clinic: **INT MED MEDICAL HOME CL C**
BE

Appt Type: **24HR**
 Provider: **AUSTIN, MARIE**

Reason for Appointment:

Followup, Genital Warts / Herpes and Bronchitis

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by TRAN,CAT D @ 28 Sep 2015 1035 EDT

BP: 122/87, HR: 79, RR: 16, T: 97.8 °F, HT: 69 in, WT: 165 lbs, SpO₂: 97%, BMI: 24.37,
 BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by TRAN,CAT D @ 28 Sep 2015 1051 EDT**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 28 Sep 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: More than half the days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN,MARIE @ 28 Sep 2015 1205 EDT**Chief complaint**

The Chief Complaint is: Bronchitis & Re-evaluate STD.

History of present illness

The Patient is a 30 year old male.

Pt reported that he came to BAZC on 18Aug2015 to evaluate Bronchitis and Herpes. He states his lab tests came back negative for all speculated STDs, but warts remain on his left genital area.

Pt states that he went to Occ Health, in Fort Meade, apprx 1 week ago to evaluate his bronchitis and he received Mucinex and Zpack but the bronchitis remains. Continues to cough, he is taking his albuterol and ran out of mucinex. He does not have a cough medicine.

General overall feeling /health - Very Good.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

History**ANNUAL QUESTIONS**Preferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever. Chills. No recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache. Nasal discharge and nasal passage blockage (stuffiness). No sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** Dyspnea controlled on albuterol and cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Skin:** Skin lesion:**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Nose:

General/bilateral:

Discharge: • Nasal discharge seen.

External Deformities: ° No external nose deformities.

Cavity: • Nasal turbinate erythematous. • Nasal turbinate swollen. ° Nasal septum normal. ° Nasal mucosa normal.

Sinus Tenderness: ° No sinus tenderness.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DoD ID: 1286180538

Created: 16 Aug 2017

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: • Abnormal cobblestone red, no papules or pustules . No drainage. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Neurological:

° Oriented to time, place, and person.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

• Skin: folliculitis barbae on the lower abd where he shaved. • Lesions on the left thigh , circular 0.02 cm lesions with indwelling centers . Molluscum contagiosum.

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Lab Result Cited by AUSTIN,MARIE @ 28 Sep 2015 1142 EDT

HIV Rapid	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
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Herpes Virus Culture

Order #	150909-02160 (NNMC Bethesda)
Filler #	150909 NVI 2193 (NNMC Bethesda)
Status:	Final
Ordering Provider:	FIACCO, NICHOLAS RYAN
Priority:	ROUTINE
Date Ordered:	09 Sep 2015 0748
Date Resulted:	14 Sep 2015 1210
COLLECT_SAMPLE:	OTHER SOURCE
Order Comment:	for specimen already in lab
VIROLOGY RESULT:	NO HERPES SIMPLEX VIRUS ISOLATED.
Specimen:	Groin, Left
Collected:	08 Sep 2015 0819

Lab Result Cited by AUSTIN,MARIE @ 28 Sep 2015 1141 EDT

HSV 1 & 2 Abs Indirect Panel	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Herpes Simplex Virus 1 Ab IgM	SERUM	<1:10	Titer units	<1:10
Herpes Simplex Virus 2 Ab IgM	SERUM	<1:10 <i>	Titer units	<1:10
Chlamydia+Gonococcus DNA Panel NAAT	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Neisseria gonorrhoeae DNA	URINE	NEGATIVE FOR N.GONORRHOEAE <i>		
Chlamydia trachomatis DNA	URINE	NEGATIVE FOR C.TRACHOMATIS <i>		(Negative)
Herpes Simplex Virus 1+2 Ab IgG	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Herpes Simplex Virus 1 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90
Herpes Simplex Virus 2 Ab IgG	SERUM	<0.91 <i>	Index	0.00-0.90
Rapid Plasma Reagin	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
Reagin Ab	SERUM	NONREACTIVE <i>		(Non-Reactive)
HIV Rapid	Site/Specimen	08 Sep 2015 0817	Units	Ref Rng
HIV-1 Ab Rapid	BLOOD	NEGATIVE-ONBOARD QC ACCEPTED <i>		(Negative)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Written by AUSTIN, MARIE @ 28 Sep 2015 1204 EDT**1. MOLLUSCUM CONTAGIOSUM** 078.0

Medication(s): -IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS #1 RF3

Consult(s): -Referred To: DERMATOLOGY MTF BE (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL BE Provisional Diagnosis: MOLLUSCUM CONTAGIOSUM

2. CHRONIC BRONCHITIS 491.9: Resolving, asthma as a child

Medication(s): -FLUTICASONE--PO 220MCG/PUFF MDI - INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #1 RF3

-BENZONATATE--PO 100MG CAP - TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #60 RF0

-GUAIFENESIN--PO 600MG TBSR - TAKE ONE TABLET BY MOUTH TWICE A DAY #90 RF0

Disposition Written by AUSTIN, MARIE @ 28 Sep 2015 1211 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: Pt to f/u as advised . USE condoms**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 28 Sep 2015 1211**CHANGE HISTORY***The following S/O Note Was Overwritten by AUSTIN, MARIE @ 28 Sep 2015 1137 EDT:**S/O Note Written by TRAN, CAT D @ 28 Sep 2015 1052 EDT***Chief complaint**

The Chief Complaint is: Bronchitis & Re-evaluate STD.

History of present illness

The Patient is a 30 year old male.

Pt came to BAZC on 18Aug2015 to evaluate Bronchitis and Herpes. He states his lab tests came back negative for all speculated STDs, but warts remain subsisted on his left genital area. Pt states that he went to Occ Health, in Fort Meade, apprx 1 week ago to evaluate his bronchitis and he received Mucinex.

General overall feeling /health - Very Good.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Behavioral: No tobacco use history.

Alcohol: Not using alcohol AUDIT-C Date:

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 28SEP2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-22126215 Primary Dx: Sleep disturbances

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **23 Sep 2015 1000 EDT**
 Clinic: **INTEGRATIVE HLTH & WELL BE**
 Provider: **JARRETT, ERICA M.**

Appt Type: **GRP**AutoCites Refreshed by JARRETT, ERICA M @ 23 Sep 2015 1551 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Sleep Pathways II

Appointment Comments:

coa

Questionnaire AutoCites Refreshed by JARRETT, ERICA M @ 23 Sep 2015 1551 EDT
Questionnaires

S/O Note Written by JARRETT, ERICA M. @ 23 Sep 2015 1551 EDT**Chief complaint**

The Chief Complaint is: Sleep pathways.

History of present illness

The Patient is a 30 year old male.

This is the patient's second visit to the IBHC clinic.

<<Note accomplished in TSWF-IBHC Group/Class tab>>

Pt attended the second of two Sleep Pathway Shared Medical Appointments.

The following topics were covered: sleep restriction, connections between anxiety/worry and insomnia; beliefs and attitudes that contribute to insomnia; worry management strategies; relaxation/imagery strategies; and relapse prevention.

Reviewed pt's sleep diary. Pt advised . Pt expressed understanding of these recommendations.

Sleep enhancement class, Getting a Good Night's Sleep, offered as part of Women's Health Week.

Discussed: Basics of sleep and treatment for insomnia: stimulus control, sleep hygiene, relaxation strategies, sleep restriction, beliefs and attitudes that contribute to insomnia, and worry management strategies. Provided handouts on the covered topics.

Practiced diaphragmatic breathing and provided a brief demonstration of progressive muscle relaxation. Provided information about the CBTi Coach application for smart phones which has a sleep diary and sleep enhancement tools. Reviewed audio downloads for relaxation on the WRNMMC Medical Home, IHWS, Mind-Body Skills Program website.

Recommendations: 1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

....

Group/Class Intervention

See above.

....

Counseling/Education

Group/Class recommendations for patient:

1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

Group/Class recommendations for PCM Team:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

☒ Reinforce recommendations for patient.☐ Consider medication for patient.☐ Other:

....

A/P Last updated by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT**1. Sleep disturbances**

Procedure(s): -Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 4

Disposition Last updated by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT**Released w/o Limitations**

Signed By JARRETT, ERICA M (Clinical Health Psychologist, NNMC Bethesda, MD) @ 23 Sep 2015 1553

CHANGE HISTORYThe following Disposition Note Was Overwritten by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT:

The Disposition section was last updated by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT - see above. Previous Version of Disposition section was entered/updated by NEKVASIL,ERIN K @ 23 Sep 2015 1332 EDT.

Released w/o LimitationsThe following A/P Note Was Overwritten by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT:

The A/P section was last updated by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT - see above. Previous Version of A/P section was entered/updated by NEKVASIL,ERIN K @ 23 Sep 2015 1331 EDT.

1. Sleep disturbances**--> Unassociated Orders, Procedures and Injuries/Accidents <--**

Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 1

The following S/O Note Was Overwritten by JARRETT,ERICA M @ 23 Sep 2015 1552 EDT:S/O Note Written by NEKVASIL,ERIN K @ 23 Sep 2015 1327 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-IBHC Group/Class tab>>

Pt attended the second of two Sleep Pathway Shared Medical Appointments.

The following topics were covered: sleep restriction, connections between anxiety/worry and insomnia; beliefs and attitudes that contribute to insomnia; worry management strategies; relaxation/imagery strategies; and relapse prevention.

Reviewed pt's sleep diary. Pt advised . Pt expressed understanding of these recommendations.

Sleep enhancement class, Getting a Good Night's Sleep, offered as part of Women's Health Week.

Discussed: Basics of sleep and treatment for insomnia: stimulus control, sleep hygiene, relaxation strategies, sleep restriction, beliefs and attitudes that contribute to insomnia, and worry management strategies. Provided handouts on the covered topics.

Practiced diaphragmatic breathing and provided a brief demonstration of progressive muscle relaxation. Provided information about the CBTi Coach application for smart phones which has a sleep diary and sleep enhancement tools. Reviewed audio downloads for relaxation on the WRNMMC Medical Home, IHWS, Mind-Body Skills Program website.

Recommendations: 1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

....

Group/Class Intervention

See above.

....

Counseling/Education

Group/Class recommendations for patient:

1) Limit nap times to less than 30 minutes X 1 and do not nap in the evening; 2) maintain consistent wake ups and bed times during the week/weekends. 3) Keep restricting caffeine use to before noon.

Group/Class recommendations for PCM Team:

☒ Reinforce recommendations for patient.☐ Consider medication for patient.☐ Other:

....

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Sep 2015 at WRNMMC, Behavioral Health Qu by MANTANONALEE, CHRISTY LIA

Encounter ID: BETH-22077716 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NHC QUANTICO**Date: **18 Sep 2015 1300 EDT**
Clinic: **BEHAVIORAL HEALTH QU**Appt Type: **PROC**
Provider: **MANTANONALEE,CHRISTY LIA**Patient Status: **Outpatient****Reason for Appointment:**

SARP/LABS

Appointment Comments:

TSB

Lab Result Cited by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1320 EDT

Drug Abuse Screen	Site/Specimen	15 Sep 2015 1400
Amphetamines	URINE	NEGATIVE <i>
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine, UA	URINE	NEGATIVE <i>
Cannabinoids	URINE	NEGATIVE <i>
Methadone	URINE	NEGATIVE <i>
Oxycodone	URINE	NEGATIVE <i>

A/P Written by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1321 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Drug Abuse Screen was negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I(OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition** Written by MANTANONALEE,CHRISTY LIA @ 18 Sep 2015 1322 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: FOLLOW UP WITH SARP AS SCHEDULED**Signed By** MANTANONALEE, CHRISTY LIA (Physician) @ 18 Sep 2015 1322

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

15 Sep 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-22034781 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **15 Sep 2015 1205 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 15 Sep 2015 1221 EDT

Problems

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
VALACYCLOVIR HCL, 500 MG, TABLET, ORAL	Active	TAKE 1 TABLET TWICE EVERY DAY FOR 10 DAYS #0 RF0	NR	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	08 Sep 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015

Reason for Appointment: Written by PATSOS,ASHLEY N @ 15 Sep 2015 1205 EDT
CC GROUP

Screening Written by PATSOS,ASHLEY N @ 15 Sep 2015 1206 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 15 Sep 2015 1205

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 15 Sep 2015 1206 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Comments: Language:English
 Contact #: 850-969-7239
 No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 Sep 2015 1207 EDT

History of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last updated by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (500 CUT-OFF) (Routine) Ordered By: BROWN,CYNTHIA E Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: BROWN,CYNTHIA E Ordering Provider: AILOR, LYNNE P

Disposition Written by BROWN,CYNTHIA E @ 16 Sep 2015 0711 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP URINE TEST
 Daniel arrived on time to group. Daniel is at session # 12 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. The group discussed "drunk dreams" and control issues. They also discussed how hard it is to be vulnerable. Daniel shared that he has been really sick with a cold. He did admit that he drank cough medicine with alcohol in it. This was revealed after he was told that he has a urine test today. He stated during group he took it Sunday but admitted that he took it yesterday. He shared how he is struggling with control issues. The girl that he is seeing now made him dinner and he was not appreciative but was more critical. The group encouraged him to respect what others do for him. As he spoke group members were seen as checking out by looking around the group and not at him. He monopolized only a few minutes of the group and cut off to allow the group to give feedback. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and overly active throughout the session. Daniel moved Problem #1, Objective #7 from his ITP to 20 October 2015. Daniel will continue with Continuing Care treatment and has Problem #1, Objective #7 due 20 October 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 20 October 2015 at 1230 for group. DANIEL WILL NOT BE IN GROUP FOR THE NEXT 4 WEEKS DUE TO LEAVE AND TRAINING.
 No evidence of SI/HI during this encounter
 Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 16 Sep 2015 0711

CHANGE HISTORY

The following A/P Note Was Overwritten by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT:

The A/P section was last updated by BROWN,CYNTHIA E @ 15 Sep 2015 1222 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS,ASHLEY N @ 15 Sep 2015 1208 EDT.

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

09 Sep 2015 at WRNMMC, Integrative Hlth & Well BE by CORSO, MEGHAN L

Encounter ID: BETH-22059314 Primary Dx: Lack of adequate sleep

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **09 Sep 2015 1000 EDT**Clinic: **INTEGRATIVE HLTH & WELL BE**Appt Type: **GRP**Provider: **CORSO, MEGHAN L**AutoCites Refreshed by CORSO, MEGHAN L @ 17 Sep 2015 0858 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

sleep pathway I

Appointment Comments:

skj

S/O Note Written by CORSO, MEGHAN L @ 17 Sep 2015 0858 EDT**History of present illness**

The Patient is a 30 year old male.

He reported: Encounter Background Information: Pt attended the first class of a two part series on sleep. This class opened with a basic discussion on sleep and the physiological effects of sleep deprivation. We also explored sleep disorders including sleep apnea and insomnia as well as treatment for both sleep apnea and insomnia. We covered topics such as: sleep hygiene, stimulus control, fight or flight response and relaxation techniques (deep breathing and PMR). Pt participated in a deep breathing exercise. Instructor also introduced the CBTi app and demonstrated how to use this app for relaxation exercises. Pt instructed to complete sleep diary (instructor walked through in detail) and the online questionnaire.

A/P Written by CORSO, MEGHAN L @ 17 Sep 2015 0859 EDT**1. Lack of adequate sleep:** Pt goals:

- 1) complete sleep questionnaire online
- 2) complete sleep diary using CBTi app or paper version
- 3) identify 3 areas of sleep habits and set SMART goal
- 4) attend class #2 in two weeks

Procedure(s): -Health And Behav Intervention, Each 15 Min Grp (2 Or More) x 3

Disposition Written by CORSO, MEGHAN L @ 17 Sep 2015 0859 EDT**Released w/o Limitations****Follow up:** as needed with PCM.Signed By CORSO, MEGHAN L (Licensed Clinical Psychologist, NNMC Bethesda) @ 17 Sep 2015 0900

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Sep 2015 at WRNMMC, Int Med Cons/Spec Care Cl Be by FIACCO, NICHOLAS RYAN

Encounter ID: BETH-21951516 Primary Dx: Penile lesion

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Sep 2015 0724 EDT**
 Clinic: **INT MED CONS/SPEC CARE CL**
BE

Appt Type: **24HR**
 Provider: **FIACCO, NICHOLAS RYAN**

Reason for Appointment: Written by HERNANDEZ, DARROCQUES D @ 08 Sep 2015 0724 EDT
 fever, swollen knee

Vitals**Vitals** Written by HERNANDEZ, DARROCQUES D @ 08 Sep 2015 0728 EDT

BP: 132/90, HR: 94, RR: 16, T: 97.8 °F, HT: 69 in, WT: 158 lbs, BMI: 23.33, BSA: 1.869 square meters,
 Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 4/10 Moderate, Pain Scale Comments: throat

S/O Note Written by FIACCO, NICHOLAS RYAN @ 09 Sep 2015 1615 EDT**History of present illness**

The Patient is a 30 year old male.

Patient is a 30 yo male with no significant PMH who presents to sick call for concern over STI. He reports having had 140 sexual partners in his lifetime - 6 since March of this year. He has been monogamous for the past month. He reports sex only with females. He developed a pustular rash and what he describes as ulcerations on his penis and left groin since Saturday. Reports subjective fever. The pustules on groin are tender and the lesions on penis are non tender. No urethral discharge or dysuria.

<<Note accomplished in TSWF-CORE>>

Fever.

Current medication

Including OTC meds, vitamins, herbals, etc.
 none.

Past medical/surgical history**Reported:**

Medical: Reported medical history
 none.

Personal history

Social history reviewed No alcohol - prior inpatient alcohol rehab. Denies tobacco.

Review of systems**Systemic:** Not feeling tired (fatigue). No chills, no night sweats, and no recent weight loss.**Otolaryngeal:** No earache and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Gastrointestinal:** No dysphagia and no heartburn. No nausea and no bright red blood per rectum.**Genitourinary:** No urinary loss of control and no testicular symptoms were present. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DoD ID: 1286180538

Created: 16 Aug 2017

Lungs:

- ° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.
- ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

- Heart Rate And Rhythm: ° Normal.
- Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.
- Murmurs: ° No murmurs were heard.

Urinary System:

- Urinary system: normal male genitalia, circumcized penis. two very superficial ulcerations/abrasions on underside of shaft. 3-6 erythematous macules that appear similar to ruptured vesicles, no intact vesicles.

Musculoskeletal System:

- Functional Exam:
- General/bilateral: ° Mobility was not limited.

Neurological:

- ° Oriented to time, place, and person.

Psychiatric:

- Mood: ° Euthymic.
- Affect: ° Normal.

Skin:

- Lesions. • A macule was seen.

Note Written by SALUJA, SHUCHI M @ 15 Sep 2015 0732 EDT

Discussed pt with Dr Fiacco, agree with a&p as documented. all labs and herpes culture negative at time of signing encounter

A/P Last Updated by FIACCO, NICHOLAS @ 09 Sep 2015 1628 EDT

1. Penile lesion: Concern is for STI and differential is broad. HIV, syphilis are possible. Given reprot of pustular lesions HSV is of concern. He may also just have irritated hair follicles. Counseled patient regarding safe sexual practices to include discretion regarding number of new partners. Will evaluate with HSV culture, HIV rapid, RPR, GC/Chlamydia, HSV IgG/IgM. Will treat empirically for HSV with valtrex twice daily x 10 days.

Medication(s):	-valACYclovir--PO 500MG TAB - TAKE 1 TABLET TWICE EVERY DAY FOR 10 DAYS #20 RFO Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN
Laboratory(ies):	-VIRAL IDENTIFICATION 6 (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; GC/CHLAMYDIA NAAT (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HSV 1 AND 2 IGM ABS, INDIRECT (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HSV 1 AND 2 SPECIFIC AB IGG (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; HIV RAPID (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN; RAPID PLASMA REAGIN (Routine) Ordered By: FIACCO, NICHOLAS Ordering Provider: FIACCO, NICHOLAS RYAN

Disposition Last Updated by FIACCO, NICHOLAS @ 09 Sep 2015 1629 EDT**Released w/o Limitations****Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** FIACCO, NICHOLAS RYAN (Physician) @ 09 Sep 2015 1629**Co-Signed By** SALUJA, SHUCHI M (Physician, General Internal Medicine, WRAMC) @ 15 Sep 2015 0733**CHANGE HISTORY***The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by SALUJA, SHUCHI M @ 15 Sep 2015 0732 EDT:*

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Aug 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-21860535 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Aug 2015 1400 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **FTR**
 Provider: **ZEMBRZUSKA, HANNA DOMINIKA**

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 27 Aug 2015 1355 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

No Labs Found.

Rads

No Rads Found.

Reason for Appointment:

Follow-up

Appointment Comments:

Jnb

Vitals**Vitals** Written by NEFF, JOANNE S @ 27 Aug 2015 1346 EDT

BP: 137/79, HR: 80, RR: 12, T: 99.3 °F, Pain Scale: 0 Pain Free

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1547 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt after Zoloft was increased to 100mg daily. Pt has been taking Zoloft 100mg daily without side effects. He did run out of the Zoloft a few weeks ago and was without the medication for 26 hours which caused him to feel dizzy and have flu-like symptoms. These symptoms resolved once he resumed Zoloft. Pt reports that his depressive and anxiety symptoms have been stable. He has been struggling with hypersomnia rather than insomnia recently. He wants to nap throughout the day despite sleeping 6-7 hours per night. His PCM referred him to sleep clinic. He is in a romantic relationship that is going well. He was separated from his shop at work which has worked out well. He has re-enlisted for 6 more years with a nice financial bonus that he will use to pay off his debts.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 100mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Penile warts (HPV)

Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

Merwin, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

- * THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.
- * MEDS: Denies other medication trials
- * INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.
- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself unable to experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use 4 cups of coffee per day. Stops drinking caffeine after 2pm and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Did consume alcohol on 27 May 2015.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic Able to smile appropriately. ° Not depressed. ° Not anxious.

Affect: ° Normal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y
 Positive Coping Skills: Y
 Responsible to/for Family: Y
 Responsible to/for Pet: N
 Frustration Tolerance: Y
 Resilience: Y
 Good Reality Testing: Y
 Amenable to Treatment: Y
 Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Therapy

• Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 8/27/2015
 Reviewed with patient on: same
 Does patient agree with plan? Yes
 If not, what part?
 Projected date of next treatment plan update: f/u in 4-5 weeks

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Vital signs reviewed. No indication for lab and radiology studies at this time.

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Continue Zoloft 100mg daily. Discussed r/b/se. Obtained informed consent for medication.
2. Continue SARP.
3. Referred pt for individual CBT today.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Continue Zoloft 100mg daily. Discussed r/b/se. Obtained informed consent for medication.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1558 EDT**1. GENERALIZED ANXIETY DISORDER** 300.02

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90**3. Patient Education - Medication** V65.49 1(MEDICATION EDUCATION)Disposition Written by ZEMBRZUSKA, HANNA DOMINIKA @ 31 Aug 2015 1601 EDT**Released w/o Limitations****Follow up:** 4 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 31 Aug 2015 1602

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21829481 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **25 Aug 2015 1218 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **HILL, LARRY D**

AutoCites Refreshed by HILL, LARRY D @ 26 Aug 2015 1443 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	11 Aug 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 25 Aug 2015 1218 EDT
CC GROUP

Screening Written by PATSOS, ASHLEY N @ 25 Aug 2015 1228 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 25 Aug 2015 1218

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 25 Aug 2015 1229 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 25 Aug 2015 1230 EDT

History of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 25 Aug 2015 1232 EDT

1. ALCOHOL DEPENDENCE (ALCOHOLISM)

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 26 Aug 2015 1444 EDT

Released w/o Limitations

Discussed: Alternatives with Patient who indicated understanding. - Comments: "SEE ADD NOTE SECTION FOR FURTHER INFORMATION CONCERNING THIS ENCOUNTER."

Note Written by HILL,LARRY D @ 26 Aug 2015 1446 EDT

Daniel CC note

Daniel arrived on time. Daniel is at session # 11 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group was allowed to process and lead the discussion. There was tension in the group and the discussion turned to planning a group social event. Several options were discussed with no definite plan was decided upon. It came to a discussion of what the group was about and how group members supported each other. The group appeared to be storming and by the end of group they began to be more cohesive and a working group. Group went over by 4 minutes because the discussion became about their recovery and how the group can help.

Daniel sounded disappointed as he said "I just do not share in group anymore because I believe no one cares about me and what is going on." Another group member spoke up in the group process saying "this is my therapy and I'm here to use it to help me with my issues because I don't have anything else." Daniel was observed validating her saying "thank you for having the balls to say what I could not." The tension in the room was high as Daniel and another group member had a disagreement with each other. Another group member told Daniel "it sounds like you are always talking out your ass." Daniel sounded defensive in his tone and then brought up an old issue that was processed and gone to take a jab back at this other group member." At this point the group almost completely shut down and the counselors took over to help group member's process what was happening in group. Daniel reported the strength of another group member saying what she felt helped him learn how to deal with and handle situations in group where he is uncomfortable.

Daniel appeared engaged and interested in the treatment process. Daniel appeared annoyed, engaged and was appropriate and active throughout the session. Daniel had no current problems or objectives due from his ITP. Daniel will continue with Continuing Care treatment and has an outdated treatment plan and will schedule an individual session on 1 Sep 15 for review and update. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 1 September 2015 at 1230 for group. No evidence of SI/HI during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 26 Aug 2015 1446

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 27 Aug 2015 1247

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

25 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-21829244 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS** Date: **25 Aug 2015 1202 EDT** Appt Type: **GRP**
Treatment Facility: **NBHC WASHINGTON** Clinic: **SUBST ABUSE NY** Provider: **BROWN,CYNTHIA E**
NAVY YARD
Patient Status: **Outpatient**

Reason for Appointment:Written by PATSOS,ASHLEY N @ 25 Aug 2015 1202 EDT
OP GROUP

Appointment Cancelled by Facility

Encounter Cancelled by PATSOS,ASHLEY N @ 25 Aug 2015 1218 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Aug 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21756984 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **18 Aug 2015 1224 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **HILL, LARRY D**

AutoCites Refreshed by HILL, LARRY D @ 19 Aug 2015 1303 EDT

Problems

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Aug 2015
Imiquimod 5%, Cream, Topical	Ordered	APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1	1 of 1	11 Aug 2015
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	0 of 2	11 Aug 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 18 Aug 2015 1224 EDT
CC GROUP

Screening Written by PATSOS, ASHLEY N @ 18 Aug 2015 1247 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 18 Aug 2015 1224

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 18 Aug 2015 1247 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 18 Aug 2015 1248 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 18 Aug 2015 1248 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 19 Aug 2015 1351 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session # 10 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. Group rules were read and explained for clarification. The entire group denied drinking or using drugs. Group discussed places and events that remind them to drink and the coping skills they are using now. Group processed the worksheet "Create a Friend" and shared how they compared to it in being friends with others. Daniel opened group up with what he called a "new addiction" in his life McDonald's hamburgers. He said "I do not know why I like them they are just good." This counselor helped him understand with a short brief of the brain reward pathway and addiction, helping his understanding. Daniel was observed relating to another group member sharing about relaxing on her patio with a cigar and drink and how hard it is to change places and things related to drinking. Daniel said "I still cannot go out on my patio due to the drinking relationship I had out there. Daniel sounded excited as he reported he no longer uses his old on-line dating sights. At some point in the group Daniel was in the role of a junior counselor and asking opened questions to other group member. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has no current problems or objectives due from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 4, Objective # 2 due 25 Aug 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 08 September 15 for group. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 2024337577

Signed By HILL, LARRY D (Physician) @ 19 Aug 2015 1353**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 19 Aug 2015 1441

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Aug 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA EEncounter ID: BETH-21685479 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **11 Aug 2015 1232 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E****AutoCites** Refreshed by BROWN,CYNTHIA E @ 12 Aug 2015 1327 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Loading...

Reason for Appointment: Written by PATSOS,ASHLEY N @ 11 Aug 2015 1232 EDT
CC GROUP**Screening** Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 11 Aug 2015 1232-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 11 Aug 2015 1233 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 12 Aug 2015 1331 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 12 Aug 2015 1341 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for group. Daniel is at session # 9 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No group member admitted to using alcohol or drugs since last seen at SARP. The group began with each member identifying their current feeling in one word. Several group members shared of current struggles including; work, stress, PCS and family issues. The group closed with one group member using the closing exercise.

Daniel was very subdued in the group today. He did not appear to have a need to counsel any other group member which is his normal mode of operando. He only really shared with the group that he has a girlfriend now. They have been together for about 10 days and she makes him really happy. He heard in the closing that he should slow down with the dating scene. The closing member shared that he did not have relationship happiness until his second marriage. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel has Problem #1, Objective #8 overdue from his ITP. This will addressed upon his return 17 July 2015. Daniel will continue with Continuing Care treatment and has Problem # 4 Objective #2 due 24 August 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 18 August at 1230 for group.

No evidence of SI/HI during this encounter.

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 12 Aug 2015 1341

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Aug 2015 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-21682013 Primary Dx: PENILE WARTS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Aug 2015 1015 EDT**
 Clinic: **INT MED MEDICAL HOME CL C**
BE

Appt Type: **EST**
 Provider: **AUSTIN, MARIE**

Reason for Appointment:

STD Screening/Possible Genetal Warts

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by NEWMAN,BRENDA W @ 11 Aug 2015 1023 EDT

BP: 122/82 Left Arm, Adult Cuff, HR: 73, RR: 16, T: 98.2 °F, HT: 69 in, WT: 163.8 lbs Upright Scale, Actual, With Shoes,
 SpO₂: 97%, BMI: 24.19, BSA: 1.898 square meters, Pain Scale: 3/10 Mild, Pain Scale Comments: Headache

Questionnaire AutoCites Refreshed by NEWMAN,BRENDA W @ 11 Aug 2015 1026 EDT**Questionnaires**

Anxiety & Depression Screening Taken On: 11 Aug 2015

The Selected Provider is AUSTIN, MARIE R in the Int Med Medical Home Cl C Be clinic.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Several days
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Several days
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Several days
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Several days
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN,MARIE @ 11 Aug 2015 1103 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-CORE>>

PO1 Merwin is a 30 y/o CM who presents to clinic for 2 concerns

1. STD check- penile warts with exposure to HPV in previous partner

2 PT wakes up 2-3 times a night to go to the BR. Sleep apnea his Epworths score is 18/21 .
 Autocited allergies verified.

Visit is not deployment-related.

admission diagnosis of HPI [use for free text].

Pain Severity 0 / 10.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated

NKDA

Current medication

NO OTC meds, vitamins, herbals, etc.

Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history

GAD

Alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history

PRK

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tosillectomy

AHLTA Problem List Updated. Date: today.

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

History

ANNUAL QUESTIONSPreferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 11Aug2015.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria and no testicular symptoms were present.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Anxiety. Not thinking about suicide. No homicidal thoughts.**Skin:** Skin lesion: penile wart s.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Genitalia:

Penis: • Abnormal 4 warts on the shaft of the penis, aprox 0.01 cm- 0.02 cm, skin colored, on the lower third of the shaft . Pt is shaving the shaft advised against that .

Scrotum: ° Normal.

Testes: ° Normal.

Neurological:

° Oriented to time, place, and person.

Sensation: ° No sensory exam abnormalities were noted.

Balance: ° Normal.

Gait And Stance: ° Normal.

Reflexes: ° Deep tendon reflexes were normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Test conclusions

Medication list was upated at the beginning of the visit.

The provider compared the medication list against any orders, and resolved any discrepancies (if required).

A written list of medications was given to the patient.

Practice Management

Preventive medicine services Pt is active duty and is up to date with all immunizations/vaccinations and PHA Screen.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

A/P Written by AUSTIN.MARIE @ 18 Aug 2015 1714 EDT**1. PENILE WARTS** 078.11

Medication(s): -IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE TIMES A WEEK #1 RF1
 Patient Instruction(s): -Instructions: Use A Condom During Sexual Intercourse
 -Guidance: Concerns About Unsafe Sexual Practices

2. MAJOR DEPRESSION RECURRENT MODERATE 296.32

Medication(s): -serTRAline--PO 100MG TAB - TAKE ONE TABLET BY MOUTH EVERY DAY #30 RF2
 Patient Instruction(s): -Community Programs
 -Limitations / Risks General - Complications from Medication
 -Patient Education - Medication

3. ORGANIC SLEEP APNEA 327.20: Scored 18/21 on the Epworths sleepiness scale . Give handout to go to the sleep pathways clinic

Patient Instruction(s): -Instructions For Patient

Disposition Written by AUSTIN.MARIE @ 18 Aug 2015 1715 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: pt to f/u as advised

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: education and counseling on STDs
 40 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 18 Aug 2015 1715**CHANGE HISTORY***The following S/O Note Was Overwritten by AUSTIN.MARIE @ 11 Aug 2015 1047 EDT:**S/O Note Written by NEWMAN,BRENDA W @ 11 Aug 2015 1029 EDT***History of present illness**

The Patient is a 30 year old male.

He reported: Visit is not deployment-related.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Allergies Verified and Updated
 NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.
 Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history
 GAD
 alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history
 PRK
 Tonsillectomy

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

History**ANNUAL QUESTIONS**Preferred language (written or spoken): ☒ English ☐ Other:What is your preferred method of learning? ☐ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact preference: [REDACTED]

PCM:

Annual Questions Date: 11Aug2015.

Family history

Family medical history
 DM father, PGM
 MI father
 hypertension father
 melanoma father

Practice Management

Preventive medicine services
 Lipid Screening -
 Diabetes Screening -
 Aspirin Prophylaxis -
 HIV Screen -
 Colonoscopy -

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Tetanus (Td/Tdap) - 2013
Influenza Vaccine - oct 2014
Zoster Vaccine -
Pneumococcal Vaccine -
HPV Vaccine -

Men:

Aortic Aneurysm Screen (if ever a smoker) -

.....

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA EEncounter ID: BETH-21539829 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **28 Jul 2015 1158 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E****AutoCites** Refreshed by BROWN,CYNTHIA E @ 29 Jul 2015 1243 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment:Written by PATSOS,ASHLEY N @ 28 Jul 2015 1158 EDT
CC GROUP**Screening** Written by PATSOS,ASHLEY N @ 28 Jul 2015 1159 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 28 Jul 2015 1158-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 28 Jul 2015 1159 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 28 Jul 2015 1200 EDT**History of present illness**

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 28 Jul 2015 1201 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 29 Jul 2015 1243 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP

Daniel arrived on time for group. Prior to group we discussed his need to have the attention of a female in group. We discussed how this was his issue and it needed to not interfere with the group process for him or for her. He was cautioned about being a Junior Counselor trying to give advice to group members instead of keeping the focus on his self. He began to discuss how he was having a female recently and she wanted to touch him but it turned him off. He is not in talk therapy and only does medication management. He was told he would best deal with these issues with Mental Health and he agreed to speak to his medication manager. Daniel is at session # 8 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The entire group denied that they drank alcohol or abused drugs. The group seemed very future oriented speaking of what is coming up for them in the next weeks and months. All group members were encouraged to make their individual treatment planning sessions prior to leaving today.

Daniel did not appear engaged or interested in the treatment process. He noted as having a side conversation with a group and making inappropriate comments to him. He appeared to provide advice to other group members again that had nothing to do with his own experience. Daniel rescheduled Problem #4, Objective #2 stating he needed more time from his ITP. He is late also on Problem #1 Objective #8 and that will be addressed next week. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 4 August 2015 at 1230 for group

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 29 Jul 2015 1243

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA EEncounter ID: BETH-21467538 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **21 Jul 2015 1219 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E****AutoCites** Refreshed by BROWN,CYNTHIA E @ 22 Jul 2015 0837 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment:Written by PATSOS,ASHLEY N @ 21 Jul 2015 1219 EDT
CC GROUP**Screening** Written by PATSOS,ASHLEY N @ 21 Jul 2015 1222 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 21 Jul 2015 1219-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 21 Jul 2015 1222 EDT

Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact # [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 21 Jul 2015 1223 EDT**History of present illness**

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 21 Jul 2015 1230 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 22 Jul 2015 0838 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for group today. Daniel is at session # 7 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group welcomed a new group member using the introduction exercise. The group denied drinking or abusing drugs since their last report to this group. The group reviewed euphoric recall as a relapse trigger. We discussed the engagement to 12 step meetings or other supportive activities and found most group members reduced the number of meetings attended since starting this program. The entire group was encouraged to make individual session to speak with their primary counselor about the requirements of this group and program.

Daniel shared that he had run out of his Zoloft and went several days without it. He described having withdrawal but stated he is back on it now. He stated that he feels better and knows that the medication is necessary for him. Daniel stated that his only 1 AA meeting and he keeps himself busy the rest of the time. He admitted that he is required to attend more AA meetings (3) by his treatment plan. Daniel appeared engaged and interested in in what the female group member was doing and not the group. He was noted as playing "jr. counselor" in stating that attending AA meetings helps others. Daniel appeared upset at the end of the session and stated that he is using his CBT to assist in his behaviors. Daniel did have Problem 4 Objective 2 due today but failed to forward it. Daniel will continue with Continuing Care treatment and has Problem #4, Objective #2 to be completed next week. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 28 July 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 22 Jul 2015 0838

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 576
AR 2563

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

15 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-21402674 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **15 Jul 2015 0711 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 17 Jul 2015 0728 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	1 of 2	17 Jul 2015

Reason for Appointment: Written by PATSOS,ASHLEY N @ 15 Jul 2015 0711 EDT
CC GROUP

Screening Written by PATSOS,ASHLEY N @ 15 Jul 2015 0718 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 15 Jul 2015 0711

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 15 Jul 2015 0718 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 Jul 2015 0719 EDT

History of present illness

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 15 Jul 2015 0721 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 2 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by BROWN,CYNTHIA E @ 17 Jul 2015 0728 EDT

Released w/o Limitations

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP

Daniel arrived on time to group. Daniel is at session #6 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. No one in group admitted to drinking or abusing drugs. The group welcomed a new group member using the introduction exercise. The group shared the struggles of the last week and any triggers to drink or abuse drugs in the past week. Group completed and discussed the worksheet "Supportive Relationships."

Daniel took up most the group talking in circles. Even when confronted he continued to contradict himself. The group was noted as checking out but no group confronted him this defensive behavior. He did report a childhood incident but did not recall the details enough to assure that the situation happened. He reported on his worksheet that he did not share about this but did. Not enough detail in this and he stated that his parents were notified. Daniel appeared monopolize the group impeding the treatment process. Daniel did not completed any treatment plan objectives and did not have any due. Daniel will continue with Continuing Care treatment and has Problem #4, Objectives #2 and 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 21 July 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 17 Jul 2015 0730

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

14 Jul 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-21399963 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
 Patient Status: **Outpatient**

Date: **14 Jul 2015 1455 EDT**
 Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
 Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 15 Jul 2015 0754 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Loading...

Reason for Appointment:Written by BROWN,CYNTHIA E @ 14 Jul 2015 1455 EDT
 CC Group

Appointment Cancelled by FacilityEncounter Cancelled by BROWN,CYNTHIA E @ 15 Jul 2015 0917 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Jul 2015 at WRNMMC, Dermatology Clinic Bethesda by TAYLOR, BRADLEY MICHAEL

Encounter ID: BETH-21343480 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **08 Jul 2015 1923 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **T-CON***
 Provider: **TAYLOR, BRADLEY MICHAEL**

Call Back Phone: [REDACTED]

AutoCites Refreshed by TAYLOR, BRADLEY M @ 08 Jul 2015 1923 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Lab Result Cited by TAYLOR, BRADLEY M @ 08 Jul 2015 1924 EDT**Tissue Exam**

Date Collected: 23 Jun 2015 1131
 POC Enc: E4520771
 Enc Fac: WRNMMC
 Clinician: TAYLOR, BRADLEY MICHAEL
 Status: Certify
 Procedure: TISSUE EXAM
 Order #: 150702-23826
 Provider: TAYLOR, BRADLEY MICHAEL
 Ordered Date: 02 Jul 2015 1925
 Priority: ROUTINE
 Specimen: TISSUE
 Resulted Date: 02 Jul 2015 1925.1-0400
 Col: 23Jun15@1131 TISSUE(TISSUE)
 Hcp: TAYLOR, BRADLEY MICHAEL Req Loc: DERMATOL
 Performing Lab: NNMC AP LAB, BETHESDA, MD
 150626 NSP 11753
 TISSUE E C: LRS02Jul15@1925
 CoPath Report
 Patient: MERWIN, DANIEL DENNIS Specimen #: NS15-11753
 Accessioned: 06/26/15
 Pathologist: Laurel R. Stearns, MAJ, MC, USA
 SPECIMEN:
 A: Skin, Scalp, Punch B: Skin, Left scalp, Punch

=====

FINAL DIAGNOSIS:**A. SKIN, SCALP, PUNCH BIOPSY:**

- MILD EARLY CHANGES OF ANDROGENETIC ALOPECIA.
 (SEE COMMENT)

B. SKIN, LEFT SCALP, PUNCH BIOPSY:

- NORMAL SCALP.

and

hair

Evidence

sections.

COMMENT: The sections were difficult to interpret due to processing

orientation. In part A, the sections show a normal number of terminal

follicles with a slightly increased number of vellus hairs. Mild
 superficial perifollicular lymphocytic inflammation is present.

of scarring alopecia is not present in multiple additional step

If clinically indicated additional biopsies may be helpful.

Irs/07/02/15

** Report Electronically Signed Out **

Laurel R. Stearns, MAJ, MC, USA

=====

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CLINICAL DIAGNOSIS AND HISTORY:

-==

overlying mild

30 y/o M, tufted, scarring alopecia on scalp after reported infection about six years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents

elected to

seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient

Perilesional and

proceed with biopsy. Two punch biopsies completed today.

LPP v

normal posterior scalp. Tolerated well. Wound care discussed. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v

PRE-OPERATIVE DIAGNOSIS:

other scarring etiologies.

other

A) Mature scar w/overlying seb derm v folliculitis decalvans v LPP v scarring etiology. B) Normal scalp.

POST-OPERATIVE DIAGNOSIS:

Operative Findings: SAA
Post-operative Diagnosis: SAA

GROSS DESCRIPTION:

name

A. The specimen is received in formalin, labeled with the patient's

0.6 cm.

Merwin, Daniel, and designated "Punch, Scalp". It consists of a tan, hair-bearing punch of skin that is previously horizontally sectioned measuring 0.4 cm in diameter and excised to a maximum depth of

name

B. The specimen is received in formalin, labeled with the patient's

tan,

Merwin, Daniel, and designated "Punch, Left Scalp". It consists of a

previously

hair-bearing punch of skin measuring 4.0 cm in diameter that is horizontally sectioned and excised to a maximum depth of 0.6 cm.

The

specimen is submitted in its entirety in one cassette. 3/1/NG

(Sponge)

CLP/PDP/LRS
CLP/mrg

CPT Codes:

; 88305 ; 88305 (LEVEL 4)
; 88305 ; 88305 (LEVEL 4)

A/P Written by TAYLOR, BRADLEY M @ 08 Jul 2015 1925 EDT

1. Visit for: administrative purpose: Left VM for patient regarding above results. Number provided to call back for questions or concerns.

Disposition Written by TAYLOR, BRADLEY M @ 08 Jul 2015 1925 EDT

Follow up: as needed with PCM.

Signed By TAYLOR, BRADLEY M (Physician/Workstation) @ 08 Jul 2015 1925

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21269597 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC DAHLGREN**
Patient Status: **Outpatient**Date: **30 Jun 2015 1157 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **HILL, LARRY D****AutoCites** Refreshed by HILL, LARRY D @ 01 Jul 2015 1330 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 30 Jun 2015 1157 EDT
CC GROUP**Screening** Written by PATSOS, ASHLEY N @ 30 Jun 2015 1211 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 30 Jun 2015 1157-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 30 Jun 2015 1211 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 30 Jun 2015 1212 EDT**History of present illness**

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 30 Jun 2015 1218 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 01 Jul 2015 1347 EDT

Released w/o Limitations

Discussed: Alternatives with Patient who indicated understanding. - Comments: "SEE ADD NOTE SECTION FOR FURTHER INFORMATION CONCERNING THIS ENCOUNTER."

Note Written by HILL,LARRY D @ 01 Jul 2015 1416 EDT

Daniel CCG note

Daniel arrived on time and is at session 5 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group performed the check-in process identifying changes or events since last group. The group discussed pleasurable activities that they already do and identified one new activity to do before next group. They discussed common styles of thinking and how they apply to themselves and identified individuals who support their addiction and those who support their recovery. No group member admitted to drinking or using since last group. Daniel appeared tense as group began dressed in shorts and a button up shirt. Daniel sounded pained as he addressed another female group member who said she felt uncomfortable with Daniel and said he is a pervert. Daniel reported feeling judge and looked discouraged at the accusations due to their brief contact outside group. They processed these feelings and safety, respect and non-judgmental behaviors for other group members and seemed able to work through their differences. Daniel has a co-occurring sex addiction and seems to be a driving factor in their personal issues that Daniel reports he is working on. Daniel reported meeting a new girl and spending the night with her jumping head first into a relationship knowing this in in direct violation of his own efforts to find a loving relationship. Daniel was able to identify those working against his recovery saying "I'm the number one problem", he additionally identified his sober network those individuals he can call when he struggles. Daniel reported he would like to cook a surprise food for the group, prior to next group. Daniel appeared uneasy, engaged, interested and was appropriate and active throughout the session even when processing tension between group members. Daniel addressed Problem #1, Objective #1, 4 & 6 from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 7 July 2015 for group. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 01 Jul 2015 1417

Co-Signed By SPADARO, SHELLIE S (Physician) @ 01 Jul 2015 1525

CHANGE HISTORY

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by HILL,LARRY D @ 01 Jul 2015 1416 EDT:

Signed HILL, LARRY D (Physician) @ 01 Jul 2015 1348

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

26 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-21238834 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **26 Jun 2015 1430 EDT**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR, LYNNE P**

Reason for Appointment:

Procedure - SARP LABS

Appointment Comments:

brh

Lab Result Cited by AILOR, LYNNE P @ 26 Jun 2015 1451 EDT**ETG/ETS, UA (250 Cut-Off)**

Ethyl Glucuronide

Site/Specimen

URINE

23 Jun 2015 1404

Negative

Units

ng/mL

Ref Rng

Cutoff=250

A/P Written by AILOR, LYNNE P @ 26 Jun 2015 1453 EDT**1. Laboratory Studies:** Labs were reviewed by undersigned provider per SARP protocol. Results of ETG/ETS were negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)**Disposition** Written by AILOR, LYNNE P @ 26 Jun 2015 1453 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: Follow up with SARP.**Signed By** AILOR, LYNNE P (Physician) @ 26 Jun 2015 1454

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Jun 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-21224749 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **25 Jun 2015 1100 EDT**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR,LYNNE P**

Reason for Appointment:

Procedure - SARP LABS

Appointment Comments:

brh

Lab Result Cited by AILOR,LYNNE P @ 25 Jun 2015 1543 EDT

Drug Abuse Screen	Site/Specimen	23 Jun 2015 1404	Units	Ref Rng
Amphetamines	URINE	NEGATIVE <i>		(Negative)
Barbiturates	URINE	NEGATIVE <i>		(Negative)
Benzodiazepines	URINE	NEGATIVE <i>		(Negative)
Cocaine	URINE	NEGATIVE <i>		(Negative)
Opiates	URINE	NEGATIVE <i>		(Negative)
Phencyclidine, UA	URINE	NEGATIVE <i>		(Negative)
Cannabinoids	URINE	NEGATIVE <i>		(Negative)
Methadone	URINE	NEGATIVE <i>		(Not-Detected)
Oxycodone	URINE	NEGATIVE <i>	ng/mL	(Negative)

A/P Written by AILOR,LYNNE P @ 25 Jun 2015 1545 EDT

1. Laboratory Studies: Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)

Disposition Written by AILOR,LYNNE P @ 25 Jun 2015 1546 EDT**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 25 Jun 2015 1546

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY D

Encounter ID: BETH-21198244 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC DAHLGREN**
Patient Status: **Outpatient**

Date: **23 Jun 2015 1203 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **HILL, LARRY D**

AutoCites Refreshed by HILL, LARRY D @ 25 Jun 2015 1207 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 23 Jun 2015 1203 EDT
CC GROUP

Screening Written by PATSOS, ASHLEY N @ 23 Jun 2015 1216 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 23 Jun 2015 1203

CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 23 Jun 2015 1216 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 23 Jun 2015 1218 EDT

History of present illness

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 23 Jun 2015 1237 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 1 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -DRUG ABUSE SCREEN (Routine) Ordered By: PATSOS,ASHLEY N Ordering Provider: AILOR, LYNNE P; ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: PATSOS,ASHLEY N Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by HILL,LARRY D @ 25 Jun 2015 1230 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session # 4 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group checked-in and reintroduced themselves to a member that had been absent. They processed cravings and shared about how they sleep now compared to when they were drinking. One group member reported struggling with lack of motivation and not caring about anything. No group member reported drinking or using since last seen at SARP WYN.

Daniel appeared frustrated as he reported feeling judged as another member reported sharing not being comfortable sharing intimate details of her life with men. Daniel said "I feel judge as a man and like you don't trust me, and I'm more comfortable sharing with women than a man." This counselor had to block this interaction noticing some tension between these two group members and identified this to them and both members decided to just drop it and not process this tension. Daniel was observed providing positive feedback to another group member struggling with motivation and not caring saying "it sounds like you could be depressed and should get seen for it." Daniel seems to struggle with female interactions in the group and is noted from him in his past relationships. Daniel wrote "I could relate to everyone today and felt a myriad of feeling."

Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem # 1, Objective # 1 & 4 from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 & 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 30 June 2015 for group. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by HILL,LARRY D @ 25 Jun 2015 1231 EDT

Shellie will co-sign note in absence of program director.

Signed By HILL, LARRY D (Physician) @ 25 Jun 2015 1231Co-Signed By SPADARO, SHELLIE S (Physician) @ 25 Jun 2015 1441

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 587
AR 2574

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Jun 2015 at WRNMMC, Dermatology Clinic Bethesda by STEARNS, LAUREL R

Encounter ID: BETH-21190437 Primary Dx: Alopecia

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **22 Jun 2015 1430 EDT**
 Clinic: **DERMATOLO CL BE**

Appt Type: **SPEC**
 Provider: **STEARNS, LAUREL**
REINHART

AutoCites Refreshed by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

alopecia areata

Appointment Comments:

anb

S/O Note Written by TAYLOR, BRADLEY MICHAEL @ 23 Jun 2015 0724 EDT**Chief complaint**

The Chief Complaint is: Scalp.

History of present illness

The Patient is a 30 year old male.

30 y/o male. Per patient, has history of MRSA infection on scalp about 5 to 6 years ago. Hair has never completely grown back. More recently has started to develop scale in same area as well as other areas of scalp. Unsure if area has remained the same size. He feels it has been getting larger.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Allergies

Current Allergies Reviewed.

Past medical/surgical history**Reported:**

Medical: Reported medical history reviewed

Review of systems**Systemic:** No fever and no chills.**Skin:** Pruritus and skin lesion: rash:**Physical findings****General Appearance:**

° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° Oriented to time, place, and person.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

- Skin: Scalp: Approx 1.5 to 2 cm annular patch of noticeably decreased hair density on posterior apex scalp. Smaller but also annular area next to it. Slightly raised scar like plaque. Follicle drop and tufting of hair noted. Mild erythema and scale.

Note Written by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

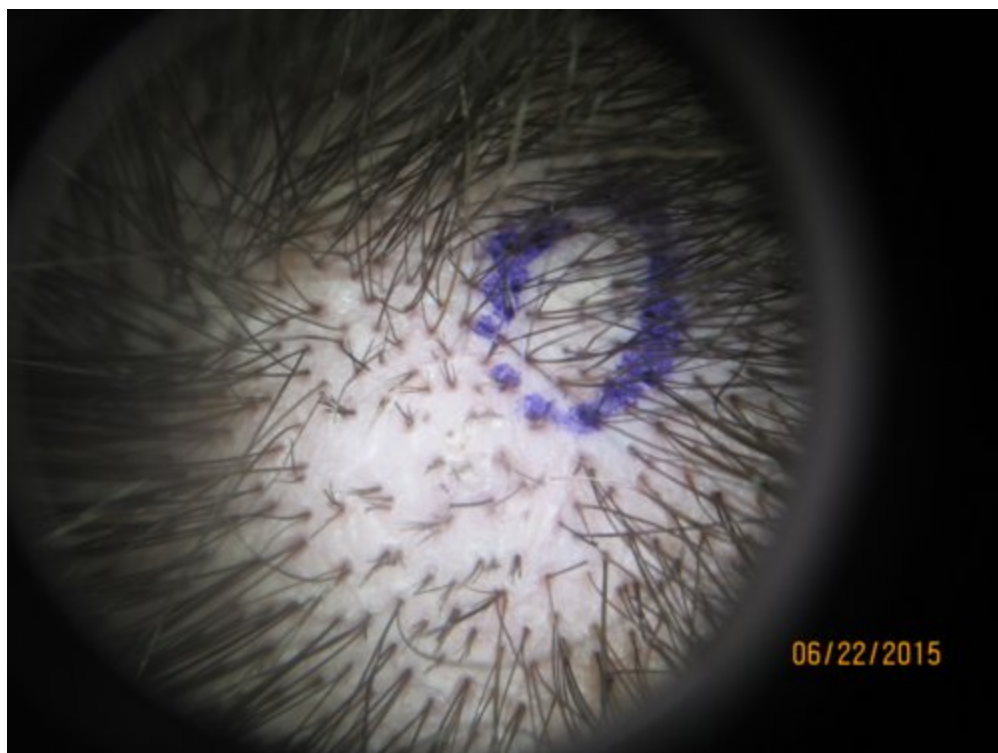
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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

**A/P** Last Updated by TAYLOR,BRADLEY M @ 23 Jun 2015 1135 EDT

1. Alopecia: Tufted, scarring alopecia on scalp after reported infection about 6 years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well. Wound care discussed. Follow up in 10 to 14 days for suture removal and biopsy results. Sooner for concerns. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v LPP v other scarring etiologies.

Seen and d/w Dr. Stearns.

Procedure(s):

-Biopsy Skin x 1 - Universal protocol requirements were met per WRNMMC Policy. Patient's identification was checked (name & birthdate). procedure and site, side matches the consent form. the lesion was prepped with alcohol. local anesthesia was provided by local injection with a 30g needle of 1ml of 1%lidocaine with epinephrine. a 4 mm punch biopsy was then performed. estimated blood loss was negligible. the wound was closed with 4 -0 suture, and a sterile dressing applied. wound care discussed, f/u 10 days for suture removal and discussion of path results.

Laboratory(ies):

-Biopsy Skin Each Additional Lesion x 1
-TISSUE EXAM (Routine) Start Date: 06/23/2015 Order Date: 06/23/2015 11:35 Ordered By: TAYLOR,BRADLEY M Ordering Provider: TAYLOR, BRADLEY MICHAEL

Disposition Last Updated by TAYLOR,BRADLEY M @ 23 Jun 2015 1136 EDT**Released w/o Limitations****Follow up:** in the DERMATOLO CL BE clinic. - Comments: 10 to 14 days**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by TAYLOR,BRADLEY M @ 23 Jun 2015 0722 EDT**Consult Order****Referring Provider:** ARGUINZONI, JUAN B.**Date of Request:** 07 May 2015**Priority:** Routine**Provisional Diagnosis:****Reason for Request:**

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

30 y/o male with alopecia areata. Please evaluate and treat as needed; thanks.

Note Written by STEARNS, LAUREL R @ 23 Jun 2015 1537 EDT

I have seen and evaluated the patient and agree with the findings as documented in the note.

Signed By STEARNS, LAUREL R (Cpt, USA, MC, NPI 1356491393, Staff Dermatologist, Dermatology, WHMC/BAMC) @ 23 Jun 2015 1537

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21126679 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC DAHLGREN**
Patient Status: **Outpatient**Date: **16 Jun 2015 1202 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **HILL, LARRY D****AutoCites** Refreshed by HILL, LARRY D @ 17 Jun 2015 1433 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2	2 of 2	11 Jun 2015

Reason for Appointment: Written by PATSOS, ASHLEY N @ 16 Jun 2015 1202 EDT
CC GROUP**Screening** Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 16 Jun 2015 1202-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS, ASHLEY N @ 16 Jun 2015 1220 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 16 Jun 2015 1221 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 17 Jun 2015 1450 EDT**Released w/o Limitations**

Discussed: Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time and is at session #3 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. The group started with checking in on happenings since last group, the group welcomed one new member and closed with two group members using the introduction and closing exercises. The group shared about life struggles while the where drinking and how they affect them now. No group member admitted to drinking or abusing drugs since last seen at SARP.

Daniel appeared interested as another group member frustratedly listed many reasons why she felt she should drink, use drugs and return to old habits. Daniel was observed relating her struggles to his own life saying "I use to think the same way and when I was drinking I would over use my prescription pain meds knowing I should not but would do it anyways." "I'm disappointed in myself because I continually struggle with relationships and have been with 126 women and had been doing very good but I had sex with two women in the past two days. This to me is my old behavior but it was worse when I was drinking." "I want a health relationship but struggle and don't know how to have one, I'm very picky." Daniel seems to be struggling with a sex addiction and dealing with a myriad of feeling including shame, guilt and disappointment in himself for lack of control.

Daniel appeared engaged and was appropriate and active throughout the session. Daniel addressed Problem #1, Objectives # 1, 4, & 6 from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objective #2 due 21 July 2015. See Daniel's "Continuing Care Progress Report" for more information on this encounter. No evidence of SI/HI during this encounter. Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 17 Jun 2015 1450Co-Signed By SPADARO, SHELLIE S (Physician) @ 18 Jun 2015 0905

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Jun 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-21077936 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **11 Jun 2015 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **ZEMBRZUSKA, HANNA DOMINIKA**

AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 11 Jun 2015 0905 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

18 May 2015 1107
ETG/ETS, UA (250 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=250

18 May 2015 1107
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>

Units

ng/mL

Ref Range

(Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Not-Detected)
 (Negative)

Rads

No Rads Found.

Reason for Appointment:

follow up

Appointment Comments:

nae

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0728 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt. Pt has been taking Zoloft 75mg daily without side effects. Pt reports that he continues to be happier more often, but it is not consistent. He reports no difference in his anxiety. He continues to have anxious ruminations about work which lead to initial insomnia. He has been taking Melatonin a few times a week at bedtime, but does not want to take it every night. He is implementing the skills he learned in CBT-I group and using the CBT-I app. Sleeping about 7 hours per night, but finds himself tired in the afternoon and will sometimes take a 30-60min nap. He reports consuming 1/2 pint of alcohol on 27May due to feeling stressed about work and interpersonal difficulty in romantic relationship. He is a people pleaser and has a hard time saying no. He may be separated from his shop at work which he thinks will be better because he does not like his current job. He needs to pick up collateral duties to pick up next rank.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 re on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged at the end of April 2015.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 75mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself unable to experience from the past or avoid having feelings related to it?

[1] Avoid activities or situations because they remind you of a stressful experience from the past?

[0] Trouble remembering important parts of a stressful experience from the past?

[0] Loss of interest in things that you used to enjoy?

[0] Feeling distant or cut off from other people?

[2] Feeling emotionally numb or being unable to have loving feelings for those close to you?

[0] Feeling as if your future will somehow be cut short?

[0] Trouble falling or staying asleep?

[1] Feeling irritable or having angry outbursts?

[1] Having difficulty concentrating?

[1] Being 'super alert' or watchful on guard?

[0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use tea and coffee 1-2x/wk. Never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Did consume alcohol on 27 May 2015.

Subjective

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms

No current cognitive symptoms

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: • Anxious. ° Euthymic Able to smile appropriately. ° Not depressed.

Affect: • Abnormal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts: Y

Organized Plan: N

Chronic Psychiatric Disorder: Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma: Y

Chronic Physical Illness: N

Family H/O Suicide/Attempts: Y

Other Recent Loss: N

Chronic Pain: N

Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N

Access to Lethal Means: N

Poor Treatment Compliance: N

Hopelessness: ?

Psychic Pain/Anxiety: Y

Acute Event: N

Insomnia: N

Low Self-Worth: Y

Impulsivity: N

Substance Abuse: Y

Financial Stress: Y, PAYING OFF DEBT

Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y

Positive Coping Skills: Y

Responsible to/for Family: Y

Responsible to/for Pet: N

Frustration Tolerance: Y

Resilience: Y

Good Reality Testing: Y

Amenable to Treatment: Y

Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:☒ [X] Released without limitations. Advised of emergency procedures.☐ [] SM released to Chain of Command with the following limitations:☐ [] SM sent to ER for evaluation for admission to inpatient psychiatry

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

[] Other:

Therapy

- Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP

Medication Prescriber: ZEMBRZUSKA

Group Therapist: TBD

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 11JUN2015

Reviewed with patient on: same

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 1 month

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft to 100mg daily. Pt's depressive symptoms appear to have responded to Zoloft, but anxiety is still not under good control. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft to 100mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0739 EDT**1. GENERALIZED ANXIETY DISORDER** 300.02

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90**Disposition** Written by ZEMBRZUSKA, HANNA DOMINIKA @ 12 Jun 2015 0740 EDT**Released w/o Limitations****Follow up:** 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 12 Jun 2015 0740

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

09 Jun 2015 at WRNMMC, Substance Abuse NY by HILL, LARRY DEncounter ID: BETH-21053074 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **09 Jun 2015 1200 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **HILL, LARRY D****AutoCites** Refreshed by HILL, LARRY D @ 10 Jun 2015 0932 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 09 Jun 2015 1200 EDT
CC GROUP**Screening** Written by PATSOS, ASHLEY N @ 09 Jun 2015 1219 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 09 Jun 2015 1200-----
CC GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 09 Jun 2015 1219 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 09 Jun 2015 1219 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 09 Jun 2015 1221 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by HILL,LARRY D @ 10 Jun 2015 1356 EDT**Released w/o Limitations****Discussed:** Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time. Daniel is at session 2 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group welcomed one new group member using the introduction exercise. The group closed with 2 group members. One group member admitted to drinking while in treatment which led to another group mentioning he drank also. The group processed how they could these struggling group members.

Daniel reported doing well during the check in process and said "I have to be honest with the group; I also had a lapse 2 weeks ago and drank most of pint of vodka. I have been struggling with a female friend that wants to be more than a friend and ended up in a liquor store and bought the bottle. I had unopened cranberry juice at home and mixed them and ended up pouring out some of it." Daniel reported feeling guilty concerning his lapse. Daniels honesty seemed to be brought forward from another group member he knows that shared of a recent lapse. Daniel seems to struggle with self-image and puts a lot of his time and efforts into others writing "I have not been worrying about others and what they think of me." Daniel reports working the 12 steps but has no sponsor. Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 and 4 attending group and sharing from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 16 June 2015 at 1230 for group. No evidence of SI/Hi during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By HILL, LARRY D (Physician) @ 10 Jun 2015 1356**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 10 Jun 2015 1417**CHANGE HISTORY****The following Disposition Note Was Overwritten by** HILL,LARRY D @ 10 Jun 2015 1356 EDT:

The Disposition section was last updated by HILL,LARRY D @ 10 Jun 2015 1356 EDT - see above.Previous Version of Disposition section was entered/updated by HILL,LARRY D @ 10 Jun 2015 0932 EDT.

Released w/o Limitations**Discussed:** Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time. Daniel is at session 2 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1400, total of 1 1/2 hours. Group welcomed one new group member using the introduction exercise. The group closed with 2 group members. One group member admitted to drinking while in treatment which led to another group mentioning he drank also. The group processed how they could these struggling group members.

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Daniel appeared engaged, interested and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 and 4 attending group and sharing from his ITP. Daniel will continue with Continuing Care treatment and has Problem # 1, Objective # 2 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 16 June 2015 at 1230 for group. No evidence of SI/Hi during this encounter Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by HILL,LARRY D @ 10 Jun 2015 1355 EDT:**Signed** HILL, LARRY D (Physician) @ 10 Jun 2015 0934**Co-Signed** BROWN, CYNTHIA E (Paraprofessional) @ 10 Jun 2015 1004

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

02 Jun 2015 at WRNMMC, Substance Abuse NY by BROWN, CYNTHIA E

Encounter ID: BETH-20970182 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON NAVY YARD**
Patient Status: **Outpatient**

Date: **02 Jun 2015 0935 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **BROWN,CYNTHIA E**

AutoCites Refreshed by BROWN,CYNTHIA E @ 03 Jun 2015 0742 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 02 Jun 2015 0935 EDT
CC INTAKE/CC GROUP

Screening Written by PATSOS,ASHLEY N @ 02 Jun 2015 0937 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 02 Jun 2015 0935

CC INTAKE/CC GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 02 Jun 2015 0937 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 02 Jun 2015 0939 EDT**History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

A/P Last Updated by PATSOS,ASHLEY N @ 02 Jun 2015 0940 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s): -BEHAVAL HEALTH SCREEN DETERMINE ELIGIBLY, ADM TX PRGM x 1 - Met with patient one-on-one from 0930-1030 to discuss Individual Treatment Plan.
 -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 6 - The patient attended group from 1230-1400.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by BROWN,CYNTHIA E @ 03 Jun 2015 0801 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: CC GROUP

Daniel is at session # 1 of the 26 scheduled sessions for the Continuing Care treatment program attending from 1230 to 1415, total of 1 1/2 hours. All members of the group denied that they drank or used drugs. The group welcomed a new group member using the introduction exercise. The group discussed in depth what they have gotten out of treatment so far. The group closed with a patient.

Daniel was introduced to the group. He appeared very comfortable with the format and other group members. He shared his coping skill as CBT. He stated that it helps him to regulate his emotions. At one point he engaged in friendly banter with a group member and other group members responded that he will fit in this group. He smiled and appeared to enjoy the engagement. Daniel appeared engaged and interested in the treatment process. Daniel appeared engaged and was appropriate and active throughout the session. Daniel addressed Problem #1, Objective #1 by attending group from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #2 and 8 due 21 July 2015. See Daniel "Continuing Care Progress Report" for more information on this encounter. Daniel is schedule to return 9 June 2015 at 1230 for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Note Written by BROWN,CYNTHIA E @ 03 Jun 2015 1342 EDT**INDIVIDUAL SESSION CC FOR GROUP INTAKE**

Daniel is at session 1 of the 26 scheduled sessions of the Continuing Care treatment program attending from 0930 to 1030, total of 1 hour. Daniel and I reviewed his treatment plan with the basic requirements for the Continuing Care group. He agreed to all of the terms and conditions. We will establish his goal for treatment when he returns on 9 June 2015 for group at 1230. We reviewed the limitations of confidentiality and he indicated he understood. He indicated that he enjoys using the CBT to regulate his emotion. He admitted that he struggles to find a long term relationship and finds most women to be objectionable in one major way or another. The large number (126) women that he has been with have been disappointing to his standard but he feels very lonely. Daniel appeared engaged and interested in the treatment process. Daniel is to start working on his treatment plan today for the CC group. He addressed Problem #1, Objective #1 by attending this appointment from his ITP. Daniel will continue with Continuing Care treatment and has Problem #1, Objectives #2 and 8 due 21 July 2015. Daniel is schedule to stay today for group.

No evidence of SI/HI during this encounter

Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By BROWN, CYNTHIA E (Paraprofessional) @ 03 Jun 2015 1354

CHANGE HISTORY

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by BROWN, CYNTHIA E @ 03 Jun 2015 1342 EDT:

Signed BROWN, CYNTHIA E (Paraprofessional) @ 03 Jun 2015 0801

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20911738 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **27 May 2015 0859 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **GONZALEZZARAZUA, JORGE A****AutoCites** Refreshed by GONZALEZZARAZUA, JORGE A @ 29 May 2015 1310 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 27 May 2015 0859 EDT
OP GROUP**Screening** Written by PATSOS, ASHLEY N @ 27 May 2015 1017 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 27 May 2015 0859

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 27 May 2015 1017 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 27 May 2015 1017 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 27 May 2015 1018 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 29 May 2015 1311 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 4, Day 1 of OP treatment attending from 0900-1100, total of 2 hours. This will be Daniel's last OP session. Today's session opened up with 3 members closing with the group as well as the other group members closing with the departing members.

Daniel performed his closing with the group prior to departing the OP group for the last time and shared that he is doing well and hopes to continue to improve and maintain his sobriety. He states that the skills he has learned are paying dividends for him and wants to use them going forward to maintain a more balanced lifestyle.

Daniel seemed at ease and comfortable performing his closing from OP group. He will be attending an intake appointment with a counselor to commence his Continuing Care.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 02 June 2015 @ 1030.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 29 May 2015 1311**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 29 May 2015 1312

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20884609 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **22 May 2015 0849 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **REGIS,JAMES****AutoCites** Refreshed by REGIS,JAMES @ 22 May 2015 1538 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 22 May 2015 0849 EDT
OP GROUP**Screening** Written by PATSOS,ASHLEY N @ 22 May 2015 0850 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 22 May 2015 0849

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 22 May 2015 0850 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Questionnaire AutoCites Refreshed by REGIS,JAMES @ 22 May 2015 1538 EDT
Questionnaires

S/O Note Written by PATSOS,ASHLEY N @ 22 May 2015 0850 EDT

History of present illness

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 22 May 2015 0851 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by REGIS,JAMES @ 22 May 2015 1539 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 3 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 12th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in with the group members going over any triggers or cravings he may have had during the past couple of days.

During Daniel's check-in, Daniel stated that he's looking forward to this weekend because he has plans with the girl that he's been hanging out with. He stated that they hung out last night and that he made dinner for her at his place and the watched a movie together. Daniel also stated that he plans on seeing her tonight and on Sunday where they're supposed to go to Kings Dominion amusement park and spend the day together. This he says will be a huge test for them because it's going to determine if they can spend an entire day together.

Daniel seemed optimistic but challenged about his new girl "friend". He appeared relaxed as if there's no pressure because he's not seeking a girlfriend but mentions several times how these encounters are measures of whether or not they can get along. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 27th of May 2015 @ 0900 to close out of OP group and start his process to CCG.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

To be reviewed by NBHC-WNY SARP Program Manager on Tuesday 26th of May 2015.

Note Written by REGIS,JAMES @ 22 May 2015 1540 EDT

To be reviewed by NBHC-WNY SARP Program Manager on Tuesday 26th of May 2015.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 22 May 2015 1540

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

21 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-20871983 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **21 May 2015 1100 EDT**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR,LYNNE P**

Reason for Appointment:

Procedure - SARP LABS

Appointment Comments:

BRH

Lab Result Cited by AILOR,LYNNE P @ 21 May 2015 1411 EDT**Drug Abuse Screen**

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site/Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

18 May 2015 1107

NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site/Specimen

URINE

18 May 2015 1107

Negative

A/P Written by AILOR,LYNNE P @ 21 May 2015 1414 EDT

1. Laboratory Studies: Labs were reviewed by undersigned provider per SARP protocol. Results of Drug Abuse Screen were negative for all substances tested. Results of ETG/ETS were negative.

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I (OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME)

Disposition Written by AILOR,LYNNE P @ 21 May 2015 1415 EDT**Released w/o Limitations**

Follow up: as needed . - Comments: Follow up with SARP.

Signed By AILOR, LYNNE P (Physician) @ 21 May 2015 1416

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

20 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20856489 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **20 May 2015 0804 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 21 May 2015 1440 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Ordered	TAKE ONE AND ONE-HALF TABLETS (75MG) BY MOUTH EVERY DAY #0 RF1	1 of 1	19 May 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 20 May 2015 0804 EDT
OP GROUP/EST

Screening Written by PATSOS,ASHLEY N @ 20 May 2015 0805 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 20 May 2015 0804

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 20 May 2015 0805 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 20 May 2015 0805 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 20 May 2015 0810 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.
 -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 21 May 2015 1441 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 11th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in with the group members going over any triggers or cravings he may have had during the past couple of days

During Daniel's check-in, Daniel stated that he was looking forward to going on a date again tonight with the same girl he went out with the other day. He also mentioned during group discussion that before he gets to the point of hating anything, that he uses his cognitive tools that he learned in residential treatment to better assess what he is going through and to try to find out what the root of his hatred is all about.

Daniel seemed indifferent regarding his date tonight but became very empathetic and inspired to question and express his thoughts on the need to not have hateful sentiments towards others. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 22nd of May 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Note Written by REGIS,JAMES @ 21 May 2015 1441 EDT**Individual 1-on-1 session w/Counselor for OP Level 1 Step-Down Treatment**

Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 20th of May 2015 from 08:00 to 09:00 (1 hour). This is Daniel's 1-on-1 Individual session for Week #4 of his OP Level 1 Step-Down Treatment at SARP WNY. He stated that he had a stomach ache and that he believes that there's something wrong with his digestive system. Daniel also stated that his Performance Evaluation for this year continues to be a source of stress for him because, although they're not received until November 15th, he has to submit it to his CoC by August (which is just a couple of months away). He said that he needs to start doing "stuff" so that he can get a decent evaluation; which is important for him for his career.

Daniel seemed worried and concerned regarding his evaluation. He appears to be putting a lot of anxiety on himself to start doing stuff that can positively reflect on his evaluation. At times, he justified his emotions by saying that if he gets a "Promotable" evaluation (which is a lower evaluation than the "Must Promote" last year) he can still pick-up the next rank in his rate even with that "Promotable" evaluation.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 20th 2015 @ 09:00
Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By **REGIS, JAMES** (Para-Professional, SARP WNY) @ 21 May 2015 1443
Co-Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 21 May 2015 1451

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20841809 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **18 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 19 May 2015 0823 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 19 May 2015 0826 EDT**Group Therapy Note****Date: 18 May 15****Time w/Patient 1300-1400****Purpose of Group:**

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #4- last session:

Members discussed past week and changes/challenges they have made and come across with incorporating CBTi components, sleep hygiene, completing sleep log and keeping to their calculated sleep window.

Agenda for session four: briefly discussed how thinking influences sleep and how to think in ways that promote sleep, discussed changing dysfunctional core beliefs, ways to quiet the mind (buffer zone). Continued to discuss sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality. Reviewed sleep log, how to calculate Sleep Efficiency for using sleep training/restriction and completed Sleep Need Questionnaire in order to identify if sleep widow should be modified. Encouraged group members to cont to use sleep log and calculate SE on their own if needed. Gave group members as needed extra sleep logs, Sleep need questionnaires, and Addressing Insomnia in the Future handout.

Summary of Patient Information and Participation:

SM reports he continues to use the CBTi app on his phone which helps him record his sleep and automatically calculates his sleep efficiency. Reports his sleep efficiency is ~ 92% and his sleep widow is 930pm-530am. Reports the behavioral and cognitive changes he has made has helped him get better quality and quantity sleep. He cont to reports getting out of bed at the scheduled time is somewhat difficult, but is trying to make it a habit.

He reports he is not as tired throughout the day. Reports he will cont to use the CBTi app and has found it helpful.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: last session- informed group members of future CBTi group sessions and encouraged members to attend for refresher or contact group leader for questions/concerns
Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 19 May 2015 0825 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s):

-Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 19 May 2015 0826 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 19 May 2015 0827

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20826838 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **18 May 2015 0848 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **REGIS,JAMES****AutoCites** Refreshed by GONZALEZZARAZUA,JORGE A @ 18 May 2015 1033 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:Written by PATSOS,ASHLEY N @ 18 May 2015 0848 EDT
OP GROUP**Screening** Written by PATSOS,ASHLEY N @ 18 May 2015 0937 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 18 May 2015 0848-----
OP GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 18 May 2015 0937 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 18 May 2015 0938 EDT**History of present illness**

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

The patient attended the Outpatient Treatment Program (OP).

A/P Last updated by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies):

-ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: GONZALEZZARAZUA, JORGE A Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: GONZALEZZARAZUA, JORGE A Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS, JAMES @ 19 May 2015 1224 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 4, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 10th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his introduction to 2 new group members followed by his check-in going over any triggers or cravings he may have had during the past couple of days

During Daniel's check-in, Daniel stated that he went on another date to a bar last week with another young lady that he met on line. Daniel stated that he found himself again sitting at a bar conversing with his date who was drinking and that he had no desire to drink. Daniel also stated that he really likes this girl because she is into sci-fi like he is which he says is rare. Daniel later said that he knew he cared about this girl because he became nervous around her which showed him that he really liked her.

Daniel seemed delighted and peaceful about his date and how successful it turned out. He continues to ask inquisitive and detailed questions in group. Daniel remains adamant when it comes to his programming project. He was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 20th of May 2015 @ 0800
 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 19 May 2015 1224

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 19 May 2015 1347

CHANGE HISTORY

The following A/P Note Was Overwritten by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT:

The A/P section was last updated by GONZALEZZARAZUA, JORGE A @ 18 May 2015 1034 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS, ASHLEY N @ 18 May 2015 0939 EDT.

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

15 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20811912 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **15 May 2015 0818 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **REGIS,JAMES****AutoCites** Refreshed by REGIS,JAMES @ 15 May 2015 1319 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:Written by PATSOS,ASHLEY N @ 15 May 2015 0818 EDT
OP GROUP**Screening** Written by PATSOS,ASHLEY N @ 15 May 2015 0824 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 15 May 2015 0818-----
OP GROUP**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 15 May 2015 0825 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 15 May 2015 0825 EDT**History of present illness**

The Patient is a 30 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 15 May 2015 0827 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 15 May 2015 1320 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 3 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 9th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in to the group members going over any triggers or cravings he may have had during the past couple of days. During Daniel's check-in, Daniel stated that he went to a bar last night on a date with a young lady that he met on line. Daniel stated that this was the first time that he found himself actually sitting at a bar conversing with his date who was drinking. Daniel stated even though the bartenders came around a couple of time asking him if he wanted a drink, he insisted on just water. Regarding the topic of Peer Pressure that came up in group today, Daniel stated that he too would use a lie as a way to defuse him not drinking. Specifically, Daniel said that he would say he has "diabetes" and that he cannot drink. Daniel seemed blissful about his night and the fact that he didn't have any urge to drink. He stated that he was able to concentrate on his date and getting to befriend her. Daniel continues to appear self-reliant and assertive when it comes to his programming project. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/Hi/ATV
Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 18th of May 2015 @ 0900
Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 15 May 2015 1320

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 15 May 2015 1346

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

14 May 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-20800148 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **14 May 2015 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **ZEMBRZUSKA,HANNA
 DOMINIKA**

AutoCites Refreshed by ZEMBRZUSKA,HANNA DOMINIKA @ 14 May 2015 1622 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

04 May 2015 0922
ETG/ETS, UA (250 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=250

04 May 2015 0922
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>
 negative <i>

Units

ng/mL

Ref Range

(Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Negative)
 (Not-Detected)
 (Negative)

28 Apr 2015 0958**Comprehensive Metabolic Panel**

Albumin
 Alkaline Phosphatase
 Alanine Aminotransferase
 Bilirubin
 Urea Nitrogen
 Calcium
 Carbon Dioxide
 Chloride
 Creatinine
 Glucose
 Potassium
 Protein
 Sodium
 Anion Gap
 GFR Calculated Non-Black
 GFR Calculated Black
 Aspartate Aminotransferase

Site Specimen

SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM
 SERUM

Result

5.1
 70
 33
 0.3
 13.4
 9.9
 29
 101
 0.97
 90
 4.6
 7.7
 143
 13
 104.3
 120.6 <i>
 26

Units

g/dL
 U/L
 U/L
 mg/dL
 mg/dL
 mg/dL
 mmol/L
 mmol/L
 mg/dL
 mg/dL
 mmol/L
 g/dL
 mmol/L
 mmol/L
 mL/min
 mL/min
 U/L

Ref Range

(3.5-5.2)
 (40-129)
 (0-41)
 (0-1.2)
 (6-20)
 (8.6-10.2)
 (22-29)
 (98-107)
 (0.7-1.2)
 (74-106)
 (3.5-5.1)
 (6.6-8.7)
 (136-145)
 (7-16)
 (60->=60)
 (60->=60)
 (0-40)

20 Apr 2015 0012

ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative <o>

Units
 ng/mL

Ref Range
 Cutoff=500

20 Apr 2015 0012 <o>**Drug Abuse Screen**

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units**Ref Range**

(Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Cannabinoids	URINE	not detected <i>	(Not-detected)
Methadone	URINE	not detected <i>	(Not-detected)
Oxycodone	URINE	not detected <i>	(Not-detected)

Rads

No Rads Found.

Reason for Appointment:

est

Appointment Comments:

ddr

Vitals**Vitals** Written by NEFF, JOANNE S @ 14 May 2015 0908 EDT

BP: 121/79, HR: 69, RR: 16, T: 97.2 °F

S/O Note Written by ZEMBRZUSKA, HANNA DOMINIKA @ 15 May 2015 0806 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder presents for f/u appt after Zoloft was increased to 75mg daily and he was started on Melatonin. Pt reports that his depressed mood has lifted and he is happier more often, but it is not consistent. He reports no difference in his anxiety, however, he has become more focused and productive. He wants to be a positive role model for others struggling with alcohol. He is again interested in volunteering which is something he did at the prime of his military career. He has been working on his computer game, created an LLC, and is tracking his hours working on the game. He continues to have anxious ruminations about work which lead to initial insomnia. He has been taking Melatonin at bedtime, but does not want to take it every night. He has been attending CBT-I group and using the CBT-I app both of which he has found helpful. He no longer reads his phone prior to bedtime. Sleeping about 7 hours per night. He reports sexual side effects (decreased interest) from Zoloft, but feels that this is beneficial since sex has been a distraction for him in the past.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 re on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged at the end of April 2015.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zoloft 75mg daily

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

- * SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself ul experience from the past or avoid having feelings related to it?

- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
 [0] Trouble remembering important parts of a stressful experience from the past?
 [0] Loss of interest in things that you used to enjoy?
 [0] Feeling distant or cut off from other people?
 [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
 [0] Feeling as if your future will somehow be cut short?
 [0] Trouble falling or staying asleep?
 [1] Feeling irritable or having angry outbursts?
 [1] Having difficulty concentrating?
 [1] Being 'super alert' or watchful on guard?
 [0] Feeling jumpy or easily startled?

Add point values from each response. TotalD.

Behavioral: Caffeine use 16 oz tea/day and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently.

Subjective

NO Learning Disability, Language or Learning Barriers.

Additional Screening Questions:

Are you having any thoughts about harming another person? Denies

Do you feel like you are at risk for workplace violence? Denies

Review of systems

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: • Dysthymic. • Anxious. ° Not depressed.

Affect: • Abnormal anxious. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide/Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Protective:

Strong Therapeutic Alliance: Y
 Positive Coping Skills: Y
 Responsible to/for Family: Y
 Responsible to/for Pet: N
 Frustration Tolerance: Y
 Resilience: Y
 Good Reality Testing: Y
 Amenable to Treatment: Y
 Social Support: Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Therapy

• Duration of the encounter 30 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: MELTON FOR CBT-I

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 14MAY2015
 Reviewed with patient on: same
 Does patient agree with plan? Yes
 If not, what part?
 Projected date of next treatment plan update: f/u in 1 month
 Discussion of assessment and intervention
 Tx Plan cont'd:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

(23APR2015) PHQ-9 = 4, GAD-7 = 5, PCL-C = 13

Diagnosis

Generalized Anxiety Disorder

Alcohol Use Disorder, moderate to severe

Active Problem List:

1. Anxiety, worry, irritability
2. Depressed/apathetic mood
3. Insomnia

Long-Term Goals:

1. Improve relationship/increase social support from mother and sister
2. Improve financial knowledge/pay off debts

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Continue Zoloft 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Continue Zoloft 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Continue Melatonin QHS prn insomnia
2. Pt to continue using CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts
3. Continue CBT-I group with Ms. Melton at WRNMMC.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by ZEMBRZUSKA,HANNA DOMINIKA @ 15 May 2015 0802 EDT**1. GENERALIZED ANXIETY DISORDER** 300.02

Procedure(s): -(90833) Psych Ther Indiv Approx 30 Min W/ Medical Evaluation & Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90**Disposition** Written by ZEMBRZUSKA,HANNA DOMINIKA @ 15 May 2015 0807 EDT**Released w/o Limitations****Follow up:** 1 month(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 15 May 2015 0807

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

13 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20783265 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **13 May 2015 0800 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 15 May 2015 0758 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 13 May 2015 0800 EDT
OP GROUP/EST

Screening Written by PATSOS,ASHLEY N @ 13 May 2015 0801 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 13 May 2015 0800

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 13 May 2015 0802 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

S/O Note Written by PATSOS,ASHLEY N @ 13 May 2015 0802 EDT

History of present illness

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 13 May 2015 0804 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 15 May 2015 0759 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 8th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with Daniel doing his check-in to the group members going over any triggers or cravings he may have had during the past couple of days. During Daniel's check-in, Daniel stated how excited he was because he had just set up a date for after group with a girl that he's been talking to online. He stated that whether anything happens with her or not, he is OK with that fact. Daniel also mentioned how the Navy is his only family and it's what has validated him throughout these years. He continued to say that the Navy is "all that he has".

Daniel seemed very suspicious and cynical while describing his date. He showed signs of why he has very little belief in his self-worth. However, while he was describing his programing abilities, Daniel continues to appear self-reliant and assertive. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level Treatment at BNHC-WNY on the 15th of May 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Note Written by REGIS,JAMES @ 15 May 2015 0800 EDT

Individual 1-on-1 session w/Counselor for Week #3 OP Level 1 Treatment

Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 13th of May 2015 from 08:00 to 09:00 (1 hour). This is Daniel's 1-on-1 Individual session for Week #3 of his OP Level 1 Treatment at SARP WNY. He stated that he just set up a lunch date with a friend of his. Daniel then stated that, although he is looking forward to seeing his date that he doesn't think she will find him to be "her type" nor like him because she's very attractive. This he explains is directly attributed to his concerns of self-worth along with his anxiety issues that he feels he has to continue working on. Daniel also stated that he continues to write the program for his game which he admits will give him recognition and will validate him as being essential.

Daniel seemed excited and enthusiastic about his lunch date but immediately appeared cautious suspicious when thoughts of his self-worth arose. He continues to show passion for his company and the development of his gaming software along with extreme eagerness to succeed and to be validated.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 11th 2015 @ 09:00

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By **REGIS, JAMES** (Para-Professional, SARP WNY) @ 15 May 2015 0803
Co-Signed By **BROWN, CYNTHIA E** (Paraprofessional) @ 15 May 2015 0827

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20774303 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 12 May 2015 1135 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 12 May 2015 1138 EDT**Group Therapy Note**

Date: **11 May 15**
 Time w/Patient **1300-1400**

Purpose of Group:

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #3:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Members discussed past week and changes/challenges they have made and come across with incorporating CBTi components, sleep hygiene, completing sleep log and keeping to their calculated sleep window. Agenda for session three: discussed how thinking influences sleep and how to think in ways that promote sleep, discussed changing dysfunctional core beliefs, ways to quiet the mind (buffer zone) and practiced and provided hand out of pleasant imagery exercise. Continued to discuss sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality. Reviewed sleep log, how to calculate Sleep Efficiency for using sleep training/restriction this week and identified sleep window for several members to begin sleep restriction.

Summary of Patient Information and Participation:

SM reports he continues to use the CBTi app on his phone which helps him record his sleep and automatically calculates his sleep efficiency. Reports his sleep efficiency is ~ 92% and his sleep window is 930pm-5am. Reports he is having a hard time getting out of bed in the morning when his alarm wakes up and is not going to bed every night when he at scheduled time. He reports he is not as tired throughout the day. Reports he will work on this but notices that he is getting to sleep faster, as he is not using his phone to watch news or be stimulated right before bed.

Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings 4 weeks

Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 12 May 2015 1137 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 12 May 2015 1137 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1wk

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 12 May 2015 1139

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20756996 Primary Dx: ALCOHOL DEPENDENCE
(ALCOHOLISM)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **11 May 2015 1055 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 15 May 2015 0746 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by BROWN,CYNTHIA E @ 11 May 2015 1055 EDT
OP GROUP

Screening Written by BROWN,CYNTHIA E @ 11 May 2015 1127 EDT

Reason For Appointment: Notes Entered by: BROWN,CYNTHIA E 11 May 2015 1055

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by BROWN,CYNTHIA E @ 11 May 2015 1127 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact Number: [REDACTED]

No vitals taken at SARP

S/O Note Written by BROWN,CYNTHIA E @ 11 May 2015 1128 EDT

Reason for Visit

OP Group.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by BROWN,CYNTHIA E @ 11 May 2015 1131 EDT**1. ALCOHOL DEPENDENCE (ALCOHOLISM)**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 15 May 2015 0747 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 3, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniel's 7th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the introduction of 1 new group member and a review of group rules followed by a brief discussion concerning phobias and pet peeves of the group.

During Daniel's introduction, Daniel stated that although he bites his nails and picks at his hair, that he is very conscious when other people do that around him. He stated that he doesn't bite them as much now because of his braces but before he had his braces; he explained how he was always doing it. Daniel went on to tell another group member that she would have hated him because he would be biting his nails all the time.

Daniel continues to appear very attentive to the groups needs by continuing to take on the "fixer" role and attempting to solve different issues that arises in group. He seems very insightful on both his current situation and that of the group. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 13th of May 2015 @ 08:00
Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 15 May 2015 0747**Co-Signed By BROWN, CYNTHIA E** (Paraprofessional) @ 15 May 2015 0751**CHANGE HISTORY**The following Disposition Note Was Overwritten by REGIS,JAMES @ 15 May 2015 0747 EDT:

The Disposition section was last updated by REGIS,JAMES @ 15 May 2015 0747 EDT - see above. Previous Version of Disposition section was entered/updated by BROWN,CYNTHIA E @ 11 May 2015 1131 EDT.

Released w/o Limitations

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 628
AR 2615

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE A

Encounter ID: BETH-20738346 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **08 May 2015 0853 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **GONZALEZZARAZUA, JORGE A**

AutoCites Refreshed by GONZALEZZARAZUA, JORGE A @ 08 May 2015 1424 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 08 May 2015 0853 EDT
OP GROUP

Screening Written by PATSOS, ASHLEY N @ 08 May 2015 0907 EDT

Reason For Appointment: Notes Entered by: PATSOS, ASHLEY N 08 May 2015 0853

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS, ASHLEY N @ 08 May 2015 0908 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 08 May 2015 0911 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 08 May 2015 0912 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 08 May 2015 1425 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 2, Day 3 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with a feeling word. Daniel and the rest of the group member also shared their respective plans for the upcoming weekend, providing insight and support to each other.

Daniel shared that he is excited about his upcoming weekend and states that he has quite a bit of work planned. He shared that he is working on developing a computer game and has set aside a few hours each morning and afternoon to sit down and write code for his game. He also states that he will be attending a Nerf gun event called Zombies vs Humans on Saturday which is a fun way to do Nerf gun battles. He also mentioned that he will be attending a couple self-help meetings each day to satisfy the requirements of his ITP.

Daniel appears comfortable in the group setting, engaging well with others and being vocal about what others are sharing or planning on doing. His check-in and sharing are mostly on the short side and rather vague. Daniel addressed Problem 1, Objective 1 and 2 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 11 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 08 May 2015 1426**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 08 May 2015 1506

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 May 2015 at WRNMMC, Int Med CL C Medical Home BE by ARGUINZONI, JUAN B.

Encounter ID: BETH-20730612 Primary Dx: ALCOHOL ABUSE - IN REMISSION

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR
 BE**
 Patient Status: **Outpatient**

Date: **07 May 2015 1330 EDT**
 Clinic: **INT MED MEDICAL HOME CL C
 BE**

Appt Type: **EST**
 Provider: **ARGUINZONI, JUAN B.**

AutoCites Refreshed by OYAWALE, BIDEMI R @ 07 May 2015 1304 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

Physical Exam (SARP Related - Navy Yard), Dermatology issue as well

Appointment Comments:

Appt self-booked via TOL

Vitals**Vitals** Written by OYAWALE, BIDEMI R @ 07 May 2015 1302 EDT

BP: 122/72, HR: 76, RR: 16, T: 97.8 °F, HT: 69 in, WT: 161 lbs, SpO₂: 99%, BMI: 23.78,
 BSA: 1.884 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by OYAWALE, BIDEMI R @ 07 May 2015 1304 EDT**Questionnaires**

Anxiety & Depression Screening Version: 1 Completed On: 07 May 2015

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Not at all
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Not at all
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by ARGUINZONI, JUAN B. @ 07 May 2015 1835 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in TSWF-CORE>>

30 y/o male (PCM Ms Austin) who comes to clinic for physical exam for SARP (Substance Abuse Rehabilitation Program). Patient used to drink 7-8 mixed drinks a day (rum, vodka) and was hospitalized for inpatient program at Fort Belvoir and discharged on 22 april 15 (his last etoh intake was 25 march 15). At present is on SARP program at Navy Yard. He takes sertraline for generalized anxiety disorder. Has had patches of dry skin on scalp and is requesting dermatology consult. Feels fine otherwise and has no other complaints.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated
 NKDA

Current medication

Including OTC meds, vitamins, herbals, etc.
 Sertraline 50mg one and a half tab a day

Past medical/surgical history**Reported:**

Medical: Reported medical history
 GAD
 alcohol dependence in remission

Surgical / Procedural: Surgical / procedural history
 PRK

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tosillectomy

Personal history

Social history reviewed Does not smoke, no etoh intake since 25 march 15.

Family history

Family medical history

DM father, PGM

MI father

hypertension father

melanoma father

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL. ° Size of the pupil was normal. ° Pupil accommodation was not impaired.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Right Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Left Ear:

External Auditory Canal: ° Normal.

Tympanic Membrane: ° No bulging tympanic membrane. ° Not erythematous.

Middle Ear: ° No fluid in middle ear.

Nose:

General/bilateral:

Discharge: ° No nasal discharge seen.

External Deformities: ° No external nose deformities.

Cavity: ° Nasal septum normal. ° Nasal mucosa normal. ° Nasal turbinate not erythematous. ° Nasal turbinate not swollen.

Sinus Tenderness: ° No sinus tenderness.

Oral Cavity:

Lips: ° Showed no abnormalities.

Buccal Mucosa: ° Examination showed no abnormalities.

Pharynx:

Oropharynx: ° Normal. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° Abdomen was soft. ° No abdominal guarding. ° Abdominal non-tender. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Hernia: ° No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: ° Mobility was not limited.

Other:

General/bilateral: ° No muscle tenderness.

Neurological:

Sensation: ° No sensory exam abnormalities were noted.

Motor (Strength): ° Strength of the upper extremities was normal. ° No lower extremity weakness was observed.

Balance: ° Normal.

Gait And Stance: ° Normal.

Reflexes: ° Deep tendon reflexes were normal.

Skin:

• Skin: two areas of alopecia on scalp.

Practice Management

Preventive medicine services

Lipid Screening -

Diabetes Screening -

Aspirin Prophylaxis -

HIV Screen -

Colonoscopy -

Tetanus (Td/Tdap) - 2013

Influenza Vaccine - oct 2014

Zoster Vaccine -

Pneumococcal Vaccine -

HPV Vaccine -

Men:

Aortic Aneurysm Screen (if ever a smoker) -

.....

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT

Comprehensive Metabolic Panel	Site/Specimen	28 Apr 2015 0958
Albumin	SERUM	5.1
Alkaline Phosphatase	SERUM	70
Alanine Aminotransferase	SERUM	33
Bilirubin	SERUM	0.3
Urea Nitrogen	SERUM	13.4
Calcium	SERUM	9.9
Carbon Dioxide	SERUM	29
Chloride	SERUM	101
Creatinine	SERUM	0.97
Glucose	SERUM	90
Potassium	SERUM	4.6
Protein	SERUM	7.7
Sodium	SERUM	143
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	104.3
GFR Calculated Black	SERUM	120.6 <i>
Aspartate Aminotransferase	SERUM	26

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT

Drug Abuse Screen	Site/Specimen	04 May 2015 0922
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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Amphetamines	URINE	NEGATIVE <i>
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine, UA	URINE	NEGATIVE <i>
Cannabinoids	URINE	NEGATIVE <i>
Methadone	URINE	NEGATIVE <i>
Oxycodone	URINE	NEGATIVE <i>

Lab Result Cited by ARGUINZONI, JUAN B. @ 07 May 2015 1844 EDT**ETG/ETS, UA (250 Cut-Off)****Site/Specimen****04 May 2015 0922**

Ethyl Glucuronide

URINE

Negative

A/P Written by ARGUINZONI, JUAN B. @ 07 May 2015 1848 EDT**1. ALCOHOL ABUSE - IN REMISSION:** Physical exam form for SARP filled and signed. Continue in substance abuse rehab program.**2. GENERALIZED ANXIETY DISORDER:** Continue sertraline**3. ALOPECIA AREATA:** Referral to dermatology clinic**Disposition** Written by ARGUINZONI, JUAN B. @ 07 May 2015 1851 EDT**Released w/o Limitations****Follow up:** with PCM. - Comments: Referral to dermatology.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** ARGUINZONI, JUAN B. (Physician) @ 07 May 2015 1851

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20709936 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **06 May 2015 0911 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **GONZALEZZARAZUA, JORGE A****AutoCites** Refreshed by GONZALEZZARAZUA, JORGE A @ 08 May 2015 1429 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 06 May 2015 0911 EDT
OP GROUP**Screening** Written by PATSOS, ASHLEY N @ 06 May 2015 0912 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 06 May 2015 0911

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 06 May 2015 0912 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 06 May 2015 0912 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 06 May 2015 0913 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 08 May 2015 1430 EDT**Released w/o Limitations****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 2, Day 2 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with a feeling word. The group was also reminded by this counselor about abiding by group rules as well as emphasized the importance of owning their own statements.

Daniel shared that he went on a date with a lady he met online. He states that this is the norm for him and that he had no triggers since his last session. He states that he also went to a meeting with a member of his old group in residential treatment after she called him to invite him to a meeting. Daniel also shared with other group members that he thought they were glamorizing their relationship with alcohol versus looking at their current situation.

Daniel appears comfortable in the group setting, engaging with other group members and providing feedback as he sees necessary. However, after his check-in this counselor noticed that Daniel focused largely on everyone else's issues, trying to help out and provide feedback, but did very little sharing of his own. Daniel addressed Problem 1, Objective 1 and 2 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 08 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 08 May 2015 1430**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 08 May 2015 1509

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20707909 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **06 May 2015 0808 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **EST**
Provider: **REGIS,JAMES****AutoCites** Refreshed by REGIS,JAMES @ 06 May 2015 0910 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 06 May 2015 0808 EDT
EST**Screening** Written by PATSOS,ASHLEY N @ 06 May 2015 0809 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 06 May 2015 0808

EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 06 May 2015 0809 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: 850-969-7239

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Questionnaire AutoCites Refreshed by REGIS,JAMES @ 06 May 2015 0910 EDT
Questionnaires

A/P Last Updated by PATSOS,ASHLEY N @ 06 May 2015 0810 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s):

-BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0900 to review Individual Treatment Plan.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Written by REGIS,JAMES @ 06 May 2015 0910 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: Daniel arrived on time for his Individual 1-on-1 session with his counselor on Wednesday 06th of May 2015 at 08:00. This is Daniel's 1-on-1 Individual session for Week #2 of his OP Level 1 Treatment at SARP WNY. He stated that he was put on night shift at his job which with treatment has become an issue for him to stay on. He stated that he is worried about how his command is going to react when he tells them that he cannot work the night schedule because of his treatment program. Daniel also stated that he realizes that his taking Zoloft has diminished his sexual turn-on which he read is a side effect. Daniel mentioned that he is getting very involved in his game writing these days and is thinking about establishing contract with different people in the industry to help with his company. He realizes that he is driving more these days (over 100 miles this past week) to support his treatments in the DMV area.

Daniel seemed indifferent when talking about his treatment plan. However, when explaining his company and the development of his gaming software, Daniel seemed extremely enthusiastic and ecstatic. His job continues to be a source of frustration for him as he deal with a civilian counterpart that is out of the loop of his treatment needs.

Daniel continues to attend AA meetings and incorporate his abstinence tools towards his sobriety. He was reminded to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will for his Level 1 OP Group here at WNY on May 06th 2015 @ 09:00

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 06 May 2015 0911

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 May 2015 at WRNMMC, Behavioral Health Qu by AILOR, LYNNE P

Encounter ID: BETH-20693884 Primary Dx: Laboratory Studies

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NHC QUANTICO**
 Patient Status: **Outpatient**

Date: **05 May 2015 0930 EDT**
 Clinic: **BEHAVIORAL HEALTH QU**

Appt Type: **PROC**
 Provider: **AILOR,LYNNE P**

Reason for Appointment:
 PROCEDURE - SARP LABS
Appointment Comments:
 BRH

Lab Result Cited by AILOR,LYNNE P @ 05 May 2015 1523 EDT**Drug Abuse Screen**

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site/Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

04 May 2015 0922

NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>
 NEGATIVE <i>

ETG/ETS, UA (250 Cut-Off)

Ethyl Glucuronide

Site/Specimen

URINE

04 May 2015 0922

Negative

A/P Written by AILOR,LYNNE P @ 05 May 2015 1526 EDT**1. Laboratory Studies**

Procedure(s): -Psychiatric Diagnostic Evaluation Review of Records and Reports x 1

2. PSYCHIATRIC DIAGNOSIS OR CONDITION DEFERRED ON AXIS I(OTHER UNKNOWN AND UNSPECIFIED CAUSES OF MORBIDITY AND MORTALITY, NOT PGW SYNDROME): Labs were reviewed by undersigned provider per SARP protocol. Results of ETG/ETS and Drug Abuse Screen were negative.

Disposition Written by AILOR,LYNNE P @ 05 May 2015 1526 EDT**Released w/o Limitations****Signed By AILOR, LYNNE P (Physician) @ 05 May 2015 1526**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 May 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20705236 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **04 May 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 05 May 2015 1604 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 05 May 2015 1620 EDT**Group Therapy Note**

Date: **04 May 15**
 Time w/Patient **1300-1400**

Purpose of Group:

Group members will learn and utilize CBTi components and follow healthy sleep guidelines to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Brief Summary of content of session #2:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Due to several new group member, Facilitator and co-facilitator provided information from session one to assist new group members in obtaining and understanding CBTi group. Participants introduced themselves, offered personal treatment goals. Agenda for session two discussed and handouts given to group members focusing on sleep guidelines, habits that influence sleep. Discussed sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality, by utilizing learned skills and adhering by sleep guidelines. Reviewed sleep log, how to calculate sleep Sleep Efficiency for using sleep training/restriction this week.

Summary of Patient Information and Participation:

SM reports this week he used the CBTi app on his phone which helped him record his sleep and automatically calculated his sleep efficiency for him. Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in civilian attire.

His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings 4 weeks

Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Last Updated by MELTON, APRIL M @ 05 May 2015 1605 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Last Updated by MELTON, APRIL M @ 05 May 2015 1607 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1 wk for group

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 05 May 2015 1621

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

04 May 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20678033 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **04 May 2015 0846 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **REGIS,JAMES****AutoCites** Refreshed by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0908 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 04 May 2015 0846 EDT
OP GROUP**Screening** Written by PATSOS,ASHLEY N @ 04 May 2015 0857 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 04 May 2015 0846

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 04 May 2015 0858 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 04 May 2015 0859 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last updated by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Laboratory(ies): -ETG/ETS, UA (250 CUT-OFF) (Routine) Ordered By: GONZALEZZARAZUA,JORGE A Ordering Provider: AILOR, LYNNE P; DRUG ABUSE SCREEN (Routine) Ordered By: GONZALEZZARAZUA,JORGE A Ordering Provider: AILOR, LYNNE P

Disposition Last Updated by REGIS,JAMES @ 06 May 2015 1225 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 2, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's 4th day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the introduction of 2 new group members and a review of group rules followed by Daniel performing his check-in to the group going over any triggers or cravings he may have had during the past couple of days.

During Daniel's check-in, Daniel stated that he had a productive weekend even though he didn't get a chance to work on his gaming program that much. Daniel stated that he is looking forward to going on a date in Baltimore with a young lady whom he met on a dating website. He stated that she is a software programmer which intrigues him because of his own interest in writing gaming programs.

Daniel seemed indifferent and cautious regarding his leisure activities during this past weekend. He seems to understand how to apply his sobriety tools in different situations even though he appears to question himself. In regards to his date, Daniel looked to be very confident and interested in its outcome. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 06th of May 2015 @ 0800 Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 06 May 2015 1225**Co-Signed By BROWN, CYNTHIA E** (Paraprofessional) @ 07 May 2015 0627**CHANGE HISTORY****The following A/P Note Was Overwritten by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT:**

The A/P section was last updated by GONZALEZZARAZUA,JORGE A @ 04 May 2015 0909 EDT - see above. Previous Version of A/P section was entered/updated by PATSOS,ASHLEY N @ 04 May 2015 0900 EDT.

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 May 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20662019 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **01 May 2015 0758 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **GRP**
Provider: **GONZALEZZARAZUA, JORGE A****AutoCites** Refreshed by GONZALEZZARAZUA, JORGE A @ 01 May 2015 1444 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 01 May 2015 0758 EDT
OP GROUP/EST**Screening** Written by PATSOS, ASHLEY N @ 01 May 2015 0800 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 01 May 2015 0758

OP GROUP/EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 01 May 2015 0800 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 01 May 2015 0805 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-on-one from 0800-0830 to review Individual Treatment Plan.
 -ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.
 -ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 01 May 2015 1445 EDT**Released w/o Limitations**

Discussed: Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his group appointment. He is in Week 1, Day 3 of OP treatment attending from 0900-1100, total of 2 hours. The group started off by doing a check-in and summarizing their current emotional state with one feeling word. The group was also reminded by this counselor about abiding by group rules as well as emphasized the importance of owning their own statements.

Daniel shared that being in OP group has been good for him as he believes there are still more things he wants to work on, pertaining to his recovery and why he used alcohol to cope with life. He states that he is getting back into the swing of things back at work and is trying to not allow himself to get stressed. He states that for the weekend, he has a trip planned to King's Dominion water park with a friend, allowing him some "fun time" and just relaxing in his place.

Daniel appears comfortable and willing to be an active participant in OP treatment. He seems to want to take charge of his recovery and used some of the tools he learned while in residential treatment. Daniel addressed Problem 1, Objective 1 of his ITP by attending his group session on time and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled apt 04 May 2015 @ 0900.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 01 May 2015 1445**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 01 May 2015 1453

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 Apr 2015 at WRNMMC, Psychiatry Be by MELTON, APRIL M

Encounter ID: BETH-20652494 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Apr 2015 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **GRP**
 Provider: **MELTON, APRIL M**

AutoCites Refreshed by MELTON, APRIL M @ 30 Apr 2015 1032 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family history of heart disease (General FHx)
- no family history of cancer (General FHx)
- family history of diabetes mellitus (General FHx)
- family history of mental illness (not retardation) (General FHx)
- family history of patient counseling (General FHx)
- family history of the options include referral (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Social History

No Social History Found.

Reason for Appointment:

CBT-i

Appointment Comments:

bst

Note Written by MELTON, APRIL M @ 30 Apr 2015 1034 EDT**Group Therapy Note**

Date: 27 April 15
Time w/Patient 1300-1400

Purpose of Group:

Group members will learn and utilize CBTi components to assist in managing insomnia. The group will also serve as opportunity for group members to share their experiences and gain support from others.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Brief Summary of content of session #1:

Facilitator and co-facilitator introduced themselves and provided information regarding CBTi group agenda. Participants introduced themselves, offered personal treatment goals and were asked to complete Insomnia Severity Index, Restless Leg Syndrome Assessment, STOP questionnaire and Dysfunctional Beliefs about Sleep survey. Education on sleep, sleep stages, insomnia and CBTi components provided. Discussed sleep diary and importance of completing every week for maximum opportunity to improve sleep quantity and quality.

Summary of Patient Information and Participation:

Pt presents with a formal diagnosis of GAD and was referred to group by Dr. Zembrzka. Pt stated mood today is good and participated in the group, offering personal treatment goals and reason for attending the group; he wants to improve quality of sleep. Reports he sleeps about 5hrs per night but is in bed for a total of 8hrs. Agreed to complete Sleep Log this week and attend next group session.

Pain: None reported

Mental Status: SM presented to the group dressed appropriately in military uniform. His mood was euthymic and affect was congruent with mood. Speech was logical and goal directed with no evidence of loosened associations or flight of ideas. Thought processes were deemed to be intact with no evidence of hallucinations or delusions.

Risk Assessment: SM did not report any SI/HI. Status will continue to be monitored in group and also by individual providers.

Plan: Continue with group meetings for ~4 weeks. Other treatment modalities (e.g. medication management, individual treatment) will continue as planned.

A/P Written by MELTON, APRIL M @ 30 Apr 2015 1032 EDT

1. GENERALIZED ANXIETY DISORDER

Procedure(s): -Psychiatric Therapy Group Interactive x 1

Disposition Written by MELTON, APRIL M @ 30 Apr 2015 1032 EDT

Released w/o Limitations

Follow up: in the PSYCHIATRY BE clinic. - Comments: 1 wk

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By MELTON, APRIL M (LCSW-C, Social Worker, 295-4427, Pin# 1085970) @ 30 Apr 2015 1035

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20634025 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **29 Apr 2015 0854 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 29 Apr 2015 1426 EDT

Problems

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 29 Apr 2015 0854 EDT
OP GROUP

Screening Written by PATSOS,ASHLEY N @ 29 Apr 2015 0924 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 29 Apr 2015 0854

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 29 Apr 2015 0924 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 29 Apr 2015 1427 EDT**Released w/o Limitations**

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 1, Day 2 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's 2nd day of treatment in group. Neither Daniel nor any other group member admitted to consuming any alcohol or illegal drugs since their last group session. Group began with the review of group rules followed by Daniel performing his check-in to the group going over any triggers or cravings he may have had during the past couple of days.

During Daniel's check-in, Daniel stated that he was feeling apathetic because he spoke to his step mother who gave him news about his father's postings on Facebook. Daniel went on to say that he thought his father's actions were childish and that he didn't care about it. He said that his triggers usually involved his being disappointed in relationships which would lead him to drinking. The group asked him about his disappointed relationship with his father and whether or not that's ever caused him to drink; to which he said no.

Daniel seemed perplexed and disappointed when explaining his relationship and arguments with his father. He appears withdrawn and exasperated regarding his rapport with his father. Daniel was reminded in group to continue working on his ITP. Daniel is currently addressing Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for a 1-on-1 Individual session with his counselor on the 1st of May 2015 @ 0800
Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 29 Apr 2015 1428**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 29 Apr 2015 1430**CHANGE HISTORY***The following S/O Note Was Deleted by PATSOS,ASHLEY N @ 29 Apr 2015 0933 EDT:***History of present illness**

The Patient is a 30 year old male.

The patient was present for the Continuing Care Support Group (CCSG).

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Apr 2015 at WRNMMC, Medical Readiness Clinic Bethesda by PARSON, MARSHEA S

Encounter ID: BETH-20618206 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **28 Apr 2015 0900 EDT**
 Clinic: **MEDICAL READINESS CL BE**

Appt Type: **WELL**
 Provider: **PARSON, MARSHEA S**

AutoCites Refreshed by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Procedures

- Postoperative Visit, Without Charge (06 Jun 2011)
- Postoperative Visit, Without Charge (06 Jun 2011)
- Ophthalmological Prior Patient Start Comprehensive Care (04 May 2011)
- Postoperative Visit, Without Charge (26 Apr 2011)
- Postoperative Visit, Without Charge (22 Apr 2011)
- PHOTOREFRACTIVE KERATECTOMY (PRK) (21 Apr 2011)
- Computerized Corneal Topography (29 Mar 2011)
- Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral (29 Mar 2011)
- Corneal Pachymetry Both Eyes (29 Mar 2011)
- Determination Of Refractive State (29 Mar 2011)
- Ophthalmological New Patient Start Comprehensive Care (29 Mar 2011)
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) (24 Mar 2011)
- Spirometry Pre-bronchodilator (24 Mar 2011)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

- 2011)
- Spirometry Post-bronchodilator (24 Mar 2011)
- Bronchial Challenge With Methacholine (24 Mar 2011)
- Special Dr. Services Analysis Of Computerized Data (24 Mar 2011)
- Pulmonary Function FRC (% Predicted Normal) (24 Mar 2011)
- Pulmonary Function MVV (24 Mar 2011)
- Pulse Oximetry (24 Mar 2011)
- Determination Of Refractive State (16 Mar 2011)
- Ophthalmological Prior Patient Start Intermediate Level Care (16 Mar 2011)
- Corneal Pachymetry Both Eyes (17 Feb 2011)
- Ophthalmological Prior Patient Start Comprehensive Care (17 Feb 2011)
- Biopsy Skin (24 Nov 2010)
- Immunization Administration One Vaccine (15 Nov 2010)
- Influenza Virus Vaccine Live Intranasal (15 Nov 2010)
- Biopsy Skin (28 Sep 2010)
- Biopsy Skin Each Additional Lesion (28 Sep 2010)
- Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia) (23 Apr 2010)
- Determination Of Refractive State (23 Apr 2010)
- Spectacles Services Fitting Monofocals (Not For Aphakia) (23 Apr 2010)
- Ophthalmological New Patient Start Comprehensive Care (23 Apr 2010)
- Anthrax Vaccine, For Subcutaneous Use (09 Mar 2010)
- Influenza Virus Vaccine Pandemic Formulation (22 Dec 2009)
- Immunization Administration One Vaccine (22 Dec 2009)
- Immunization Administration One Vaccine (23 Sep 2009)
- Influenza Virus Vaccine Live Intranasal (23 Sep 2009)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

pha/navy

Appointment Comments:

ash8056967239

Screening Written by PONDS, BRANDON J @ 28 Apr 2015 0910 EDT**Reason For Appointment:** pha/navy

Allergen information verified by PONDS, BRANDON J @ 28 Apr 2015 0910 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by POND, BRANDON J @ 28 Apr 2015 0924 EDT

BP: 129/76, HR: 61, RR: 14, T: 98.1 °F, HT: 69 in, WT: 150 lbs, Uncorr OD: 20/25, Uncorr OS: 20/25, Uncorr OU: 20/25, BMI: 22.15,

BSA: 1.828 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: EPWORTH SLEEP: 8**Questionnaire AutoCites** Refreshed by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT**Questionnaires**

Tuberculosis Exposure Risk Assessment Version: 3 Completed On: 28 Apr 2015

1. Since your last Tuberculosis Exposure Questionnaire were you exposed to anyone known to have or suspected of having active tuberculosis (i.e. with persistent cough, weight loss, night sweats, and/or fever)? No

2. Since your last Tuberculosis Exposure Questionnaire or Post Deployment Health Assessment (DD Form 2796), did you have direct & prolonged contact with any individuals of the following groups: refugees or displaced persons: patients hospitalized with tuberculosis, prisoners, or homeless shelter populations? No

3. Write the name of any country or countries where you have traveled or deployed to since your last Tuberculosis Exposure Questionnaire.: N/A

4. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least eight consecutive hours on a single day, or for a total of at least fifteen hours per week of a multi-week stay.: No

5. Have you had a prior history of TB or prior treatment for Latent TB? No

6. PROVIDER: Have you recently had a chronic cough AND did you have any of the following at the same time? Fever, Coughed up Blood, Unexplained Weight Loss, Night Sweats: No

7. PROVIDER: Since your last risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day> 1 month) or other immunosuppressive medication such as Humira, Enbrel or Remicade? No

8. PROVIDER: Since your last TB risk assessment did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal weight) or injection drug use? No

EPWORTH Sleepiness Scale Version: 1 Completed On: 28 Apr 2015

1. How likely are you to doze off or fall asleep while SITTING and READING?: 3

2. How likely are you to doze off or fall asleep while WATCHING TV?: 1

3. How likely are you to doze off or fall asleep while INACTIVE in a meeting, theater, or other similar place?: 0

4. How likely are you to doze off or fall asleep as a PASSENGER in a car for an HOUR without a break?: 3

5. How likely are you to doze off or fall asleep while LYING DOWN to rest in the afternoon when circumstances permit?: 0

6. How likely are you to doze off or fall asleep while sitting and TALKING to someone?: 0

7. How likely are you to doze off or fall asleep while SITTING QUIETLY after a lunch without alcohol?: 1

8. How likely are you to doze off or fall asleep in a CAR, while stopped for a few minutes in the traffic?: 0

S/O Note Written by PARSON, MARSHEA S @ 28 Apr 2015 0945 EDT**Chief complaint**

The Chief Complaint is: FACE TO FACE PHA, ACTIVE DUTY.

Reason for Visit

Visit for: FACE TO FACE PHA.

History of present illness

The Patient is a 30 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Past medical history reviewed, problem list reviewed, medication list reviewed, family history reviewed, and surgical history reviewed.

Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

[] Y [X] N Deployment/Shipboard limiting conditions identified

. Currently on active duty.

No systemic symptoms.

Navy ADMS educated to the Face to Face PHA. Ft Meade, CTN1. Denies new behavioral health, new medical health complaints. Reviewed problem list. No deployment limiting conditions. Reviewed and educated to Framingham and survey results.

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [X] No. No chronic illness. An allergy SEE ABOVE.

Medications: Medication history SEE ABOVE. Not taking medication for high blood pressure.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

- 2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No
 3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No
 4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No
 5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [X] No.

SEE ABOVE.

Family history

No family history of cancer
 Mental illness (not retardation) MATERNAL
 Heart disease PATERNAL GF, Father
 Diabetes mellitus PATERNAL GF and Father.

Review of systems**Head:** No head symptoms.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Otolaryngeal:** No otolaryngeal symptoms.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms.**Gastrointestinal:** No gastrointestinal symptoms.**Genitourinary:** No genitourinary symptoms.**Endocrine:** No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Musculoskeletal:** No musculoskeletal symptoms.**Neurological:** No neurological symptoms.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

General Appearance:

° Well-appearing.

Head:

Appearance: ° Head normocephalic.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.

Neurological:

° Level of consciousness was normal.

Speech: ° Normal.

Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Affect: ° Normal.

Thought Processes: ° Not impaired.

Thought Content: ° Revealed no impairment.

Objective

Health Record [] Reviewed [X] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Therapy

• No electronic medical alert pendant in possession as indicated.

Plan

• Referred elsewhere for the options include referral

[] Physical Activity

[] Safety

[] Diabetes Counseling

[] Cholesterol

[X] Nutrition

[X] Sexuality

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

[] Other:

• Referred elsewhere for patient counseling

[] Tobacco Use

[] Alcohol Use

[] Weight Management

[] Dental Care

[] Mental Health

[] Hypertension

[X] Other: STRESS MANAGEMENT, SLEEP

Updated DD 2766 Sections: NO RECORD

Health counseling performed or scheduled documented on the DD 2766 and for additional topics below:

Notes

Follow-up in one year.

Practice Management

Risk factor counseling individual, 30 minutes.

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0920 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0914 EDT

Comprehensive Metabolic Panel	Site/Specimen	27 Mar 2015 1600
Albumin	SERUM	4.9
Alkaline Phosphatase	SERUM	71
Alanine Aminotransferase	SERUM	29 <i>
Bilirubin	SERUM	0.3
Urea Nitrogen	SERUM	14
Calcium	SERUM	10.0
Carbon Dioxide	SERUM	29
Chloride	SERUM	98
Creatinine	SERUM	0.9
Glucose	SERUM	82
Potassium	SERUM	4.7
Protein	SERUM	7.9
Sodium	SERUM	139
Anion Gap	SERUM	13
GFR Calculated Non-Black	SERUM	114.7
GFR Calculated Black	SERUM	132.6 <i>
Aspartate Aminotransferase	SERUM	<5

Lab Result Cited by PONDS, BRANDON J @ 28 Apr 2015 0913 EDT

HIV-1/O/2 Ab	Site/Specimen	27 Mar 2015 1600
HIV-1/O/2 Ab	SERUM	*****

A/P Last updated by PARSON, MARSHEA S @ 28 Apr 2015 0950 EDT**1. Visit for: military services physical (PERIODIC PREVENTION EXAMINATION):** PHA updated in MRRS.Procedure(s): -Screening Test Of Visual Acuity, Quantitative, Bilateral x 1 ADDITIONAL PROVIDER(S):
PONDS, BRANDON JLaboratory(ies): -HEPATITIS C AB (Routine) Ordered By: PONDS, BRANDON J Ordering Provider: PARSON,
MARSHEA S**2. ASTHMA (ASTHMA, UNSPECIFIED, MILD):** See Pulmonary SF 600 Written by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1135 CDT

1. ASTHMA (ASTHMA, UNSPECIFIED, MILD): Pt with a symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. HIs symptoms are confined to allergen exposure, particularly to cats. Given the mild

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS. Follow up in 6 months.

3. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR: SM recently discharged for inpatient for alcohol abuse.

4. MAJOR DEPRESSION RECURRENT MODERATE: SM is being followed in Behavioral Health. Being seen every three weeks.

5. ANXIETY DISORDER NOS

6. ESSENTIAL HYPERTRIGLYCERIDEMIA: SM had lifestyle change to decrease levels. See lipid panel 2014.

7. POSTSURGICAL STATE OF EYE AND ADNEXA: SM had PRK, OU. No complications.

8. ROSACEA: SM states working diagnosis. He was in Florida and had redness when in sun.

9. Patient Education(OTHER SPECIFIED COUNSELING): SM educated to the PHA visit. Reviewed HRA survey results, discussed, education provided. Epworth Sleepiness Scale review and discussed. Update PHA in birth month.

Disposition Last updated by PARSON,MARSHEA S @ 28 Apr 2015 0950 EDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by PONDS,BRANDON J @ 28 Apr 2015 0928 EDT

Thank You for Completing the Fleet and Marine Corps Health Risk Assessment

You rated your health as Good. Personal perception about how healthy you are is usually quite accurate. Your Personal Health Risk Appraisal Report identified 4 risk categories from the answers you provided that relate to overall health, which places you in a **MEDIUM** risk group. Numbers of risk factors have been shown to predict future health care use and health care costs. It is important for individuals to move toward the "low risk" category by reducing the number of behavioral risks, and for those already at low risk, to avoid increasing the number of risk factors over time.

<table border="1"> <tr> <td>High Risk</td> <td>= 5 or more risk categories</td> </tr> <tr> <td>Medium Risk</td> <td>= 3-4 risk categories</td> </tr> <tr> <td>Low Risk</td> <td>= 0-2 risk categories</td> </tr> </table>	High Risk	= 5 or more risk categories	Medium Risk	= 3-4 risk categories	Low Risk	= 0-2 risk categories	<p>You reported 4 categories, which places you at MEDIUM risk.</p> <p>The categories you scored "unhealthy" on included:</p> <ul style="list-style-type: none"> • Stress Management • Sexual Health • Nutrition • Sleep
High Risk	= 5 or more risk categories						
Medium Risk	= 3-4 risk categories						
Low Risk	= 0-2 risk categories						

 **Body Mass Index (Note the limitations of BMI below) — Normal Weight**

http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

YOUR BODY MASS INDEX = 22.1.

Both being overweight or being underweight are related to increased risk of disease and death. Among most Americans, BMI is a reliable indicator of total body fat. It is an inexpensive and easy-to-perform method of screening for weight categories that may

Medical Record

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

lead to health problems. Limitations of BMI are that it may overestimate body fat in athletes and others who have a muscular build or underestimate body fat in individuals who lack lean muscles mass.


 **TOBACCO USE— *Never used tobacco*** <http://www.ucanquit2.org>
<http://betobaccofree.hhs.gov/>

You are doing the single most important thing to stay healthy! Not smoking saves you money (over \$2000/year for one pack per day), helps you avoid many tobacco related diseases, and adds to your fitness level and overall health.

 **TOBACCO USE— *Never used tobacco*** <http://www.ucanquit2.org>
<http://betobaccofree.hhs.gov/>

Not using smokeless tobacco is a great choice. You can avoid oral cancer, tooth and gum disease, and maintain a fresh and clean mouth.

 **ALCOHOL USE— *No*** <http://www.nlm.nih.gov/medlineplus/alcoholconsumption.html>

 **ALCOHOL USE— *Never*** <http://www.rethinkingdrinking.niaaa.nih.gov/>

You indicate a healthy choice not to drink heavily, even during celebrations. Sailors and Marines also look out for their shipmates and fellow Marines who have been drinking.

 **ALCOHOL USE— *Never (i.e. not during the past year)***
<http://www.rethinkingdrinking.niaaa.nih.gov/>

You are being a responsible Sailor or Marine by never driving drunk or riding with someone who has been drinking. You can also help fellow Sailors and Marines avoid alcohol related incidents by looking out for those who try to drink and drive - and help them get home safely.

 **INJURY PREVENTION— *Always*** <http://www.nhtsa.gov/Driving+Safety>

By always using your seat belt, you decrease your risk of serious injury or death after an accident by about 50%.

 **INJURY PREVENTION— *Always*** <http://www.nhtsa.gov/Driving+Safety>

Your use of a protective helmet provides significant protection against head injury or death. Wearing other protective gear, maintaining control of your vehicle, and driving defensively can also reduce your risk.

 **INJURY PREVENTION— *Always*** <http://www.cdc.gov/niosh/topics/safety.html>

You are protecting yourself against injuries and disease at your worksite by using appropriate safety equipment

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

**STRESS MANAGEMENT— *Somewhat satisfied***<http://www.nlm.nih.gov/medlineplus/stress.html> <http://afterdeployment.dcoe.mil>

You are only somewhat satisfied with your life. Life satisfaction is a common goal that we as human beings strive to achieve. Work, relationships and social activities can all contribute to life satisfaction. Look to these sources for improving your level of satisfaction.

**STRESS MANAGEMENT— *Sometimes***<http://www.med.navy.mil/sites/nmcscd/nccosc/serviceMembersV2/stressManagement/theStressContinuum/Pages/default.aspx> <http://startmovingforward.dcoe.mil>

Occasional stress in your work or at home is common. Problem-solving or discussing possible solutions with someone else may help reduce or eliminate some of your stress.

**STRESS MANAGEMENT— *Sometimes***<http://www.helpguide.org/topics/relationships.htm> <http://afterdeployment.dcoe.mil>

Finding someone with whom you can talk can help you see that you are not alone in how you feel. Talking with others can also provide you with strategies to successfully manage your concerns. Counselors and chaplains are available to assist you. .

**SEXUAL HEALTH— *Most of the time***[http://www.med.navy.mil/sites/nmcphc/health-](http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/condoms.aspx)[promotion/reproductive-sexual-health/Pages/condoms.aspx](http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/condoms.aspx)

Choosing to use a latex condom consistently and correctly each time you have sex will significantly reduce your risk of acquiring a sexually transmitted infection

**PHYSICAL ACTIVITY— *3 weeks per month***<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

To promote and maintain health, all healthy adults aged 18-64 years need moderate-intensity aerobic activity for a minimum of 150 minutes each week or vigorous-intensity aerobic activity for 75 minutes each week. Combinations of moderate- and vigorous-intensity activity can be performed to meet this recommendation. Exercise sessions can be broken up into as little as 10 minutes at a time.

**PHYSICAL ACTIVITY— *2 days per week***<http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html>

Muscle-strengthening activities should work all the major muscle groups of your body (legs, hips, back, chest, abdomen, shoulders, and arms). To gain health benefits, muscle-strengthening activities need to be done to the point where it is hard for you to do another repetition without help. Adding muscle allows you to do more activities, improves appearance, and reduces the risk of several chronic diseases.

**NUTRITION— *At least 3-5 times per week or more***<http://www.cdc.gov/nutrition/everyone/basics/fat/index.html>

Some dietary fat is needed for good health, but high levels of fat in your diet may lead to excessive weight gain and increase your risk of certain cancers. Eating foods high in saturated and trans-fats also increases your risk of heart disease. Select foods low in

Merwin, Daniel Dennis

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Merwin, Daniel Dennis

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

saturated fats, trans fats, and cholesterol; eat plenty of whole grains, fruits and vegetables; and choose low fat milk products and lean meats.

NUTRITION— *Two* <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is to consume at least two servings of fruits per day. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help protect you from chronic diseases and can make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SUPPLEMENTS— *Never* <http://humanperformancecenter.org/dietary-supplements>

People choosing to supplement their diets with herbals, vitamins, minerals, or other substances need to know about the products they choose so that they can make informed decisions about them. The choice to use a dietary supplement can be a wise decision that provides health benefits. However, under certain circumstances, these products may be unnecessary for good health or they may even create unexpected risks or interact with medications. It is wise to ask your physician or pharmacist before taking supplements.

DENTAL— *Daily* <http://www.ada.org/public.aspx>

You are to be commended for flossing your teeth daily. Daily flossing is recommended to remove plaque and food particles from between the teeth and under the gum line, which prevents gum disease, tooth loss, decay, and bad breath. In addition to flossing , the American Dental Association recommends brushing your teeth twice a day with fluoride toothpaste to achieve good dental health.

NUTRITION— *Two* <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>

The national goal for Americans is three servings of vegetables per day, with at least one being a dark green or orange vegetable. Fruits and vegetables contain essential vitamins, minerals, and fiber that may help you from chronic diseases and can make make weight control easier. The actual number of cups of fruits and vegetables needed daily also depends on an individuals age, gender, and level of physical activity.

SLEEP— *Sometimes* <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/sleep.aspx>

People who get enough restful sleep are able to concentrate on their activities, have more energy, and generally feel better. For many people with busy schedules, it is important to set aside enough time for sleep and to avoid issues at bedtime that can interfere with sleep. Talk with your physician if you are frequently unable to achieve restful sleep.

PREGNANCY— *My partner or I are correctly and consistently using birth control ALL the time* <http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive->

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

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[sexual-health/Pages/contraception.aspx](#)

There is a wide range of new, safe and effective contraception options available, some that work for years after you have started them. Some are permanent and others are easily and quickly reversible when you are ready to have a baby. But not all forms of contraception are equally effective. It makes sense to carefully consider your parenting plans and get informed about contraception so you and your partner can select the option that works best for you. Be well informed about contraception, and talk with your partner and doctor.

Signed By **PARSON, MARSHEA S** (Advanced Nurse Practitioner) @ 28 Apr 2015 0950**CHANGE HISTORY***The following Disposition Note Was Overwritten by PARSON,MARSHEA S @ 28 Apr 2015 0950 EDT:*

The Disposition section was last updated by PARSON,MARSHEA S @ 28 Apr 2015 0950 EDT - see above. Previous Version of Disposition section was entered/updated by POND, BRANDON J @ 28 Apr 2015 0921 EDT.

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.*The following S/O Note Was Overwritten by PARSON,MARSHEA S @ 28 Apr 2015 0948 EDT:**S/O Note Written by POND, BRANDON J @ 28 Apr 2015 0926 EDT***History of present illness**

The Patient is a 30 year old male.

Annual Periodic Health Assessment includes record review/assessment/counseling of avoidable health risk factors, clinical preventive services, deployment health history, and individual medical readiness assessment IAW MANMED.

Military service [] Y [X] N Deployed since previous PHA

[] Y [X] N Post-Deployment Health Assessment completed

[] Y [X] N Post-Deployment Health Reassessment completed

[] Y [X] N Post-Deployment labs/tests completed

[] Y [X] N Deployment/Shipboard limiting conditions identified

Past medical/surgical history**Reported:**

Medical: Not currently wearing eyeglasses If Yes, do they have 2 pairs? [] Yes [X] No. No chronic illness. An allergy SEE ABOVE.

Medications: Medication history SEE ABOVE. Not taking medication for high blood pressure.

Tests: A hearing test was performed 1) Is there a DD 2215 (baseline hearing test) in the health record? [X] Yes [] No

2) Is there a complaint of tinnitus that has not been addressed? [] Yes [X] No

3) Is there a complaint of changes in hearing since the last hearing test? [] Yes [X] No

4) Is there an in-depth audiometric evaluation in the record when existing hearing tests shows thresholds in either ear at 500, 1000 and 2000 Hz that average 30 dB or greater or 45 dB or greater at 3000 Hz or 55 dB or greater at 4000 Hz? [] Yes [X] No

5) If the patient is enrolled in a Hearing Conservation Program, has there been a monitoring audiogram within the past 12 months? [] Yes [X] No.

SEE ABOVE.

Family history

No family history of cancer

Mental illness (not retardation) MATERNAL

Heart disease PATERNAL

Diabetes mellitus PATERNAL.

Physical findings**Vital Signs:**

° Current vital signs reviewed.

Objective

Health Record [] Reviewed [X] Not available [] Remarkable for:

Dental Classification [X] Reviewed [] Not available [] See Plan:

Immunization record [X] Reviewed [] Not available [] See Plan:

Assessment

• Military service status

IMR Category:

Fully Medically Ready (X)

Partially Medically Ready ()

Not Medically Ready ()

Medical Readiness Indeterminant ()

Comments:

Therapy

• No electronic medical alert pendant in possession as indicated.

Plan

• Referred elsewhere for the options include referral

[] Physical Activity

[] Safety

[] Diabetes Counseling

[] Cholesterol

[X] Nutrition

[X] Sexuality

[] Other:

• Referred elsewhere for patient counseling

[] Tobacco Use

[] Alcohol Use

[] Weight Management

[] Dental Care

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

- ☐ Mental Health
- ☐ Hypertension
- ☒ Other: STRESS MANAGEMENT, SLEEP

Updated DD 2766 Sections: NO RECORD

Health counseling performed or scheduled documented on the DD 2766 and for additional topics below:

Notes

Follow-up in one year.

Practice Management

Risk factor counseling individual, 30 minutes.

The following A/P Note Was Overwritten by PARSON, MARSHEA S @ 28 Apr 2015 0943 EDT:

The A/P section was last updated by PARSON, MARSHEA S @ 28 Apr 2015 0943 EDT - see above. Previous Version of A/P section was entered/updated by POND, BRANDON J @ 28 Apr 2015 0921 EDT.

1. Visit for: military services physical (PERIODIC PREVENTION EXAMINATION)

Procedure(s):	-Screening Test Of Visual Acuity, Quantitative, Bilateral x 1	ADDITIONAL PROVIDER(S): POND, BRANDON J
Laboratory(ies):	-HEPATITIS C AB (Routine) Ordered By: POND, BRANDON J Ordering Provider: PARSON, MARSHEA S	

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Apr 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20600047 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**

Date: **27 Apr 2015 0824 EDT**
Clinic: **SUBST ABUSE NY**

Appt Type: **GRP**
Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 29 Apr 2015 0721 EDT

Problems

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 27 Apr 2015 0824 EDT
OP GROUP

Screening Written by PATSOS,ASHLEY N @ 27 Apr 2015 0837 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 27 Apr 2015 0824

OP GROUP

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 27 Apr 2015 0837 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact # [REDACTED]

No vitals taken for SARP Treatment.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by PATSOS,ASHLEY N @ 27 Apr 2015 0840 EDT**History of present illness**

The Patient is a 30 year old male.

The patient attended the Outpatient Treatment Program (OP).

A/P Last Updated by PATSOS,ASHLEY N @ 27 Apr 2015 0847 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-ALCOHOL &/ DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN x 8 - The patient attended group session from 0900-1100.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 29 Apr 2015 0721 EDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: Daniel arrived on time for his Out Patient (OP) group appointment. He is in Week 1, Day 1 of OP Level 1 treatment which meets from 0900-1100, total of 2 hours here at SARP-WNY. Today was Daniels's first day of treatment in group. Daniel did his introduction to the group which consisted of two other members present; as well as performed a check-in exercise and elaborated on his weekend.

During the introductions, Daniel stated that he had recently completed Level III Residential treatment at Fort Belvoir hospital and that he was encouraged by the knowledge and tools that he gained from his stay there. Daniel also stated that he is currently working on designing a video game which is taking up a lot of his time and that he wants to make sure he's addressing this need he has to please other people vs himself.

Daniel seemed determined and anxious to address his need to do things for himself and not others. He looked decisive prepared regarding him sharing the circumstances and events that got him here with the group. Daniel addressed Problem 3, Objectives 1 through 4 of his ITP by attending his group session and abstaining from alcohol/drugs.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel will be for OP Level 1 on 29th of April 2015 @ 0900

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 29 Apr 2015 0722**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 29 Apr 2015 1118

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Apr 2015 at WRNMMC, Psychiatry Be by ZEMBRZUSKA, HANNA DOMINIKA

Encounter ID: BETH-20572704 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **23 Apr 2015 0900 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **SPEC**
 Provider: **ZEMBRZUSKA,HANNA
 DOMINIKA**

AutoCites Refreshed by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0853 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Labs

20 Apr 2015 0012
ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative <o>

Units
 ng/mL

Ref Range
 Cutoff=500

20 Apr 2015 0012 <o>
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

13 Apr 2015 0548
ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=500

13 Apr 2015 0548
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

06 Apr 2015 0722
ETG/ETS, UA (500 Cut-Off)
 Ethyl Glucuronide

Site Specimen
 URINE

Result
 negative

Units
 ng/mL

Ref Range
 Cutoff=500

06 Apr 2015 0722
Drug Abuse Screen

Amphetamines
 Barbiturates
 Benzodiazepines
 Cocaine
 Opiates
 Phencyclidine, UA
 Cannabinoids
 Methadone
 Oxycodone

Site Specimen

URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE
 URINE

Result
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>
 not detected <i>

Units

Ref Range
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)
 (Not-detected)

Merwin, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

30 Mar 2015 2236

Chlamydia+Gonococcus DNA Panel NAAT Site Specimen

	Site Specimen	Result	Units	Ref Range
Neisseria gonorrhoeae DNA	URINE	negative for n.gonorrhoeae <i>		
Chlamydia trachomatis DNA	URINE	negative for c.trachomatis <i>		(Negative)

30 Mar 2015 0805

ETG/ETS, UA (500 Cut-Off)

	Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	URINE	negative	ng/mL	Cutoff=500

30 Mar 2015 0805

Drug Abuse Screen

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	not detected <i>		(Not-detected)
Barbiturates	URINE	not detected <i>		(Not-detected)
Benzodiazepines	URINE	not detected <i>		(Not-detected)
Cocaine	URINE	not detected <i>		(Not-detected)
Opiates	URINE	not detected <i>		(Not-detected)
Phencyclidine, UA	URINE	not detected <i>		(Not-detected)
Cannabinoids	URINE	not detected <i>		(Not-detected)
Methadone	URINE	not detected <i>		(Not-detected)
Oxycodone	URINE	not detected <i>		(Not-detected)

27 Mar 2015 2159

Urinalysis Panel

	Site Specimen	Result	Units	Ref Range
Color	URINE	straw		(Yellow)
Ketones	URINE	neg	mg/dL	(neg)
Hemoglobin	URINE	neg		(neg)
Nitrite	URINE	neg		(neg)
pH	URINE	7.0		(5.0-9.0)
Protein	URINE	neg	mg/dL	(neg)
Appearance	URINE	clear		(Clear)
Leukocyte Esterase	URINE	neg		(neg)
Specific Gravity	URINE	1.006		(1.000-1.035)
Urobilinogen	URINE	normal	mg/dL	(norm 0.2-1)
Glucose	URINE	neg	mg/dL	(neg)
Bilirubin	URINE	neg		(neg)

27 Mar 2015 1630

Mephedrone, MDPV, Methylone

	Site Specimen	Result	Units	Ref Range
Mephedrone	URINE	negative		NEGATIVE
Methylenedioxypyrovalerone	URINE	negative		NEGATIVE
Methylone	URINE	negative <r>		NEGATIVE

27 Mar 2015 1630

Cannabinoids (THC), Synthetic

	Site Specimen	Result	Units	Ref Range
Cannabinoids, Synthetic	URINE	negative <r>		

27 Mar 2015 1630

Chlamydia+Gonococcus DNA Panel NAAT Site Specimen

	Site Specimen	Result	Units	Ref Range
Neisseria gonorrhoeae DNA	URINE	negative for n.gonorrhoeae <i>		
Chlamydia trachomatis DNA	URINE	negative for c.trachomatis <i>		(Negative)

27 Mar 2015 1630

ETG/ETS, UA (250 Cut-Off)

	Site Specimen	Result	Units	Ref Range
Ethyl Glucuronide	URINE	negative	ng/mL	Cutoff=250

27 Mar 2015 1630

Drug Abuse Screen

	Site Specimen	Result	Units	Ref Range
Amphetamines	URINE	not detected <i>		(Not-detected)
Barbiturates	URINE	not detected <i>		(Not-detected)
Benzodiazepines	URINE	not detected <i>		(Not-detected)
Cocaine	URINE	not detected <i>		(Not-detected)
Opiates	URINE	not detected <i>		(Not-detected)
Phencyclidine, UA	URINE	not detected <i>		(Not-detected)
Cannabinoids	URINE	not detected <i>		(Not-detected)
Methadone	URINE	not detected <i>		(Not-detected)
Oxycodone	URINE	not detected <i>		(Not-detected)

27 Mar 2015 1630

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Urinalysis Panel	Site Specimen	Result	Units	Ref Range
Color	URINE	straw		(Yellow)
Ketones	URINE	neg	mg/dL	(neg)
Hemoglobin	URINE	neg		(neg)
Nitrite	URINE	neg		(neg)
pH	URINE	7.0		(5.0-9.0)
RBC	URINE	< 1	/HPF	(0-3)
Protein	URINE	neg	mg/dL	(neg)
Appearance	URINE	clear		(Clear)
Leukocyte Esterase	URINE	mod (H)		(neg)
Specific Gravity	URINE	1.008		(1.000-1.035)
Urobilinogen	URINE	normal	mg/dL	(norm 0.2-1)
WBC	URINE	3 (H)	/HPF	(0-2)
Glucose	URINE	neg	mg/dL	(neg)
Bilirubin	URINE	neg		(neg)
27 Mar 2015 1600				
Vitamin D, 1,25-Dihydroxy (Calcitriol) Panel	Site Specimen	Result	Units	Ref Range
Vitamin D, 1,25-Dihydroxy	SERUM	78 <r>	pg/mL	
Vitamin D2, 1,25-Dihydroxy	SERUM	<10	pg/mL	
Vitamin D3, 1,25-Dihydroxy	SERUM	76	pg/mL	
27 Mar 2015 1600				
Vitamin B1 (Thiamine)	Site Specimen	Result	Units	Ref Range
Vitamin B1 (Thiamine)	BLOOD	193.4	nmol/L	66.5-200.0
27 Mar 2015 1600				
HIV-1/O/2 Ab	Site Specimen	Result	Units	Ref Range
HIV-1/O/2 Ab	SERUM	*****		
27 Mar 2015 1600				
Rapid Plasma Reagin	Site Specimen	Result	Units	Ref Range
Reagin Ab	SERUM	nonreactive <i>		(Non-Reactive)
27 Mar 2015 1600				
Homocysteine	Site Specimen	Result	Units	Ref Range
Homocysteine	SERUM	9.1 <r> <i>	mcmol/L	(4.0-15.4)
27 Mar 2015 1600				
Vitamin B12 (Cyanocobalamin)+Folate Panel	Site Specimen	Result	Units	Ref Range
Vitamin B12 (Cobalamins)	SERUM	329 <i>	pg/mL	(211-946)
Folate	SERUM	>20.00 <i>	ng/mL	(4.6-34.8)
27 Mar 2015 1600				
Magnesium	Site Specimen	Result	Units	Ref Range
Magnesium	SERUM	2.2	mg/dL	(1.7-2.6)
27 Mar 2015 1600				
Thyroid Stimulating Hormone	Site Specimen	Result	Units	Ref Range
Thyrotropin	SERUM	0.757 <i>	mIU/mL	(0.27-4.20)
27 Mar 2015 1600				
Gamma Glutamyl Transferase	Site Specimen	Result	Units	Ref Range
Gamma-Glutamyl Transferase	SERUM	40	U/L	(10-71)
27 Mar 2015 1600				
Comprehensive Metabolic Panel	Site Specimen	Result	Units	Ref Range
Albumin	SERUM	4.9	g/dL	(3.5-5.2)
Alkaline Phosphatase	SERUM	71	U/L	(40-130)
Alanine Aminotransferase	SERUM	29 <i>	U/L	(0-41)
Bilirubin	SERUM	0.3	mg/dL	(0-1.0)
Urea Nitrogen	SERUM	14	mg/dL	(6-20)
Calcium	SERUM	10.0	mg/dL	(8.6-10.2)
Carbon Dioxide	SERUM	29	mmol/L	(22-31)
Chloride	SERUM	98	mmol/L	(98-107)
Creatinine	SERUM	0.9	mg/dL	(0.7-1.4)

Merwin, Daniel Dennis

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Glucose	SERUM	82	mg/dL	(74-106)
Potassium	SERUM	4.7	mmol/L	(3.5-5.1)
Protein	SERUM	7.9	g/dL	(6.4-8.3)
Sodium	SERUM	139	mmol/L	(135-145)
Anion Gap	SERUM	13	mmol/L	(8-18)
GFR Calculated Non-Black	SERUM	114.7	mL/min	(>=90)
GFR Calculated Black	SERUM	132.6 <i>	mL/min	(>=90)
Aspartate Aminotransferase	SERUM	<5	U/L	(0-40)

27 Mar 2015 1600**CBC W/Diff**

	Site Specimen	Result	Units	Ref Range
WBC	BLOOD	6.8	x10(3)/mcL	(3.6-10.6)
RBC	BLOOD	4.65	x10(6)/mcL	(4.21-5.92)
Hemoglobin	BLOOD	14.5	g/dL	(12.8-17.7)
Hematocrit	BLOOD	43.1	%	(37.5-50.9)
MCV	BLOOD	92.6	fL	(79.5-96.8)
MCH	BLOOD	31.1	pg	(26.2-33.1)
MCHC	BLOOD	33.6	g/dL	(32.6-35.0)
RDW CV	BLOOD	12.0	%	(12.0-16.2)
Platelets	BLOOD	296	x10(3)/mcL	(162-427)
MPV	BLOOD	8.5	fL	(7.0-10.9)
Neutrophils	BLOOD	67.0	%	(40.7-76.4)
Lymphocytes	BLOOD	25.1	%	(15.9-47.8)
Monocytes	BLOOD	6.7	%	(4.5-11.8)
Eosinophils	BLOOD	0.9	%	(0.3-7.1)
Basophils	BLOOD	0.3	%	(0.2-1.2)
ABS Neutrophils	BLOOD	4.5	x10(3)/mcL	(1.8-7.5)
ABS Lymphocytes	BLOOD	1.7	x10(3)/mcL	(1.0-3.1)
ABS Monocytes	BLOOD	0.5	x10(3)/mcL	(0.2-0.8)
ABS Eosinophils	BLOOD	0.1	x10(3)/mcL	(0.0-0.5)
ABS Basophils	BLOOD	0.0	x10(3)/mcL	(0.0-0.4)
Differential Review	BLOOD	manual diff not performed		

27 Mar 2015 16**Coagulation Panel 1 (PT+APTT)**

	Site Specimen	Result	Units	Ref Range
Protime	PLASMA	12.5	Sec	(12.4-14.4)
INR	PLASMA	1.0 <i>		
APTT	PLASMA	32.9 <i>	Sec	(23.4-36.2)

Microbiology Results**Urine Culture**

Order # 150327-24502 (NNMC Bethesda)
 Filler # 150327 DWB 64394 (NNMC Bethesda)
 Status: Final
 Ordering Provider: CEREMUGA, GEORGE J
 Priority: ROUTINE
 Date Ordered: 27 Mar 2015 1557
 Date Resulted: 29 Mar 2015 0651
 COLLECT_SAMPLE: URINE/CLEAN CATCH

BACTERIOLOGY RESULT: 03/28/15: LESS THAN 24 HOURS,
 FURTHER INCUBATION REQUIRED
 BACTERIOLOGY RESULT: 03/29/15 URINE CULTURE NEGATIVE

Specimen: Urine
 Collected: 27 Mar 2015 1630

Results: Final report

Rads

No Rads Found.

Reason for Appointment:

Generalized Anxiety Disorder & Alcohol Use Disorder, Severe

Appointment Comments:

ddr

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals**Vitals** Written by ERICKSON,NANCY A @ 23 Apr 2015 0855 EDT

BP: 122/68, HR: 70, RR: 16, T: 96.0 °F, HT: 5' 9", WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters

Comments: PT weighed in uniform and boots.**S/O Note** Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1113 EDT**History of present illness**

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder. Pt initially presented to Integrative Care on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged yesterday. SARP would like psychiatrist to evaluate pt for psychotropic medication for his depressed mood, anxiety, and sleep symptoms. Pt reports that every day he experiences either a depressed mood or apathy. He does have moments of happiness when he works on his computer game or cooks, but these moments don't last long. He often wonders what the point of life is and what his purpose in life is. He often worries about the future and tasks he has to complete. He feels that he is always planning and runs through scenarios (good version, bad version) of things in his head. He is frequently irritable, impatient, and judgmental of others. His anxious ruminations lead to initial insomnia. He did sleep well last night, but in rehab he was using Melatonin at bedtime. He has been started on Zolof, but has not noticed a benefit yet. Denies side effects.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 ? 3 self-poured drinks, which has an estimated 4 ounces of alcohol per drink. He described the appeal in terms of the calming effect on his mind, specifically to dampen his anxious ruminations and ?obsessing.? He further reported that drinking helps prepare him for sleep onset (he has had problems with initial insomnia). Clinical interview further revealed evidence for marked tolerance, significant spending on alcohol (\$400 - \$500 per month), hangovers (every other week), being told that he drinks too much (past girlfriends), drinking despite the consistent worsening of his negative mood state, and unsuccessful efforts to reduce/quit drinking. In his personal reflection, he indicated that he does not like himself relative to his drinking and desires to stop. He recognizes that there are multiple triggers to his drinking and usually these involve longstanding feelings of disappointment, frustration, and loneliness. It should be noted that the SM indicated that he has been engaging in painful introspection, particularly regarding his childhood and family life.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.

Allergies

Current Allergies Reviewed. NKDA.

Current medication

Zolof 50mg daily started on 26MAR2015

Melatonin for insomnia.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Page 667
AR 2654

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

Personal history

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself 'bored' with college. He enlisted in the Navy in October, 2005, after dropping out of college, working two jobs, and being on the verge of 'living on the street.' There were mounting debts (rent, college tuition, basic apartment furniture) also at the time. He started as an Aviation Boatswain's Mate, then cross-rated in 2009 to Cryptologic Technician 'Network'. His duty stations have included USS ESSEX, Pensacola, and NIOC Maryland. He has been very successful in his enlisted service thus far, but has been disenchanted at his current Command because everyone is physically separated and it is not a tight knit command.

Pt was engaged to a Filipino girl he met while stationed overseas, but he ended the engagement in 2010 because she was 'crazy.' No kids.

Behavioral: Caffeine use 16 oz tea/day and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Discharged yesterday from Ft. Belvoir 28 day Residential Alcohol Treatment.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? Denies

Do you feel like you are at risk for workplace violence? Denies

PTSD CHECKLIST (PCL-C)

- [2] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- [0] Repeated, disturbing dreams of a stressful experience from the past?
- [0] Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- [2] Feeling very upset when something reminded you of a stressful experience from the past?
- [2] Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- [1] Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- [1] Avoid activities or situations because they remind you of a stressful experience from the past?
- [0] Trouble remembering important parts of a stressful experience from the past?
- [0] Loss of interest in things that you used to enjoy?
- [0] Feeling distant or cut off from other people?
- [2] Feeling emotionally numb or being unable to have loving feelings for those close to you?
- [0] Feeling as if your future will somehow be cut short?
- [0] Trouble falling or staying asleep?
- [1] Feeling irritable or having angry outbursts?
- [1] Having difficulty concentrating?
- [1] Being 'super alert' or watchful on guard?
- [0] Feeling jumpy or easily startled?

Add point values from each response. Total Score = 13 DATE:

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? [] Not difficult [X] Somewhat difficult [] Very difficult [] Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? [] Yes [X] No

If 'Yes', how often? [] Several days [] More than half the days [] Almost everyday.

Depression Screening:

- [1] 1. Little Interest or pleasure in doing things
- [1] 2. Feeling down depressed or hopeless

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

[0] 3. Trouble sleeping or sleeping too much
 [1] 4. Feeling tired or little energy
 [0] 5. Poor appetite or overeating
 [0] 6. Feeling bad about self
 [0] 7. Trouble concentrating on things
 [1] 8. Moving or speaking slowly or being restless
 [0] 9. Thoughts that you would be better off dead
 Add point values from each response. Total (PHQ-9) Score = 4

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely.

Generalized Anxiety Disorder Screening:

[1] 1. Feeling nervous, anxious, or on edge
 [1] 2. Not being able to stop or control worrying
 [1] 3. Worrying too much about different things
 [0] 4. Trouble relaxing
 [0] 5. Being so restless that it's hard to sit still
 [2] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 5

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [X] Somewhat [] Very [] Extremely.

NO Learning Disability, Language or Learning Barriers.

Review of systems

No current substance use symptoms
 No current cognitive symptoms
 No current psychotic symptoms

Physical findings**Psychiatric:**

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y
 H/O Suicide Attempts: Y
 Organized Plan: N
 Chronic Psychiatric Disorder: Y
 Recent Psychiatric Hospitalization: RECENT REHAB
 H/O Abuse or Trauma: Y
 Chronic Physical Illness: N
 Family H/O Suicide/Attempts: Y
 Other Recent Loss: N
 Chronic Pain: N
 Age (risk factor if <25 or >60): N

Modifiable:

Suicidal ideation/plans/intent: N
 Access to Lethal Means: N
 Poor Treatment Compliance: N
 Hopelessness: ?
 Psychic Pain/Anxiety: Y
 Acute Event: N
 Insomnia: N
 Low Self-Worth: Y
 Impulsivity: N
 Substance Abuse: Y
 Financial Stress: Y, PAYING OFF DEBT
 Legal Stress: N

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Protective:

Strong Therapeutic Alliance:Y
 Positive Coping Skills:Y
 Responsible to/for Family:Y
 Responsible to/for Pet:N
 Frustration Tolerance:Y
 Resilience:Y
 Good Reality Testing:Y
 Amenable to Treatment:Y
 Social Support:Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP
 Medication Prescriber: ZEMBRZUSKA
 Group Therapist: MELTON FOR CBT-I

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 23APR2015

Reviewed with patient on: 23APR2015

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 3 weeks

Discussion of assessment and intervention

Tx Plan cont'd:

Diagnosis

Generalized Anxiety Disorder
 Alcohol Use Disorder, moderate to severe

Active Problem List:

1. Anxiety, worry, irritability
2. Depressed/apathetic mood
3. Insomnia

Long-Term Goals:

1. Improve relationship/increase social support from mother and sister
2. Improve financial knowledge/pay off debts

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Pt to obtain Melatonin OTC to help with insomnia
2. Pt to download free CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts
3. Pt referred to CBT-I group with Ms. Melton at WRNMMC. First group starts Monday, 27 April 13-14:00 for 4 weeks

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0856 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0856 EDT

Hemoglobin A1c	Site/Specimen	04 Jun 2013 0925
Hemoglobin A1c	BLOOD	5.4 <i>

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0855 EDT

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1026 EDT**1. GENERALIZED ANXIETY DISORDER** 300.02

Procedure(s): -(90792) Psychiatric Diagnostic Evaluation With Medical Evaluation And Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90**Disposition** Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1134 EDT**Released w/o Limitations****Follow up:** 3 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0852 EDT**Consult Order****Referring Provider:** EDWARDS, OLUSOLA O**Date of Request:** 15 Apr 2015**Priority:** Routine**Provisional Diagnosis:**

Generalized Anxiety Disorder ~T~ Alcohol Use Disorder,Severe

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Reason for Request:

Patient will need follow-up appointment for inpatient discharge. Patient was diagnosed with generalized anxiety disorder. Patient reported history of physical and emotional abuse from his father.

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter Reed National Military Medical Center, Bethesda, MD) @ 23 Apr 2015 1134

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Apr 2015 at WRNMMC, Substance Abuse NY by GONZALEZZARAZUA, JORGE AEncounter ID: BETH-20560323 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Inpatient**Date: **22 Apr 2015 1019 EDT**
Clinic: **SUBST ABUSE NY**
Inpatient Location:Appt Type: **EST**
Provider: **GONZALEZZARAZUA, JORGE A****AutoCites** Refreshed by GONZALEZZARAZUA, JORGE A @ 22 Apr 2015 1113 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
SERTRALINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE AND ONE-HALF TABLET BY MOUTH EVERY NIGHT #0 RF0	NR	22 Apr 2015
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 22 Apr 2015 1019 EDT
OP INTAKE**Screening** Written by PATSOS, ASHLEY N @ 22 Apr 2015 1031 EDT**Reason For Appointment:** Notes Entered by: PATSOS, ASHLEY N 22 Apr 2015 1019

OP INTAKE

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS, ASHLEY N @ 22 Apr 2015 1031 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

Contact #: [REDACTED]

No vitals taken for SARP Treatment.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 22 Apr 2015 1033 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s):

-BEHAVAL HEALTH SCREEN DETERMINE ELIGIBLY, ADM TX PRGM x 1 - Met with patient one-on-one from 1030-1130 to discuss Individual Treatment Plan.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by GONZALEZZARAZUA,JORGE A @ 23 Apr 2015 1333 EDT**Continued Stay****Discussed:** Diagnosis, Alternatives with Patient who indicated understanding. - Comments: Daniel arrived on time for his OP treatment intake. Treatment plan has been developed and Daniel has agreed to the terms and conditions of treatment, to include abstinence from alcohol and any other drugs starting 22 April 2015. Furthermore, he has agreed to complete the pre-confinement physical prior to his Tx start date or as soon as he can get an appointment with his PCM. CDP handout binder was provided to Daniel and he was also given instructions for completing his assignments.

P) Start working on treatment plan issues.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By GONZALEZZARAZUA, JORGE A (PARAPROFESSIONAL) @ 23 Apr 2015 1333**Co-Signed By** BROWN, CYNTHIA E (Paraprofessional) @ 23 Apr 2015 1341

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20234361 Primary Dx: ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON NAVY YARD**
 Patient Status: **Outpatient**

Date: **23 Mar 2015 0909 EDT**
 Clinic: **SUBST ABUSE NY**

Appt Type: **EST**
 Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 25 Mar 2015 1411 EDT**Problems**

- ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 23 Mar 2015 0909 EDT
 EST

Screening Written by PATSOS,ASHLEY N @ 23 Mar 2015 0909 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 23 Mar 2015 0909

EST

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 23 Mar 2015 0909 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

A/P Last Updated by PATSOS,ASHLEY N @ 23 Mar 2015 0910 EDT

1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

on-one from 0800-0900 to review Individual Treatment Plan.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 25 Mar 2015 1415 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his individual 1-on-1 session with his counselor on Monday 23rd of March 2015 at 08:00.

Daniel was told that his bed was confirmed for him to attend Level 3 Inpatient Treatment at Fort Belvoir Residential Treatment Center in VA. Daniel stated that he is ready to go to treatment; then mentioned that he was unable to reframe from abstaining from alcohol this weekend past weekend. Daniel stated that he had a date on Friday night that stood him up. While there waiting for her at the bar, he felt "upset" and decided to start drinking rum and cokes. After 6 rum and cokes, he decided to stop. Daniel mentioned that that was the 3rd time this week that he's been stood up. He further stated that he went home in a cab and passed out. He also mentioned that he stayed in his apartment the entire weekend and did nothing.

Daniel appeared miserable and fully aware of how different triggers can lead him to start drinking to mask his discontent. Realizing that Daniel does not have the necessary tools to handle these deterrence's, Daniel was asked to use a "feelings chart" to describe how he felt when he was at the bar. Daniel mentioned several to include, frustrated, disappointed, envious (of other couples), idiotic, enraged, jealous, hurt. This exercise made Daniel understand the importance of acknowledging all of the feelings he is going through and to understand that it's not just being "upset".

Daniel has not drunk since Friday night and states that he will abstain from alcohol throughout his treatment. He will check in to Fort Belvoir Level 3 Residential Treatment facilities in VA at 08:30 on Wednesday 25th of March 2015.

Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel is upon completion of Level 3 Residential Program at Ft Belvoir.

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 25 Mar 2015 1415

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 25 Mar 2015 1441

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

20 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMESEncounter ID: BETH-20216692 Primary Dx: ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
Patient Status: **Outpatient**Date: **20 Mar 2015 0737 EDT**
Clinic: **SUBST ABUSE NY**Appt Type: **EST**
Provider: **REGIS,JAMES****AutoCites** Refreshed by REGIS,JAMES @ 20 Mar 2015 0806 EDT**Problems**

- ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING
BEHAVIOR
- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:Written by PATSOS,ASHLEY N @ 20 Mar 2015 0737 EDT
EST**Screening** Written by PATSOS,ASHLEY N @ 20 Mar 2015 0737 EDT**Reason For Appointment:** Notes Entered by: PATSOS,ASHLEY N 20 Mar 2015 0737-----
EST**Reason(s) For Visit (Chief Complaint):** Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals****Vitals** Written by PATSOS,ASHLEY N @ 20 Mar 2015 0737 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

A/P Last Updated by PATSOS,ASHLEY N @ 20 Mar 2015 0739 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES x 1 - Met with patient one-

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

on-one from 0800-0900 to review Individual Treatment Plan.

-ALCOHOL AND/OR DRUG SERVICES; CASE MANAGEMENT x 1 - Conducted Case Management to review and update the overall SARP Clinical Record. In addition, reviewed additional services to help assist the patient and to monitor treatment progress and overall service delivered.

Disposition Last Updated by REGIS,JAMES @ 20 Mar 2015 1448 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Daniel arrived on time for his individual 1-on-1 session with his counselor on Friday 20th of March 2015 at 07:30. Daniel was told that his LIP assessment confirmed the recommendation for him to attend Level 3 Inpatient Treatment. Daniel completed the package for admission to Fort Belvoir Residential Treatment Center. Daniel stated that he is ready to go next week. Daniel then mentioned that he's noticed that he is eating more now than when he was drinking and that he was stood up twice this week; both on Tuesday and on Thursday by the same girl which made him feel disappointed and lonely. Daniel also mentioned that he didn't know what he was doing this weekend but that he did have a date for tonight who already knows that he will not be drinking. Daniel appeared bashful and optimistic regarding his willingness to attend treatment next week. When communicating about being stood up this week, Daniel seemed hurt and perplexed. While expressing his disappointment about being stood up, he seemed in disbelief that this happened to him twice. Regarding his abstaining from alcohol, Daniel gives the impression of being very cautious. Daniel will continue to abstain from alcohol throughout his treatment. He was asked to make a weekend plan which included snowboarding and his 1st AA meeting on Saturday and then going to the gym and another AA meeting on Sunday. Daniel showed no evidence of SI/HI/ATV

Next scheduled appointment for Daniel is on the 23rd of March 2015 @ 07:30

Secondary record maintained at SARP Washington Navy Yard (202) 433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 20 Mar 2015 1448

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 20 Mar 2015 1514

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Mar 2015 at WRNMMC, Substance Abuse NY by ARITA, ANTHONY A

Encounter ID: BETH-20203468

Primary Dx:

ALCOHOL DEPENDENCE WITH
CONTINUOUS DRINKING BEHAVIORPatient: **MERWIN, DANIEL DENNIS**Date: **19 Mar 2015 0755 EDT**Appt Type: **EST**Treatment Facility: **NBHC WASHINGTON**Clinic: **SUBST ABUSE NY**Provider: **ARITA, ANTHONY AKIO****NAVY YARD**Patient Status: **Outpatient**AutoCites Refreshed by ARITA, ANTHONY A @ 19 Mar 2015 1548 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDT
LIP APPOINTMENTScreening Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDTReason For Appointment: Notes Entered by: PATSOS, ASHLEY N 19 Mar 2015 0755

LIP APPOINTMENT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (Follow-Up) ;**Vitals**Vitals Written by PATSOS, ASHLEY N @ 19 Mar 2015 0755 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language: English

No vitals taken at SARP treatment.

A/P Written by ARITA, ANTHONY A @ 19 Mar 2015 1549 EDT**1. ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Written by ARITA, ANTHONY A @ 19 Mar 2015 1743 EDT**Released w/o Limitations**Note Written by ARITA, ANTHONY A @ 19 Mar 2015 1743 EDT**Washington Navy Yard – Branch Health Clinic
Substance Abuse Rehabilitation Program (SARP)**

DEMOGRAPHIC/BACKGROUND SNAPSHOT	
Patient Name	Merwin, Daniel Dennis 20/[REDACTED]
Rank / Rate/MOS	E-6 / CTN1 (cryptologic technician – network), first class petty officer
Duty Station	Navy Information Operations Command (NIOC), Maryland
Branch of Service	USN
DoB / Age	[REDACTED] 1985 / 30 years old

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Marital Status	Single; no children
Current Duty Status	Fit for Full Duty
Notes	<ul style="list-style-type: none"> • Primary Language: English • Education: 13 • TBI/Concussive Events: <ul style="list-style-type: none"> • denied • Medical: <ul style="list-style-type: none"> • Recurrent abdominal pains • Psych Health: <ul style="list-style-type: none"> • History of intermittent SI • History of SA (in 10th or 11th grade) • Alcohol Dependence (documented this visit) • Anxiety Disorder, NOS (documented 04 AUG 2014)

19 MAR 2015**Psychological Health Evaluation**

IDENTIFYING DATA AND REASON FOR REFERRAL: The Service Member (SM) is a 30-year old, single, Caucasian male, E-6/AD/USN, with approximately 9 ½ years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland. The SM was seen as a self-referral, based on his concern about his drinking.

CONSENT/PRIVACY: The SM was given an explanation of the nature and purpose of the present evaluation, as well as the limits of confidentiality and he consented to the procedures. He signed the Privacy Act statement on 17 MAR 2015 – a copy is in his secondary (clinic) file.

HISTORY OF PRESENT CONCERNS: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 – 3 self-poured drinks, which has an estimated 4 ounces of alcohol per drink. He described the appeal in terms of the calming effect on his mind, specifically to dampen his anxious ruminations and “obsessing.” He further reported that drinking helps prepare him for sleep onset (he has had problems with initial insomnia). Clinical interview further revealed evidence for marked tolerance, significant spending on alcohol (\$400 - \$500 per month), hangovers (every other week), being told that he drinks too much (past girlfriends), drinking despite the consistent worsening of his negative mood state, and unsuccessful efforts to reduce/quit drinking. In his personal reflection, he indicated that he does not like himself relative to his drinking and desires to stop. He recognizes that there are multiple triggers to his drinking and usually these involve longstanding feelings of disappointment, frustration, and loneliness. It should be noted that the SM indicated that he has been engaging in painful introspection, particularly regarding his childhood and family life. Over the past couple of years, he has been frustrated in his job (is preparing to leave the Navy at his EAOS in OCT 2015) and disappointed in his romantic life. He reported a longstanding history of intermittent suicidal ideation. He reported a couple of instances of suicide attempts in adolescence. In his adult life, his suicidal ideations, which occur about once per month, might include consideration of various methods, but without intense distress or intent to follow through. He further revealed that the thought of pain associated with any act of self-harm discourages serious consideration of suicide. Additionally, the SM reported that he tends to pick at the hair in particular places on his scalp – he pointed to some visible bald patches at the crown of his head that has become a source of embarrassment to him.

REVIEW OF RECORDS: the SM's AHLTA records were reviewed. SM's record was notable for multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014.

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She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

HISTORY OF HEAD INJURIES AND BLAST EXPOSURE: The SM denied any history of head or concussive injuries.

PSYCHIATRIC HISTORY: Much of his history is reported in sections above. Family history was significant for depression (mother, sister) and Bipolar Disorder (sister, maternal grandmother). SM denied past and present use of illicit substances. He reported abusing his albuterol inhaler during his childhood/adolescence. With regard to conduct problems, the SM described himself as a "good kid," however noted school suspensions due to computer hacking, fighting, and being connected with the presence of stink bombs at school. He denied any past legal problems or history of arrests.

MEDICAL HISTORY: The SM reported a history of asthma during childhood, but also that he had an allergic response to pets, which were kept in the home. He used an inhaler throughout his childhood. At times, he had to be hospitalized due to his asthma response and he estimates that, summed together, he spent a total of about 30 days hospitalized. He reported a problem with recurrent intestinal pain that has not yet been definitively diagnosed. This has been a problem since about age 15 and is tied to having to go to the bathroom. He had PRK performed in 2011. He was not taking any prescription or OTC medications at the time of the evaluation. There were no known drug allergies. He denied use of tobacco products. He reported his consumption of caffeinated beverages in terms of 14 oz. of coffee daily, more on weekends.

PAIN: The SM reported mild dental pain associated with his orthodontic braces. He reported his pain as a 2 on a scale from 0 – 10 (10 = most excruciating; 0 = none).

SOCIAL AND FAMILY HISTORY: The SM was the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler. He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. The SM indicated that he had few friends. He was often by himself; he was absorbed playing with Legos and watching Star Trek. He left his family abruptly, upon graduation from high school, in 2003. He enlisted in the Navy in October, 2005, after dropping out of college, working two jobs, and being on the verge of "living on the street." There were mounting debts also at the time. He started as an Aviation Boatswain's Mate, then cross-rated in 2009 to Cryptologic Technician – Network. His duty stations have included USS ESSEX, Pensacola, and NIOC Maryland. He has been very successful in his enlisted service thus far, but has been disenchanted at his current Command. He expressed an interest in getting out of the Navy and continuing his current line of work as a civilian contractor.

MENTAL STATUS AND BEHAVIORAL OBSERVATIONS: SM was an adequately groomed and dressed, Caucasian male with red hair. He appeared younger than his age of 30. SM was alert and fully oriented. Eye contact was good. He was cooperative with the interview and answered all questions. Behavior and conduct were appropriate to the interview. Affect was subdued, but responsive. He reported his mood as "mixed...crappy...anxious...frustrated." Immediate and remote memory appeared good. Thought processes were clear, coherent, linear, logical, and goal-directed. Speech was of normal rate, rhythm, and volume. There was no evidence for psychosis as indicated by hallucinations, delusions, and bizarre thinking. Intelligence, based on verbal skills and vocabulary, was estimated to be average. Judgment and impulse control appeared intact, without evidence for gross impairment. Treatment motivation was viewed to be good.

PRIMARY FINDINGS: The SM's pattern of drinking meets the criteria for Alcohol Dependence. He is unable to manage or control his drinking and has little confidence that he can discontinue on his own. He appreciates the multiple triggers, usually mood related, that make him vulnerable to resumption of drinking. He will require the high structure and controlled environment of a residential setting. Level III care is therefore indicated. He also presents with prominent psychological concerns – persistent dysphoria with intermittent, mild suicidal ideation. There is an anxiety component, obsessive/ruminative

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thinking, and compulsions. Trichotillomania may explain his compulsion to pick at his hair (leaving bald patches). A repeat mental health evaluation to specifically address his mood/anxiety symptoms and possible Axis II contributions to his recurrent dysphoria is also appropriate.

SAFETY ISSUES: The Service Member is not currently reporting suicidal or homicidal ideation, intentions, or plans. At present, the Service Member has sufficient ego strength and functional capacity to alert others should he experience a crisis. There are no acute signs of distress presently requiring more extensive suicide risk assessment at this time. Neither is there a need to increase his level of care or restrict autonomy.

FITNESS FOR DUTY AND DISPOSITION: The Service Member is currently psychologically fit for full duty. There is no psychological condition at present that warrants medical board action. The impact of his psychological symptoms described above have largely been associated with distress, to a lesser degree decrements in functioning

DIAGNOSIS:

AXIS I: Alcohol Use Disorder, Moderate – Severe
History of Anxiety Disorder, NOS
R/O Trichotillomania
AXIS II: Cluster C traits
AXIS III: No known contributory physical illnesses
AXIS IV: multiple sources of dissatisfaction
AXIS V: Current GAF: 51

SUMMARY OF FINDINGS AND RECOMMENDATIONS:

1. Based on the available data, the Service Member meets the criteria for Alcohol Dependence.
2. The Service Member is recommended to attend Level III (Residential) treatment, which will afford him the high structure, monitoring, and support required to sustain his abstinence over the course of treatment. His risk of drinking resumption is unacceptably high on an outpatient basis. Level III care will help equip him with the tools/skills he will need to maintain his sobriety and participate meaningfully in his recovery trajectory following completion of residential care.
3. He is to remain abstinent throughout the period of treatment and continuing care.
4. The Service Member is to attend AA meetings at the frequency recommended by the SARP counselor.
5. The Service Member is recommended to resume mental health care at Walter Reed – Bethesda. He will benefit most from a re-evaluation, particularly for psychotropic medication consultation with regard to his mood, anxiety, and sleep symptoms. Cognitive behavioral therapy for insomnia might also be helpful, given his ruminative style.
6. These findings and recommendations were discussed with the SM, who expressed understanding and willingness to comply.

Anthony A. Arita, PhD
CAPT, MSC, USN
Clinical Psychologist / Neuropsychologist

Signed By ARITA, ANTHONY A (Clinical Psychologist/Neuropsychologist) @ 19 Mar 2015 1744

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 Mar 2015 at WRNMMC, Substance Abuse NY by REGIS, JAMES

Encounter ID: BETH-20171109 Primary Dx: Visit for: screening exam alcoholism

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC WASHINGTON**
NAVY YARD
 Patient Status: **Outpatient**

Date: **17 Mar 2015 0725 EDT**
 Clinic: **SUBST ABUSE NY**

Appt Type: **SPEC**
 Provider: **REGIS,JAMES**

AutoCites Refreshed by REGIS,JAMES @ 18 Mar 2015 1505 EDT**Problems**

- MAJOR DEPRESSION RECURRENT
MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND
ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN
BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL
DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment: Written by PATSOS,ASHLEY N @ 17 Mar 2015 0725 EDT
 ASSESSMENT

Screening Written by PATSOS,ASHLEY N @ 17 Mar 2015 0730 EDT

Reason For Appointment: Notes Entered by: PATSOS,ASHLEY N 17 Mar 2015 0725

 ASSESSMENT

Reason(s) For Visit (Chief Complaint): Psychiatric Therapy For Drug And Alcohol Abuse/Dependence (New) ;

Vitals

Vitals Written by PATSOS,ASHLEY N @ 17 Mar 2015 0730 EDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: Language:English

No vitals taken at SARP treatment.

S/O Note Written by REGIS,JAMES @ 18 Mar 2015 1506 EDT

History of present illness

The Patient is a 30 year old male.

He reported: Encounter Background Information: This 30 year old, Single, Male, AD, E-6, USN, NIOC, Fort Meade, MD service member with 9 years active service, was command self-referred for substance abuse evaluation due to: Pt states that he has concerns about his inability to resist drinking; which he feels contributes to his growing lack of motivation.

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Last Updated by PATSOS,ASHLEY N @ 17 Mar 2015 0731 EDT

1. Visit for: screening exam alcoholism

Procedure(s): -ALCOHOL AND/OR DRUG ASSESSMENT x 1 - The patient arrived at 0730 and was provided a screening assessment questionnaire, which he completed at 0830. The questionnaire was reviewed and a face to face conducted from 0845-1030.

Disposition Last Updated by REGIS,JAMES @ 18 Mar 2015 1506 EDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: The patient was briefed on the screening process with Privacy Act and Informed Consent reviewed and discussed. The patient was also briefed on DSM-IV and ASAM/PPC indicating his understanding.
No evidence of HI/SI during this encounter
Secondary Record maintained at SARP Washington Navy Yard 202-433-7577.

Signed By REGIS, JAMES (Para-Professional, SARP WNY) @ 18 Mar 2015 1509

Co-Signed By BROWN, CYNTHIA E (Paraprofessional) @ 18 Mar 2015 1524

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18858979 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **30 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 04 Nov 2014 1356 EST**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 04 Nov 2014 1357 EST**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

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10-30-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient stated that his sleep is not good. He wakes up in the middle of the night and sometimes has a hard time going back to sleep. Over the weekend, he had a date with a woman who lives in Harrisburg, PA. While he was in the area, he also tried to look up a woman he dated several years ago. He is trying to accept other's points of view. He did not find the one, and the other didn't turn out. One of his main concerns with women he dates, is he needs alone time to do his own thing (computer programming mainly).

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lots, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day: Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

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Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
☐ Repeated, disturbing dreams of a stressful experience from the past?
☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
☐ Feeling very upset when something reminded you of a stressful experience from the past?
☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
☐ Avoid activities or situations because they remind you of a stressful experience from the past?
☐ Trouble remembering important parts of a stressful experience from the past?
☐ Loss of interest in things that you used to enjoy?
☐ Feeling distant or cut off from other people?
☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
☐ Feeling as if your future will somehow be cut short?
☐ Trouble falling or staying asleep?
☐ Feeling irritable or having angry outbursts?
☐ Having difficulty concentrating?
☐ Being
'super alert
'or watchful on guard?
☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

', how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
☐ 2. Feeling down depressed or hopeless
☐ 3. Trouble sleeping or sleeping too much
☐ 4. Feeling tired or little energy
☐ 5. Poor appetite or overeating
☐ 6. Feeling bad about self
☐ 7. Trouble concentrating on things
☐ 8. Moving or speaking slowly or being restless
☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
☐ 2. Not being able to stop or control worrying
☐ 3. Worrying too much about different things
☐ 4. Trouble relaxing
☐ 5. Being so restless that it's hard to sit still
☐ 6. Becoming easily annoyed or irritable
☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

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Neurological:

° No disorientation was observed, oriented x3 , oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed , they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.

2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal # 2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 04 Nov 2014 1359 EST**1. ANXIETY DISORDER NOS**

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 04 Nov 2014 1359 EST**Released w/o Limitations****Follow up:** for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Nov 2014 1400

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18795728 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **23 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 24 Oct 2014 0906 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 24 Oct 2014 0907 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10-23-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient is re-enlisting for another 4 years. His family (Mom, sister, sister's child and brother) are coming to the event on Dec 12. They are staying at his house. He is not close to his family, but is working on getting closer. Patient is also going home for Christmas. He feels guilty and anxious about them. He feels guilty because if other people knew how little he sees them, they would think less of him. After his parents divorced, he rarely saw his Mom. He says he has probably seen her in total about a year since the divorce. His mother is bi-polar. She has been in therapy in the past. Her mother is also bi-polar and takes meds. Patient likes his mom's side of the family. They were nice to him when he was a child. His grandfather taught him Doss, other computer stuff, and played video games with him. He has not seen his dad for 5 years. Dad now has another family and lives in Cal. Dad's brother was in jail for having sex with an under-aged girlfriend. He was about 20 years older than her and was married at the time. His other brother is disabled and lives with their mom. He is mean. The grandmother is mean too. When he was a child, he stayed with them for several weeks at a time. (He visited his mom for about 2 weeks a summer.) Patient states that his sister seems to have inherited the worst parts of both families-she is bi-polar and is the same kind of mean as his father's mother.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lots, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DoD ID: 1286180538

Created: 16 Aug 2017

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still

Merwin, Daniel Dennis

DOB: [REDACTED]

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

- [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people
 Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very []
 Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of asprin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:
 Behavioral Health Advanced directives completed? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Do you use a Personal Health Record (PHR)? ☐ Yes ☒ No Specify:
 Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention
 Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Written by NILSEN,LINDA M @ 24 Oct 2014 0912 EDT

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 24 Oct 2014 0912 EDT

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 24 Oct 2014 0912

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Oct 2014 at WRNMMC, SRP Cl Ki by JORDAN, TIMOTHY W

Encounter ID: BETH-18765071 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH
AMBULATORY CARE CENTER**
Patient Status: **Outpatient**Date: **22 Oct 2014 0935 EDT**
Clinic: **SRP CL KI**Appt Type: **PROC**
Provider: **JORDAN,TIMOTHY W****AutoCites** Refreshed by JORDAN,TIMOTHY W @ 22 Oct 2014 0936 EDT**Problems**

No Problems Found.

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- family medical history (General FHx)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Social History

No Social History Found.

Reason for Appointment:Written by JORDAN,TIMOTHY W @ 22 Oct 2014 0935 EDT
flu vaccine**Questionnaire AutoCites** Refreshed by JORDAN,TIMOTHY W @ 22 Oct 2014 0936 EDT
Questionnaires**S/O Note** Written by JORDAN,TIMOTHY W @ 22 Oct 2014 0936 EDT**Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

Vaccinations

- Received dose of influenza live virus vaccine, for intranasal use MEDIMMUNE 'FLUMIST'
- Lot#: CK2008 Expiration Date: 8 Dec2014
- 0.2 ML PRE-FILLED, SINGLE-USE, INTRANASAL SPRAY;
- FOR IMMUNIZING PERSONS 2 TO 49 YRS. OF AGE;
- PRESERVATIVE-FREE, NOT FOR USE DURING PREGNANCY
- Information Sheet: 19August 2014
- Manufacturer by: MedImmune Biologics
- Date vaccinated: 14 OCT 2014
- Vaccination/injection Site: IN

Past medical/surgical history**Reported:**

Recent Events: No active illness.

Medical: Reviewed no allergies. No allergy to certain foods; and not to eggs. No known drug allergies.

Review of systems**Systemic:** No fever.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

A/P Last Updated by JORDAN, TIMOTHY W @ 22 Oct 2014 0937 EDT

1. Vaccines Prophylactic Need Against Influenza

Procedure(s):
-Immunization Admin By Intranasal / Oral Route One Vaccine x 1
-Influenza Virus Vaccine Live Intranasal Quadrivalent x 1

Disposition Last Updated by JORDAN, TIMOTHY W @ 22 Oct 2014 0937 EDT

Released w/o Limitations

Follow up: as needed with PCM and/or in the SRP CL KI clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By JORDAN, TIMOTHY W (Health Care Specialist) @ 22 Oct 2014 0951

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Oct 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18694226 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **16 Oct 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 16 Oct 2014 0946 EDT**Family History**

- family medical history (General FHx)
- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 16 Oct 2014 0958 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

10-16-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Pt saw his PCM who excused his PTR, but did not fill out the paper for his regular PT. His ankle is still giving him trouble. He said that she was rude. When asked if he told her, he said no, he does not confront people. He learned as a child to just deal with whatever is going on. He was at sea the first 3 years in the Navy, stationed by Japan. They were on 12 hr shifts, not much down time. He tried to be the "perfect" worker-did his job the best that he could. He does believe this is where some of his anxiety came from. He started pulling his hair out during this time. So he has continued to put up with bad behavior. I encouraged him to tell the providers he finds them rude. He talked about his problems with reading and writing. In the past he has not been able to do well in school. He can handle books on tape and videos. It sounds like he might have a learning disability. We discussed ways he could work around this and on it. Patient stated he is going home to his mom's for X-mas. He said that he jokingly said that they needed to find some girlfriend possibilities for him. He said he was joking, but they have already found someone for him to meet.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't

want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut

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down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

', how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
 - ☐ 2. Feeling down depressed or hopeless
 - ☐ 3. Trouble sleeping or sleeping too much
 - ☐ 4. Feeling tired or little energy
 - ☐ 5. Poor appetite or overeating
 - ☐ 6. Feeling bad about self
 - ☐ 7. Trouble concentrating on things
 - ☐ 8. Moving or speaking slowly or being restless
 - ☐ 9. Thoughts that you would be better off dead
- Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable

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[0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psych Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Merwin, Daniel Dennis

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of aspirin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.

2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal # 2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Last Updated by NILSEN,LINDA M @ 16 Oct 2014 1001 EDT

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Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Last Updated by NILSEN,LINDA M @ 16 Oct 2014 1002 EDT

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 16 Oct 2014 1054

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

07 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by RINIS, DONNA L

Encounter ID: BETH-18590652 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **07 Oct 2014 0938 EDT**
 Clinic: **INT MED MEDICAL HOME CL C
 BE**

Appt Type: **T-CON***
 Provider: **RINIS,DONNA L**

Call Back Phone: [REDACTED]

AutoCites Refreshed by RINIS,DONNA L @ 07 Oct 2014 0938 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult:Written by RINIS,DONNA L @ 07 Oct 2014 0938 EDT

MRI results

Questionnaire AutoCites Refreshed by RINIS,DONNA L @ 07 Oct 2014 0938 EDT**Questionnaires**A/P Written by RINIS,DONNA L @ 07 Oct 2014 0947 EDT

1. Visit for: administrative purpose
2. ANKLE SPRAIN LEFT

Disposition Written by RINIS,DONNA L @ 07 Oct 2014 0947 EDTNote Written by RINIS,DONNA L @ 07 Oct 2014 0946 EDT

PCM _ NP Austin, out of office this week.

RelayHealth sent to patient -

NP Austin is out of the office this week, so I am looking at her lab & xray results.

Below are copies of your recent MRI's, showing evidence of a prior lateral (the outside of the ankle) ankle sprain and, also, mild degenerative changes over the "bunion" area of your foot.

This is just a "FYI". Please keep your pending appointments with NP Austin 10/20/14 and with Physical Therapy 11/4/14, at which times you can review the results again, if needed.

v/r

Dr.Rinis

MERWIN, DANIEL DENNIS 20[REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M

***** MRI, ANKLE LT W OR W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, ANKLE LT W OR W/O CON
 Event Date: 26-Sep-2014 13:28:00
 Exam #: 14327823
 Exam Date/Time: 05-Oct-2014 14:43:00
 Transcription Date/Time: 06-Oct-2014 15:51:00
 Provider: AUSTIN, MARIE
 Requesting Location: INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: LUTYNSKI, MATTHEW LEO

Supervised By: FRANK E. MULLENS, LCDR, MC, USN

Merwin, Daniel Dennis

DOB: [REDACTED]

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Approved By: LUTYNSKI, MATTHEW LEO
 Approved Date: 06-Oct-2014 15:52:00
 Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN
 Supervised By Date: 06-Oct-2014 15:52:00
 Amended Report Text:

HISTORY: Continuous pain following injury

COMPARISONS:

Left foot and ankle radiographs dated 5/6/14

TECHNIQUE:

WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:

ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons:

Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments:

Syndesmotc ankle ligaments: within normal limits.

Low lateral ankle ligaments:

The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT:

Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments:

Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae:

No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity:

Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION:

Findings suggestive of prior lateral ankle sprain.

Electronically signed by resident:

Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time: 14:23

Electronically signed by:

FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military Medical Center

Date: 10/06/14 Time: 15:52

MERWIN, DANIEL DENNIS 20 [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M

***** MRI, FOOT LT W OR W/O CON *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, FOOT LT W OR W/O CON

Event Date: 26-Sep-2014 13:27:00

Exam #: 14327819

Exam Date/Time: 05-Oct-2014 14:43:00

Transcription Date/Time: 06-Oct-2014 15:51:00

Provider: AUSTIN, MARIE

Requesting Location:

INT MED MEDICAL HOME CL C BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: LUTYNSKI, MATTHEW LEO

Supervised By: FRANK E. MULLENS, LCDR, MC, USN

Approved By: LUTYNSKI, MATTHEW LEO

Approved Date: 06-Oct-2014 15:52:00

Supervised By: 206272 FRANK E. MULLENS, LCDR, MC, USN

Supervised By Date: 06-Oct-2014 15:52:00

Amended Report Text:

HISTORY: Continuous pain following injury

COMPARISONS:

Left foot and ankle radiographs dated 5/6/14

TECHNIQUE:

WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat,

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DoD ID: 1286180538

Created: 16 Aug 2017

sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:

ANKLE: A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons:

Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments:

Syndesmotric ankle ligaments: within normal limits.

Low lateral ankle ligaments:

The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT:

Tendons: Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments:

Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae:

No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity:

Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION:

Merwin, Daniel Dennis

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Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Findings suggestive of prior lateral ankle sprain.

Electronically signed by resident:
Dr. MATTHEW LEO LUTYNSKI Date: 10/06/14 Time:14:23

Electronically signed by:
FRANK EDWARD MULLENS Department of Radiology Walter Reed National Military
Medical Center

Date: 10/06/14 Time:15:52

Signed By RINIS, DONNA L (Physician/Workstation) @ 07 Oct 2014 0948

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Oct 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-18536263 Primary Dx: Foot pain (soft tissue)

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **01 Oct 2014 1834 EDT**
 Clinic: **INT MED MEDICAL HOME CL C
 BE**

Appt Type: **T-CON***
 Provider: **AUSTIN, MARIE**

Call Back Phone: [REDACTED]

AutoCites Refreshed by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	SWISH AND SPIT 15 ML TWICE A DAY FOR 2 WEEKS STARTING TOMORROW #0 RF0	NR	18 Sep 2014
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Telephone Consult: Written by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT
 Really health message

Questionnaire AutoCites Refreshed by AUSTIN, MARIE @ 01 Oct 2014 1834 EDT
Questionnaires

S/O Note Written by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT**Subjective**

From Daniel Merwin To Ms. Marie Austin, NPP Provider Ms. Marie Austin NPP Patient Daniel Merwin Sent Date Sep 30, 2014 8:53 AM Subject Medical Waiver - Foot Details Message I was in to have my ankle looked at and medical waiver signed. Two signatures were missed. I will be at Walter Reed in the morning on 02 October 2014 for another appointment. I will stop by with the paper work. The MRI is scheduled for Sunday October 5th, 2014 and the follow up with Austin, Marie is set for 20 October 2014. A note on my foot. It was definitely swollen yesterday around the area of pain. I was actually able to purposely hurt it along with making a popping/grinding sound when I rotated my ankle within its normal range of motion. I discovered it when I accidentally stretched my ankle when lying in bed. So I decided to test it by pointing my toe forward and then rotating it in 360 degrees, each revolution made a sound or two and increased the pain. The pain lasted through the night and still exists this morning at a level of about 3.

A/P Last Updated by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT**1. Foot pain (soft tissue)** 729.5**Disposition** Last Updated by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT**Note** Written by AUSTIN, MARIE @ 01 Oct 2014 1835 EDT

Closed a relay health message if he stops by I will see

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 01 Oct 2014 1835

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

26 Sep 2014 at WRNMMC, Int Med CL C Medical Home BE by AUSTIN, MARIE R

Encounter ID: BETH-18481751 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **26 Sep 2014 1330 EDT**
 Clinic: **INT MED MEDICAL HOME CL C
 BE**

Appt Type: **EST**
 Provider: **AUSTIN, MARIE**

Reason for Appointment:

Left knee pain/ paper work

Vitals**Vitals** Written by NEWMAN, BRENDA W @ 26 Sep 2014 1249 EDT

BP: 118/76 Left Arm, Adult Cuff, HR: 84, RR: 16, T: 97.8 °F, HT: 69 in, WT: 158.4 lbs, SpO₂: 98%,
 BMI: 23.39, BSA: 1.871 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 2/10 Mild, Pain Scale
 Comments: Left ankle

Questionnaire AutoCites Refreshed by NEWMAN, BRENDA W @ 26 Sep 2014 1306 EDT**Questionnaires**

Copy of Anxiety & Depression Screening Taken On: 26 Sep 2014

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?: Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?: Nearly every day
3. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?: Not at all
4. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?: Not at all
5. Over the last 2 weeks, how often have you been bothered by the thoughts that you would be better off dead or hurting yourself in some way?: Not at all

S/O Note Written by AUSTIN, MARIE @ 02 Oct 2014 0801 EDT**Chief complaint**

The Chief Complaint is: Scalp issues, PT referral for left ankle and PRT waiver.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

PO1 needed a PARFQ and PRT waiver as a result of injured he sustained in April of 2014. Initial injury occurred while he was running and stepped into a hole hyperextending his foot. He was seen in the ER with a negative xray r/o a fx . He continued to have increased swelling and pain and was seen and x rayed again no fx seen . He then was sent for traing and has returned to WR and underwent PT . There is some improvement in pain . However he continues to have pain and swelling over the medial malleolus and is unable to run or walk fast .

PMH is positive for several stress fx in the foot in his young adult years.

Patient is compliant with medications.

Current medication

Motrin but no OTC meds, vitamins, herbals, etc.

Past medical/surgical history**Reported:**

Medical: Reported medical history Ankl pain

Surgical / Procedural: Surgical / procedural history none.

Personal history

Social history reviewed No tob no etoh.

Family history

Family medical history

Noncontributory.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

Pulmonary: No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° Oriented to time, place, and person.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Practice Management

Preventive medicine services Pt is active duty and up to date in all immunization and vaccines.

Note Written by AUSTIN,MARIE @ 02 Oct 2014 0805 EDT

pt is back to clinic on 10/2 to get weight and the rest of the paperwork complete . we do not do that part and I directed them to paul cachon. Command is insiting it be completed

Rad Result Cited by AUSTIN,MARIE @ 26 Sep 2014 1320 EDT**MERWIN, DANIEL DENNIS 20** [REDACTED] **DoD ID: 1286180538 29yo** [REDACTED] **1985 M**

***** FOOT, LT WT BEARING 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete

Procedure: FOOT, LT WT BEARING 3 VIEWS

Event Date: 06-May-2014 14:46:00

Order Comment: NO BRIEF COMMENT

Reason for Order:

left foot pain x 2 weeks following a recent injury, re-evaluate for fracture

Exam #: 14151531

Exam Date/Time: 06-May-2014 15:03:00

Transcription Date/Time: 06-May-2014 16:04:00

Provider: UDE, ASSUMPTA O

Requesting Location: AMHM01AREDKI KIMBROUGH ACC

Status: COMPLETE

Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MUNTER, FLETCHER M

Approved By: MUNTER, FLETCHER M

Approved Date: 06-May-2014 15:57:00

Report Text:

CHCS 14151531

History: Left foot pain for 2 weeks.

Technique: AP and lateral weight-bearing images of the left foot were performed.

FINDINGS: No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. No soft tissue abnormality is identified.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

IMPRESSION: Normal left foot.

Rad Result Cited by AUSTIN,MARIE @ 26 Sep 2014 1320 EDT**MERWIN, DANIEL DENNIS 20** [REDACTED] **DoD ID: 1286180538 29yo** [REDACTED] **1985 M**

***** ANKLE, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete

Procedure: ANKLE, LT 3 VIEWS
 Event Date: 06-May-2014 14:45:00
 Order Comment: with weight bearing
 Reason for Order:
 left lateral ankle pain and swelling 2 weeks following a sprained ankle,
 re-evaluate for fracture
 Exam #: 14151527
 Exam Date/Time: 06-May-2014 15:03:00
 Transcription Date/Time: 06-May-2014 16:05:00
 Provider: UDE, ASSUMPTA O
 Requesting Location: AMHM01AREDKI KIMBROUGH ACC
 Status: COMPLETE
 Result Code: SEE RADIOLOGIST'S REPORT
 Interpreted By: MUNTER, FLETCHER M
 Approved By: MUNTER, FLETCHER M
 Approved Date: 06-May-2014 15:58:00
 Report Text:
 CHCS 14151527

History: Ankle sprain 2 weeks ago.

Technique: 3 images of the left ankle were performed.

FINDINGS: No fracture is demonstrated. Osseous alignment and mineralization are normal. The articular surfaces are normal. There are no focal lytic or sclerotic lesions. There is mild lateral swelling.

IMPRESSION: No fractures demonstrated.

A/P Last Updated by AUSTIN,MARIE @ 26 Sep 2014 1342 EDT**1. Left ankle joint pain 719.47**

Laboratory(ies): -COMPREHENSIVE METABOLIC PANEL (Routine)
 Radiology(ies): -MRI, FOOT LT W OR W/O CON (Routine) Impression: Pt had and ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment
 -MRI, ANKLE LT W OR W/O CON (Routine) Impression: Pt had a L ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment. r/o stress fx

Disposition Written by AUSTIN,MARIE @ 02 Oct 2014 0805 EDT**Released w/o Limitations****Follow up:** as needed . - Comments: parfq and waiver completed

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By AUSTIN, MARIE (Nurse Practitioner, WRNMMC) @ 02 Oct 2014 0806

CHANGE HISTORY

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

The following S/O Note Was Overwritten by AUSTIN, MARIE @ 26 Sep 2014 1320 EDT:

S/O Note Written by NEWMAN, BRENDA W @ 26 Sep 2014 1306 EDT

Chief complaint

The Chief Complaint is: Scalp issues, PT referral for left ankle and PRT waiver.

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18459536 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **25 Sep 2014 0730 EDT**
 Clinic: **Psychiatry Be**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 25 Sep 2014 0936 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 16 Oct 2014 0822 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

9-25-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient saw a physical therapist yesterday. He has been having problems with his left ankle since April 2014. He wanted to get light limited duty. He found out after he got there that only his PCM can issue light limited duty. They did give him a brace to help immobilize the ankle. He is working on his list of serious dating potentials. So far he has decided he does not want kids and does want someone who is OK with he doing things he likes to do (like computer work for long periods of time). Focus on sleep problems - mainly getting to sleep. It takes him 1 - 2 hours to get to sleep each night. His mind is very active. He thinks about problems he wants to solve, etc. If he stops thinking about one problem, he starts thinking about another problem. This writer suggested he write down the problem so he can let it go for the night. He said he could then have to keep rereading what he wrote to make sure he got it right. During the next week, he is going to think about how to set things aside for the night without forgetting them and not getting them quite right when he starts thinking about them the next day.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day: Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being 'super alert' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

', how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
 - ☐ 2. Feeling down depressed or hopeless
 - ☐ 3. Trouble sleeping or sleeping too much
 - ☐ 4. Feeling tired or little energy
 - ☐ 5. Poor appetite or overeating
 - ☐ 6. Feeling bad about self
 - ☐ 7. Trouble concentrating on things
 - ☐ 8. Moving or speaking slowly or being restless
 - ☐ 9. Thoughts that you would be better off dead
- Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

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DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

[0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psych Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- ☒ Gender (risk factor if male):
☒ H/O Suicide Attempts: age 17, bottle of asprin
Organized Plan:
Chronic Psychiatric Disorder:
Recent Psychiatric Hospitalization:
☒ H/O Abuse or Trauma:
Chronic Physical Illness:
☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
Other Recent Loss:
Chronic Pain:
Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
☒ Access to Lethal Means: gun in house
Poor Treatment Compliance:
Hopelessness:
☒ Psychic Pain/Anxiety: anxiety
Acute Event:
Insomnia:
Low Self-Worth:
☒ Impulsivity:
Substance Abuse:
☒ Financial Stress: got into debt, working on it
Legal Stress:

Protective:

- Strong Therapeutic Alliance:
Positive Coping Skills:
Responsible to/for Family:
Responsible to/for Pet:
Frustration Tolerance: likes to hid his feelings
☒ Resilience:
Good Reality Testing: can add details that are not true
☒ Amenable to Treatment:
Social Support: just his girl friend, no one to talk to
Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
☐ SM released to Chain of Command with the following limitations:
☐ SM sent to ER for evaluation for admission to inpatient psychiatry
☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

DoD ID: 1286180538

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Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal # 2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Last Updated by NILSEN, LINDA M @ 25 Sep 2014 0939 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

1. ANXIETY DISORDER NOS

Procedure(s): -Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Last Updated by NILSEN, LINDA M @ 25 Sep 2014 0940 EDT**Released w/o Limitations****Follow up:** for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 16 Oct 2014 0832**CHANGE HISTORY***The following S/O Note Was Overwritten by NILSEN, LINDA M @ 16 Oct 2014 0824 EDT:**S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0936 EDT***History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

9-25-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient arrived on time. Patient saw a physical therapist yesterday. He has been having problems with his left ankle since April 2014. He wanted to get light limited duty. He found out after he got there that only his PCM can issue light limited duty. They did give him a brace to help immobilize the ankle. He is working on his list of serious dating potentials. So far he has no kids and someone who is OK with he doing things he likes to do (like computer work for long periods of time).

Focus on sleep problems - mainly getting to sleep. It takes him 1 - 2 hours to get to sleep each night. His mind is very active. He thinks about problems he wants to solve, etc. If he stops thinking about one problem, he starts thinking about another problem. This writer suggested he write down the problem so he can let it go for the night. He said he could then have to keep rereading what he wrote to make sure he got it right. During the next week, he is going to think about how to set things aside for the night without forgetting them and not getting them quite right when he starts thinking about them the next day.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history
See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page 724
AR 2711

Medical Record

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DOB: [REDACTED]

1985

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DoD ID: 1286180538

Created: 16 Aug 2017

She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
☐ Repeated, disturbing dreams of a stressful experience from the past?
☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
☐ Feeling very upset when something reminded you of a stressful experience from the past?
☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
☐ Avoid activities or situations because they remind you of a stressful experience from the past?
☐ Trouble remembering important parts of a stressful experience from the past?
☐ Loss of interest in things that you used to enjoy?
☐ Feeling distant or cut off from other people?
☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
☐ Feeling as if your future will somehow be cut short?
☐ Trouble falling or staying asleep?
☐ Feeling irritable or having angry outbursts?
☐ Having difficulty concentrating?
☐ Being
'super alert
' or watchful on guard?
☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

If you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

', how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
☐ 2. Feeling down depressed or hopeless
☐ 3. Trouble sleeping or sleeping too much
☐ 4. Feeling tired or little energy
☐ 5. Poor appetite or overeating
☐ 6. Feeling bad about self
☐ 7. Trouble concentrating on things
☐ 8. Moving or speaking slowly or being restless
☐ 9. Thoughts that you would be better off dead
Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
☐ 2. Not being able to stop or control worrying
☐ 3. Worrying too much about different things
☐ 4. Trouble relaxing
☐ 5. Being so restless that it
's hard to sit still
☐ 6. Becoming easily annoyed or irritable
☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.**Physical findings****General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

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DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.
 Mood: ° Euthymic. ° Not depressed. ° Not anxious.
 Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.
 Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities.
 ° Attention span was not decreased.
 Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans.
 ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- [x] Released without limitations. Advised of emergency procedures.
- [] SM released to Chain of Command with the following limitations:
- [] SM sent to ER for evaluation for admission to inpatient psychiatry
- [] Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:

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Good Reality Testing: can add details that are not true
 x Amenable to Treatment:
 Social Support: just his girl friend, no one to talk to
 Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.
 [] SM released to Chain of Command with the following limitations:
 [] SM sent to ER for evaluation for admission to inpatient psychiatry
 [] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont-"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety

2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.

2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal #2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by NILSEN, LINDA M @ 16 Oct 2014 0822 EDT:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page 727
AR 2714

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

Signed NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0940

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

24 Sep 2014 at WRNMMC, Orthotics & Prosthetics Srv Be by ANDERSON, PETER P

Encounter ID: BETH-18452120 Primary Dx: Brace

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **24 Sep 2014 1201 EDT**
 Clinic: **ORTHOTICS & PROSTHETICS**
SRV BE

Appt Type: **EST**
 Provider: **ANDERSON,PETER P**

Reason for Appointment: Written by TIVEY-ANDERSON,MILAN D @ 24 Sep 2014 1201 EDT
 ASO ankle brace

A/P Written by ANDERSON,PETER P @ 25 Sep 2014 0834 EDT

1. Brace: Pt fit with aso brace.

Procedure(s): -Phys Ther Ed Checkout For Ortho/Prosth Use Estab Patient x 1
 -ANKLE FOOT ORTHOSIS,MULTILIGAMENTUS ANKLE SUPPORT,PREFAB,OTS x 1

Disposition Written by ANDERSON,PETER P @ 25 Sep 2014 0835 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by ANDERSON,PETER P @ 25 Sep 2014 0835 EDT

Pt received device.

Signed By ANDERSON, PETER P (Physician) @ 25 Sep 2014 0835

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Sep 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-18457059 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **24 Sep 2014 1100 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **EST**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 24 Sep 2014 1506 EDT**Problems**

- MAJOR DEPRESSION RECURRENT MODERATE
- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OXYCODONE HCL/ACETAMINOPHEN, 5MG-325MG, TABLET, ORAL	Active	TAKE ONE TABLET EVERY 4-6 HOURS AS NEEDED FOR PAIN #0 RF0	NR	18 Sep 2014
Chlorhexidine Gluconate 0.12%, Solution, Oral	Active	SWISH AND SPIT 15 ML TWICE A DAY FOR 2 WEEKS STARTING TOMORROW #0 RF0	NR	18 Sep 2014
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0	NR	18 Sep 2014
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Appointment Comments:

tan

Note Written by LAI, PHILOMENA C @ 24 Sep 2014 1547 EDT**Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation

(9/24/2014)

Subjective: Patient presents to clinic reporting continue L ankle pain since his return doing PT as he has been walking, running, jumping a lot, L ankle swelling resurface, now pain on L ankle even walking for long distance. Patient states he will be doing his PFT in 2 weeks but will not be able to do the running portion of PT.

(8/8/2014)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout. Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: Improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment, mild swelling L lateral malleolus area

palpation: TTP lateral L ankle anterior to lateral malleolus

flexibility: mod tightness hamstrings, calf

Joint Mobility: normal L ankle joint mobility

Sensation/Reflex: intact

ROM: ankle: DF L 15 deg R 13 deg, PF L 44 deg R 50 deg, IV L 35 deg R 35 deg, EV L 12 deg R 15 deg, 1st ray ext L 50 deg R 70 deg, flex L 12 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 5/5 R 5/5, EV L 5/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted but fatigue quickly L with pain

Tests

Re-evaluation (9/24/2014): Patient with recurrent ankle pain, most likely repeated strain from excessive impact activities .

Recommend patient hold off from jumping, squatting and running activities at this time to allow sufficient time for healing. Patient will need to continue strengthening and stretching program. Provided prescription for ankle brace to provide support.

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP- met

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg - met

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5 - met

Improve function to: tolerate long distance walking without increased in symptoms
running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (8/8/2014): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Continue HEP for stretching and strengthening. Follow up in 5-6 weeks for re-evaluation.

A/P Written by LAI, PHILOMENA C @ 24 Sep 2014 1509 EDT

1. Left ankle joint pain

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI, PHILOMENA C @ 24 Sep 2014 1547 EDT

Released w/o Limitations

Follow up: 5 to 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 24 Sep 2014 1548

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

18 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18463167 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **18 Sep 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 25 Sep 2014 0929 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0930 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

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9-18-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Focus on relationships. He has turned match.com back on. He did this before his girlfriend moved out. Realized he should have talked to her about ending their relationship first. Pt stated he has had numerous sexual encounters. He needs to slow down how quickly he gets very involved in a relationship. Patient is going to work on making a list of the top 10 things he wants in a potential partner.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL. Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't

want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
☐ Repeated, disturbing dreams of a stressful experience from the past?
☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
☐ Feeling very upset when something reminded you of a stressful experience from the past?
☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
☐ Avoid activities or situations because they remind you of a stressful experience from the past?
☐ Trouble remembering important parts of a stressful experience from the past?
☐ Loss of interest in things that you used to enjoy?
☐ Feeling distant or cut off from other people?
☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
☐ Feeling as if your future will somehow be cut short?
☐ Trouble falling or staying asleep?
☐ Feeling irritable or having angry outbursts?
☐ Having difficulty concentrating?
☐ Being
'super alert
' or watchful on guard?
☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
☐ 2. Feeling down depressed or hopeless
☐ 3. Trouble sleeping or sleeping too much
☐ 4. Feeling tired or little energy
☐ 5. Poor appetite or overeating
☐ 6. Feeling bad about self
☐ 7. Trouble concentrating on things
☐ 8. Moving or speaking slowly or being restless
☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
☐ 2. Not being able to stop or control worrying
☐ 3. Worrying too much about different things
☐ 4. Trouble relaxing
☐ 5. Being so restless that it
's hard to sit still
☐ 6. Becoming easily annoyed or irritable
☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Merwin, Daniel Dennis

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SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of asprin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other: Suicide Risk and Protective Factors Review:

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Non-Modifiable:

- ☒ Gender (risk factor if male):
- ☒ H/O Suicide Attempts: age 17, bottle of aspirin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- ☒ H/O Abuse or Trauma:
- Chronic Physical Illness:
- ☒ Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- ☒ Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- ☒ Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- ☒ Impulsivity:
- Substance Abuse:
- ☒ Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- ☒ Resilience:
- Good Reality Testing: can add details that are not true
- ☒ Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- ☒ Released without limitations. Advised of emergency procedures.
- ☐ SM released to Chain of Command with the following limitations:
- ☐ SM sent to ER for evaluation for admission to inpatient psychiatry
- ☐ Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

☐ Verbal ☐ Written ☐ Visual ☒ Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

☐ Yes ☒ No Specify:

Behavioral Health Advanced directives completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Do you use a Personal Health Record (PHR)?

☐ Yes ☒ No Specify:

Contact info: [REDACTED]

Therapy

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal # 2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 25 Sep 2014 0934 EDT**1. ANXIETY DISORDER NOS**

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 25 Sep 2014 0935 EDT**Released w/o Limitations****Follow up:** for therapy 1 to 2 week(s) in the PSYCHIATRY BE clinic.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.
60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0935

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Sep 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18447431 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **11 Sep 2014 0730 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **EST**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 24 Sep 2014 0918 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

est

Appointment Comments:

ddr

S/O Note Written by NILSEN, LINDA M @ 25 Sep 2014 0909 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

9-11-14: Follow-up appointment for patient being seen for adjustment disorder and anxiety disorder. Patient trying to decide whether to reenlist or not. He thinks he might be better off owning his own business. If he stays in the military and he advances, he will end up supervising more which he does not like as much. He is more than qualified for his job now. He gets bored easily. His girlfriend moved out. She had been talking to her X. She is not as neat as the SM, he likes to have everything clean again.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009 Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10 Pain Severity 0 / 10.

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't

want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient

's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't

want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't

want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent

the rest of the time hiding her drinking. She also was taking anti-depressants and didn't

tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more 20 oz a day of coffee - sometimes more. Tobacco use current smoker. Used to smoke hooka when overseas - Amt per Day: Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

PTSD CHECKLIST (PCL-C)

- ☐ Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
- ☐ Repeated, disturbing dreams of a stressful experience from the past?
- ☐ Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
- ☐ Feeling very upset when something reminded you of a stressful experience from the past?
- ☐ Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
- ☐ Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
- ☐ Avoid activities or situations because they remind you of a stressful experience from the past?
- ☐ Trouble remembering important parts of a stressful experience from the past?
- ☐ Loss of interest in things that you used to enjoy?
- ☐ Feeling distant or cut off from other people?
- ☐ Feeling emotionally numb or being unable to have loving feelings for those close to you?
- ☐ Feeling as if your future will somehow be cut short?
- ☐ Trouble falling or staying asleep?
- ☐ Feeling irritable or having angry outbursts?
- ☐ Having difficulty concentrating?
- ☐ Being
'super alert
' or watchful on guard?
- ☐ Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Yes ☐ No

If

'Yes

, how often? ☐ Several days ☐ More than half the days ☐ Almost everyday.

Depression Screening:

- ☐ 1. Little Interest or pleasure in doing things
- ☐ 2. Feeling down depressed or hopeless
- ☐ 3. Trouble sleeping or sleeping too much
- ☐ 4. Feeling tired or little energy
- ☐ 5. Poor appetite or overeating
- ☐ 6. Feeling bad about self
- ☐ 7. Trouble concentrating on things
- ☐ 8. Moving or speaking slowly or being restless
- ☐ 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

- ☐ 1. Feeling nervous, anxious, or on edge
- ☐ 2. Not being able to stop or control worrying
- ☐ 3. Worrying too much about different things
- ☐ 4. Trouble relaxing
- ☐ 5. Being so restless that it's hard to sit still
- ☐ 6. Becoming easily annoyed or irritable
- ☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. , regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed, they were linear, logical, and goal directed.

° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psych Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

☒ Released without limitations. Advised of emergency procedures.

☐ SM released to Chain of Command with the following limitations:

☐ SM sent to ER for evaluation for admission to inpatient psychiatry

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

[] Other: Suicide Risk and Protective Factors Review:

Non-Modifiable:

- x Gender (risk factor if male):
- x H/O Suicide Attempts: age 17, bottle of asprin
- Organized Plan:
- Chronic Psychiatric Disorder:
- Recent Psychiatric Hospitalization:
- x H/O Abuse or Trauma:
- Chronic Physical Illness:
- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
- Other Recent Loss:
- Chronic Pain:
- Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
- x Access to Lethal Means: gun in house
- Poor Treatment Compliance:
- Hopelessness:
- x Psychic Pain/Anxiety: anxiety
- Acute Event:
- Insomnia:
- Low Self-Worth:
- x Impulsivity:
- Substance Abuse:
- x Financial Stress: got into debt, working on it
- Legal Stress:

Protective:

- Strong Therapeutic Alliance:
- Positive Coping Skills:
- Responsible to/for Family:
- Responsible to/for Pet:
- Frustration Tolerance: likes to hid his feelings
- x Resilience:
- Good Reality Testing: can add details that are not true
- x Amenable to Treatment:
- Social Support: just his girl friend, no one to talk to
- Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- [x] Released without limitations. Advised of emergency procedures.
- [] SM released to Chain of Command with the following limitations:
- [] SM sent to ER for evaluation for admission to inpatient psychiatry
- [] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED] ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Contact info: [REDACTED]

Therapy

- Duration of the encounter 60 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated: 9-11-14

Reviewed with patient on: 9-11-14

Does patient agree with plan? yes

If not, what part?

Projected date of next treatment plan update: 12-11-14

Discussion of assessment and intervention

Tx Plan cont~"d:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

1. Anxiety
2. Relationship problems

Long-Term Goals:

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Develop the necessary skills for effective, open communication

Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #1):

- The patient will learn, and by self-report, implement skills to reduce overall anxiety and manage anxiety symptoms.

Interventions:

1. Establish rapport with the client toward building a therapeutic alliance.

Objective 2 (Corresponds to Goal # 2):

- By self report, Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within relationships.

Interventions:

1. Help patient review any new relationships for possible problems.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 25 Sep 2014 0927 EDT**1. ANXIETY DISORDER NOS**

Procedure(s):

-Clinical Social Work Individual Outpatient Counseling 45 Minutes x 1

Disposition Written by NILSEN,LINDA M @ 25 Sep 2014 0928 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Released w/o Limitations

Follow up: for therapy 1 to 2 week(s) .

Discussed: Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 25 Sep 2014 0928

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18110266

Primary Dx:

MAJOR DEPRESSION RECURRENT
MODERATEPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **21 Aug 2014 0757 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **NILSEN, LINDA M**

Call Back Phone: [REDACTED]

AutoCites Refreshed by NILSEN, LINDA M @ 21 Aug 2014 0914 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Telephone Consult: Written by AZARRAGA, ANN B @ 21 Aug 2014 0757 EDT

Pt wanted clarification if he is being seen weekly starting on the 28th at 0730.

Telephone Consult Comments: Written by AZARRAGA, ANN B @ 21 Aug 2014 0757 EDT

Pt was confused whether he was supposed to see you today or next week. Please phone pt back to clear the confusion.

Note Written by NILSEN, LINDA M @ 21 Aug 2014 1407 EDT**Returned phone call**

This writer called patient back to let him know he missed his appointment this morning, and that he has appointments on Thursdays through the end of September at 7:30.

A/P Written by NILSEN, LINDA M @ 21 Aug 2014 1411 EDT**1. MAJOR DEPRESSION RECURRENT MODERATE****Disposition** Last Updated by NILSEN, LINDA M @ 21 Aug 2014 1411 EDT

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 21 Aug 2014 1412

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

21 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-18110190

Primary Dx:

MAJOR DEPRESSION RECURRENT
MODERATEPatient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**Date: **21 Aug 2014 0756 EDT**
Clinic: **PSYCHIATRY BE**Appt Type: **T-CON***
Provider: **NILSEN, LINDA M**

Call Back Phone: [REDACTED]

AutoCites Refreshed by NILSEN, LINDA M @ 21 Aug 2014 0756 EDT**Family History**

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Telephone Consult: Written by NILSEN, LINDA M @ 21 Aug 2014 0756 EDT
N/S This wrtier called and left a message for patient at 7:45**A/P** Last Updated by NILSEN, LINDA M @ 21 Aug 2014 0758 EDT**1. MAJOR DEPRESSION RECURRENT MODERATE****Disposition** Last Updated by NILSEN, LINDA M @ 21 Aug 2014 0758 EDT**Signed By NILSEN, LINDA M** (LCSW-C, Behavioral Health) @ 21 Aug 2014 0758

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Aug 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-17983790 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **08 Aug 2014 0700 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **EST**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 08 Aug 2014 0649 EDT**Problems**

- ANXIETY DISORDER NOS
- Left ankle joint pain
- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

est

Appointment Comments:

tan

S/O Note Written by LAI, PHILOMENA C. @ 08 Aug 2014 0735 EDT**Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout. Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: Improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10

best 0/10 worst 3/10

Description of pain: comes and goes

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment

palpation: no TTP

flexibility: mod tightness hamstrings, calf

Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob

Sensation/Reflex: intact

ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg, EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted.

Tests

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5

Improve function to: tolerate long distance walking without increased in symptoms
running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (15 min): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..

A/P Written by LAI, PHILOMENA C @ 08 Aug 2014 0653 EDT**1. Left ankle joint pain**

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI, PHILOMENA C @ 08 Aug 2014 0750 EDT**Released w/o Limitations****Follow up:** 4 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 08 Aug 2014 0751**

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Aug 2014 at WRNMMC, Psychiatry Be by NILSEN, LINDA M

Encounter ID: BETH-17934643 Primary Dx: ANXIETY DISORDER NOS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **04 Aug 2014 1300 EDT**
 Clinic: **PSYCHIATRY BE**

Appt Type: **ROUT**
 Provider: **NILSEN, LINDA M**

AutoCites Refreshed by NILSEN, LINDA M @ 04 Aug 2014 1054 EDT**Family History**

- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Reason for Appointment:

Rout

Appointment Comments:

Jnb

S/O Note Written by NILSEN, LINDA M @ 04 Aug 2014 1525 EDT**History of present illness**

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient "picks" at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Insomnia Severity Index: 8/28 Patient has a hard time getting to sleep, at times it takes 2 hrs. He wakes up during the night when he has something on his mind. If he listens to rain and storms it helps him sleep better.

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10.

Merwin, Daniel Dennis

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

Current medication

See ALTHA, per patient, none

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing.

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings.

Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more. Current smoker Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Generalized Anxiety Disorder Screening:

- [3] 1. Feeling nervous, anxious, or on edge
 [1] 2. Not being able to stop or control worrying
 [2] 3. Worrying too much about different things
 [2] 4. Trouble relaxing
 [1] 5. Being so restless that it's hard to sit still
 [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 12/27 on 8-4-14

It is very difficult for him to do his work, take care of things at home, or get along with other people

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [] Somewhat [] Very [] Extremely.

PTSD CHECKLIST (PCL-C)

- [] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
 [] Repeated, disturbing dreams of a stressful experience from the past?
 [] Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
 [] Feeling very upset when something reminded you of a stressful experience from the past?

Merwin, Daniel Dennis

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DOB: [REDACTED]

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[] Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?

[] Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?

[] Avoid activities or situations because they remind you of a stressful experience from the past?

[] Trouble remembering important parts of a stressful experience from the past?

[] Loss of interest in things that you used to enjoy?

[] Feeling distant or cut off from other people?

[] Feeling emotionally numb or being unable to have loving feelings for those close to you?

[] Feeling as if your future will somehow be cut short?

[] Trouble falling or staying asleep?

[] Feeling irritable or having angry outbursts?

[] Having difficulty concentrating?

[] Being

'super alert

'or watchful on guard?

[] Feeling jumpy or easily startled?

Add point values from each response. Total Score = 0 DATE: 8-4-14

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? [] Not difficult [] Somewhat difficult [] Very difficult [] Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? [] Yes [] No

If

'Yes

', how often? [] Several days [] More than half the days [] Almost everyday.

Depression Screening:

[1] 1. Little Interest or pleasure in doing things

[0] 2. Feeling down depressed or hopeless

[2] 3. Trouble sleeping or sleeping too much

[0] 4. Feeling tired or little energy

[0] 5. Poor appetite or overeating

[1] 6. Feeling bad about self

[1] 7. Trouble concentrating on things

[2] 8. Moving or speaking slowly or being restless

[1] 9. Thoughts that you would be better off dead

Add point values from each response. Total (PHQ-9) Score = 7/27 on 8-4-14

Difficulty doing work, taking care of things at home, or getting along with other people? [] Not at all [x] Somewhat [] Very [] Extremely.

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed, oriented x3. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal, regular rate, non-pressured. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: ° Behavior demonstrated no abnormalities - appropriate and cooperative. ° No psychomotor retardation. ° Behavior demonstrated no psychomotor agitation. ° No decreased eye-to-eye contact was observed.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability.

Thought Processes: ° Not impaired, they were linear, logical, and goal directed. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Neurovegetative Assessment: • Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive

Other Recent Loss:

Chronic Pain:

Age (risk factor if <25 or >60): age 29

Modifiable:

Suicidal ideation/plans/intent:

x Access to Lethal Means: gun in house

Poor Treatment Compliance:

Hopelessness:

x Psychic Pain/Anxiety: anxiety

Acute Event:

Insomnia:

Low Self-Worth:

x Impulsivity:

Substance Abuse:

x Financial Stress: got into debt, working on it

Legal Stress:

Protective:

Strong Therapeutic Alliance:

Positive Coping Skills:

Responsible to/for Family:

Responsible to/for Pet:

Frustration Tolerance: likes to hid his feelings

x Resilience:

Good Reality Testing: can add details that are not true

x Amenable to Treatment:

Social Support: just his girl friend, no one to talk to

Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

[x] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other

(Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

• Duration of the encounter 90 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated:

Reviewed with patient on:

Does patient agree with plan?

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

If not, what part?

Projected date of next treatment plan update:

THIS WAS THE FIRST SESSION. WE SPENT THE TIME FILLING OUT THE ASSESSMENT. NEXT SESSION THE ITP
WILL BE FINISHED Discussion of assessment and intervention

Tx Plan cont

'd:

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

- 1.
- 2.
- 3.

Long-Term Goals:

- 1.
- 2.
- 3 Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Objective 2 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Objective 3 (Corresponds to Goal #):

-

Interventions:

- 1.
- 2.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

A/P Written by NILSEN,LINDA M @ 04 Aug 2014 1424 EDT**1. ANXIETY DISORDER NOS**

Procedure(s): -Psychiatric Diagnostic Evaluation x 1

Disposition Written by NILSEN,LINDA M @ 04 Aug 2014 1536 EDT**Released w/o Limitations****Follow up:** for therapy 1 to week(s) in the PSYCHIATRY BE clinic.**Discussed:** Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

90 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Aug 2014 1537

CHANGE HISTORY*The following S/O Note Was Overwritten by NILSEN,LINDA M @ 04 Aug 2014 1530 EDT:**S/O Note Written by NILSEN,LINDA M @ 04 Aug 2014 1055 EDT*

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

INITIAL ASSESSMENT 8-4-14: 29 year old SWM Navy, E-6, with 9 years TIS, 2 years at NIOC at Ft Meade. 2 years to go, not sure if he wants to stay in - will have to stay in or some time due to braces on teeth. Self referral. Patient believes that his family of origin is impacting on how he relates to others now that he is an adult. During the past month, he has experienced the following symptoms: anxiety or worries and difficulty concentrating. Patient 'picks' at his scalp. Has several dry patches where he has scraped/picked the hair out in circles. He has been doing this since 2009. He thinks it is a combination of dry skin and his picking at the scalp.

Nutrition: tries to eat healthy, goes out 1 X a week, has some family issues - father is large, has diabetes - does not want to turn out like him

Abuse: Father was physically abusive of sisters more so than with him. Dad also shaved patient's head when he was 17 because he thought Sm's hair was too long. Patient was allergic to animals, Father kept cats and dogs. SM used emergency inhaler 3 or 4 X a day.

Goals he would like to deal with: 1.) anxiety, 2.) past issues - family abuse (verbal, physical), 3.) new way of handling issues - rather than ignore them.

Visit is deployment-related Stress got to him while in Japan and stationed on ship 3/2006 - 4/2009.

Pain Severity 0 / 10.

Current medication

See ALTHA

Past medical/surgical history**Reported:**

Medical: Reported medical history

See ALTHA

and psychiatric history

* THERAPY: Fleet and Family Aug 2012 for 4 or 5 months

* MEDS: none

* INPATIENT/RESIDENTIAL CARE: denied

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: in H/S, swallowed a whole bottle of aspirin - felt sick, never told anyone

* FPMH: sister is bi-polar, other sister depressed. Mom and grandmother are bi-polar. Father is obese, diabetic, alcoholic? - drinks every other or every night - has not seen him since 2009 so is not sure how he is doing.

Personal history

Social history Born and raised in Riverside, CAL, Dad was in military for 2 years. SM is 29, sisters are 27 and 26. All full siblings. Parents divorced when he was 2 or 3. Dad got full custody immediately. He didn't want mother to ever see them.

Mother left bruises on his sister. Lost full custody. Dad was really more abusive. Age 8, got step-mother, they were together for 10 years. Step-mother later told patient that she stayed with their father for their sakes as long as she could. Before their divorce, father started seeing his next wife. Brought her to patient's track events. Dad got divorced from her about 1 yr ago. SM lived in Cal until 14.

EDUCATION/MILITARY: H/S in NJ. Really awful, started Freshman yr at one school, then they moved again during that yr. He lost most of his credits that yr. Got along at school because he was a runner. 2.2 GPA, no scholarships. Worked during the school yr and summers. Rented a room from his step-mom (told his dad he was going away to school). Lived with her for 2 yrs and went to college for 1 semester. Drinking lot, dating crazies, decided to join the military. Planned on making a career of the military, not sure now. Doesn't want to move anymore.

ADULT RELATIONSHIPS: never married, no children. Last relationship - Kristina, age 29. They have been together 6 months, living together 4 months. Her lease was up so they moved in together. He thinks he wants to break up with her. She doesn't want to talk about anything. The relationship before this one lasted 2 years. The first 6 months were good. The rest of the time was rocky. They started out as house mates. She had drinking problems. He tried to help by not drinking either. She spent the rest of the time hiding her drinking. She also was taking anti-depressants and didn't tell him.

SPIRITUAL: none

Behavioral: Caffeine use 20 oz a day of coffee - sometimes more. Current smoker Used to smoke hooka when overseas - Amt per Day:

Alcohol: Alcohol use Liquor - 1-3 drinks, 1 or 2 X a week if liquor in fridge, 6 or more drinks one time or less a month, trying to cut down.

Subjective

Additional Screening Questions:

Are you having any thoughts about harming another person? denied

Do you feel like you are at risk for workplace violence? denied

Physical findings**General Appearance:**

* Alert. * Well developed. * Well nourished. * In no acute distress.

Neurological:

* No disorientation was observed, oriented x3. * No hallucinations. * Memory was unimpaired. * Remote memory was not impaired. * Recent memory was not impaired. * Judgement was not impaired.

Speech: * Normal, regular rate, non-pressured. * Rate was not slowed. * Not pressured. * Tone was not a monotone.

Psychiatric:

Demonstrated Behavior: * Behavior demonstrated no abnormalities - appropriate and cooperative. * No psychomotor retardation. * Behavior demonstrated no psychomotor agitation. * No decreased eye-to-eye contact was observed.

Mood: * Euthymic. * Not depressed. * Not anxious.

Affect: * Normal. * Not labile. * Not flat. * Not constricted. * Showed no irritability.

Thought Processes: * Not impaired, they were linear, logical, and goal directed. * Attention demonstrated no abnormalities. * Attention span was not decreased.

Thought Content: * Insight was intact. * No delusions. * No suicidal ideation. * No suicidal plans. * No suicidal intent. * No homicidal ideations. * No homicidal plans.

* No homicidal intent.

Neurovegetative Assessment: * Dangerousness assessment: suicide risk Suicide Risk and Protective Factors Review:

Non-Modifiable:

x Gender (risk factor if male):

x H/O Suicide Attempts: age 17, bottle of aspirin

Organized Plan:

Chronic Psychiatric Disorder:

Recent Psychiatric Hospitalization:

x H/O Abuse or Trauma:

Chronic Physical Illness:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

- x Family H/O Suicide/Attempts: both sisters have made attempts - he is surprised one is still alive
 Other Recent Loss:
 Chronic Pain:
 Age (risk factor if <25 or >60): age 29

Modifiable:

- Suicidal ideation/plans/intent:
 x Access to Lethal Means: gun in house
 Poor Treatment Compliance:
 Hopelessness:
 x Psychic Pain/Anxiety: anxiety
 Acute Event:
 Insomnia:
 Low Self-Worth:
 x Impulsivity:
 Substance Abuse:
 x Financial Stress: got into debt, working on it
 Legal Stress:

Protective:

- Strong Therapeutic Alliance:
 Positive Coping Skills:
 Responsible to/for Family:
 Responsible to/for Pet:
 Frustration Tolerance: likes to hid his feelings
 x Resilience:
 Good Reality Testing: can add details that are not true
 x Amenable to Treatment:
 Social Support: just his girl friend, no one to talk to
 Religious Beliefs Contrary to Suicide:

Risk of Harm to Others: denied

Action Taken Based on Risk Assessment:

- [x] Released without limitations. Advised of emergency procedures.
 [] SM released to Chain of Command with the following limitations:
 [] SM sent to ER for evaluation for admission to inpatient psychiatry
 [] Other:

Assessment

• History ANNUAL SCREENING DATE:

Primary language: English

What is your preferred method of learning?

[] Verbal [] Written [] Visual [x] Other (Specify): visual and hands on

Do you have a learning disability, language barrier, hearing/vision deficit?

[] Yes [x] No Specify:

Behavioral Health Advanced directives completed?

[] Yes [x] No

Do you have any cultural or religious beliefs that may affect your care?

[] Yes [x] No

Are you enrolled in EFMP?

[] Yes [x] No

Do you use a Personal Health Record (PHR)?

[] Yes [x] No Specify:

Contact info: [REDACTED]

Therapy

- Duration of the encounter 90 min.

Practice Management

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: L Nilsen, LCSW-C

Date last updated:

Reviewed with patient on:

Does patient agree with plan?

If not, what part?

Projected date of next treatment plan update:

THIS WAS THE FIRST SESSION. WE SPENT THE TIME FILLING OUT THE ASSESSMENT. NEXT SESSION THE ITP WILL BE FINISHED Discussion of risk of assessment and intervention

Interventions Provided at this session:

supportive therapy

Objective 1 (Corresponds to Goal #):

-

Interventions:

1.

2.

Objective 2 (Corresponds to Goal #):

-

Interventions:

1.

2.

Objective 3 (Corresponds to Goal #):

-

Interventions:

1.

2.

Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop Discussion of assessment and intervention

Tx Plan cont

id:

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Diagnosis

I. 300.00 Anxiety D/O NOS

II. 799.9 deferred

III. none

IV. Limited support system, few friends

V. current GAF: 65

Active Problem List:

- 1.
- 2.
- 3.

Long-Term Goals:

- 1.
- 2.
- 3.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by NILSEN, LINDA M @ 04 Aug 2014 1431 EDT:

Signed NILSEN, LINDA M (LCSW-C, Behavioral Health) @ 04 Aug 2014 1424

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by YORK, CARLA M

Encounter ID: BETH-17580231 Primary Dx: Anxiety

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **27 Jun 2014 1000 EDT**
 Clinic: **HEALTH PROMOTION CL BE**

Appt Type: **EST**
 Provider: **YORK,CARLA M.**

AutoCites Refreshed by YORK,CARLA M @ 27 Jun 2014 0829 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

F/u

Appointment Comments:

anb

S/O Note Written by YORK,CARLA M. @ 27 Jun 2014 1007 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

Referred here

By PCM, Thomas S. Clark, FNP.

History of present illness

The Patient is a 29 year old male.

This is the patient's second visit to the IBHC clinic.

Source of information was self.

Feedback was provided to the PCM.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Previous history of visit is not deployment-related. No decrease in concentrating ability.

Pain Severity 0 / 10.

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Progress and barriers in adhering to behavior change plan: work-related stress, on a 30 day assignment to 'fix

' a systems problem; feels that his symptoms have been evident since he was a child and therefore not likely to change with brief intervention

Changes in symptoms and/or functioning: reports some improvement in mood, anxious thoughts; however, that he continues to constantly think about getting tasks done, believes it traces back to his childhood and father's authoritarian parenting style

....

Anxiety Intervention:

[] Trained in relaxation strategies

[x] Trained in improving communication skills

[x] Discussed potential treatments for anxiety (i.e. PE, CPT, CBT)

[x] Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).

[] Developed Crisis Response plan.

[x] Trained in strategies for increasing balanced thinking.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

[] Other:

....

Personal history

Behavioral: Caffeine use 16 oz. Coffee per day; up to 32 oz. On weekend. No tobacco use in the last 10 years.

Alcohol: Alcohol use Occasional-approximately 3-5 drinks a week or less.

Review of systems**Systemic:** Feeling tired (fatigue).**Gastrointestinal:** Normal appetite.**Neurological:** No disorientation.**Psychological:** No sleep disturbances. Normal enjoyment of activities, a desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No frequent thoughts of death /morbid ideation and no impulsive behavior.**Physical findings****General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Euthymic. ° Not depressed. ° Not anxious.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results:	Value
PHQ-9 Score	4
Tests:	Value
GAD-7 Score	15

• DEPRESSION SCREENING / MONITORING (PHQ-9)

- [0] Little Interest or pleasure in doing things
 [1] Feeling down depressed or hopeless
 [2] Trouble sleeping or sleeping too much
 [0] Feeling tired or little energy
 [0] Poor appetite or overeating
 [0] Feeling bad about self
 [1] Trouble concentrating on things
 [0] Moving or speaking slowly or being restless
 [0] Thoughts that you would be better off dead

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Thoughts that you would be better off dead: [] Yes [x] No

....

Generalized Anxiety Disorder Screening:

- [3] 1. Feeling nervous, anxious, or on edge
 [2] 2. Not being able to stop or control worrying
 [3] 3. Worrying too much about different things
 [2] 4. Trouble relaxing
 [2] 5. Being so restless that its hard to sit still
 [2] 6. Becoming easily annoyed or irritable
 [1] 7. Feeling afraid as if something awful might happen

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

....

Counseling/Education

Anxiety Recommendations for patient:

Continue with relaxation exercises as previously trained in initial session

Follow through with BH specialty care referral-appointment 4 AUG 14 at 1300-Psychology

F/U IBHC as needed

Anxiety Recommendations for PCM Team:

Encourage attendance at scheduled BH visit

....

Practice Management

Patient exercises-has started with physical therapy; previously was running 5+ miles per day, now starting physical therapy due to ankle sprain.

A/P Written by YORK,CARLA M @ 27 Jun 2014 1028 EDT

1. Anxiety 300.00: Pt. Presenting with longstanding symptoms of anxiety; he has completed 2 sessions with the IBHC program.

Due to duration of symptoms, patient in agreement with recommendation at this time to participate in specialty BH treatment.

Referral placed and appointment made during session for 4 AUG 14.

Consult(s): -Referred To: TBI/DEPLOYMENT BEH HLTH MTF BE (Routine) Specialty: PSYCHOLOGY Clinic:
NEUROPSYCHOL HLTH SVC BE Provisional Diagnosis: Anxiety

Disposition Written by YORK,CARLA M @ 27 Jun 2014 1029 EDT

Released w/o Limitations

Follow up: in the PSYCHOLOGY HEALTH BE clinic. - Comments: 4 AUG 14

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: Availability of BH services, including emergency services, was discussed with SM

Administrative Options: Consultation requested

Signed By YORK, CARLA M (Clinical Health Psychologist, Walter Reed National Military Medical Center-Bethesda) @ 27 Jun 2014 1029

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

27 Jun 2014 at WRNMMC, Phys Therapy CL BE by LAI, PHILOMENA C

Encounter ID: BETH-17579298 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **27 Jun 2014 0700 EDT**
 Clinic: **PHYS THERAPY CL BE**

Appt Type: **SPEC**
 Provider: **LAI, PHILOMENA C.**

AutoCites Refreshed by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT**Problems**

- NEUROTIC EXCORIATION
- ANKLE SPRAIN LEFT
- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
- paternal history of preliminary background HPI [use for free text] (Father)
- paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL	Ordered	TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1	1 of 1	16 Jun 2014

Reason for Appointment:

ANKLE SPRAIN LEFT

Appointment Comments:

snf

Vitals**Vitals** Written by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT**Comments:** Patient has falls in the past 6 months, minor injury to L ankle. Patient is not a fall risk.**S/O Note** Written by LAI, PHILOMENA C. @ 27 Jun 2014 1034 EDT**Chief complaint**

The Chief Complaint is: L ankle sprain

Visit for: Initial Evaluation

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole. Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical/surgical history**Reported:**

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment

palpation: no TTP

flexibility: mod tightness hamstrings, calf

Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob

Sensation/Reflex: intact

ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg, EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted.

Tests

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5

Improve function to: tolerate long distance walking without increased in symptoms
running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (15 min): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..

A/P Written by LAI, PHILOMENA C @ 27 Jun 2014 1043 EDT**1. Left ankle joint pain**

Procedure(s):

-Physical Therapy Service Evaluation x 1

-Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

Disposition Written by LAI, PHILOMENA C @ 27 Jun 2014 1043 EDT**Released w/o Limitations****Follow up:** 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Note Written by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT****Consult Order****Referring Provider:** DOUGHERTY, DIANA L**Date of Request:** 04 Jun 2014**Priority:** Routine**Provisional Diagnosis:**

ANKLE SPRAIN LEFT

Reason for Request:

29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM. Please eval and provide exercises to improve strength, ROM. Please consider soft brace for stability while recovering.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 27 Jun 2014 1043

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Jun 2014 at WRNMMC, Integrative Hlth & Well BE by JARRETT, ERICA M

Encounter ID: BETH-17458952 Primary Dx: GENERALIZED ANXIETY DISORDER

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **16 Jun 2014 1300 EDT**
 Clinic: **HEALTH PROMOTION CL BE**

Appt Type: **EST**
 Provider: **JARRETT, ERICA M.**

AutoCites Refreshed by TURNER, RHONDA S @ 16 Jun 2014 1241 EDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

anxiety

Appointment Comments:

snf

S/O Note Written by O'SULLIVAN, ROBIN R @ 16 Jun 2014 1505 EDT**Chief complaint**

The Chief Complaint is: Anxiety.

Referred here

By PCM, Thomas S. Clark, FNP.

History of present illness

The Patient is a 29 year old male.

This is the initial visit to the IBHC clinic.

Source of information was self.

Feedback was provided to the PCM.

- Pt was given IBHC brochure describing the behavioral health program. Discussed with patient model of service to include the limits of confidentiality (i.e. abuse reporting, suicide intervention, etc.) and short-term intervention focused approach

- Pt indicated understanding.

Patient was seen for 30 minute IBHC appointment.

Normal appetite.

Sleep disturbances.

Previous history of visit is not deployment-related. No decrease in concentrating ability.

Pain Severity 3 / 10 (dental and ankle).

<<Note accomplished in TSWF-IBHC Anxiety tab>>

Description of Symptoms:

Anxiety symptoms include irritable bowel, anxious mood, biting nails, picking hair, attentional difficulties, irritable, insomnia. No issue with sleep onset, but difficulty with sleep maintenance (averaging 5 - 8 hours in bed, but awake much of that time; Pt estimated 3 - 4 hrs sleeping).

Duration of Problem:

Since age 14 has experienced most of symptoms of anxiety listed above, with exception of hair difficulty (began August 2011).

Factors correlated with onset: Pt described difficult childhood and home environment (father alcoholic & harsh disciplinarian, mother bipolar). More recently, Pt spent 850 days at sea over 3 years & had mersa 3xs during this, contributing to scalp/hair picking. Currently, Pt was selected for new job which is high stress, with increased responsibility, leadership and management duties (would prefer to do computer work in isolation). Pt is considering separation (eligible in 2 years) due to dissatisfaction with Navy, but anxious about alternative future options;

Frequency of symptoms: daily and pervasive throughout the day.

Severity of symptoms: Very difficult - able to perform well at work but is uncomfortable by feeling anxious and inability to relax.

Course of problem: slightly worse lately, which Pt attributed to recent dispute with girlfriend and increasing work-related stress.

Psychosocial factors: Stress from work enhances a preexisting anxious tendency; Pt described his relationship with his girlfriend as conflict avoidant and desires it to have more honest communication.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Aggravating factors: over-planning, anxious ruminating thoughts; obsessively planning procedures to optimize efficiency; rigid with cleaning at home.

Alleviating factors: Drinking coffee is reported to be helpful; Reading technical material and computer programming; alone time and spending time with his girlfriend.

Current tx: Pt stated has he has avoided seeking help for fear of impacting career.

Past tx: Pt received therapy for about 18 months at Ft Meade and found this helpful.

Functional impact: Pt stated it is hard to enjoy free time and is constantly stressed at work.

....
Anxiety Intervention:

[] Trained in relaxation strategies

[x] Trained in improving communication skills

[x] Discussed potential treatments for anxiety (i.e. PE, CPT, CBT)

[x] Discussed various factors related to the development and maintenance of anxiety (including biological, cognitive, behavioral, and environmental factors).

[] Developed Crisis Response plan.

[x] Trained in strategies for increasing balanced thinking.

[] Other:

Personal history

Behavioral: Caffeine use 2 - 4 cups / coffee daily, rare energy drinks. No tobacco use in the last 10 years.

Alcohol: Alcohol use 2-3 drinks / week.

Review of systems

Systemic: Not feeling tired (fatigue).

Neurological: No disorientation.

Psychological: Normal enjoyment of activities, a desire to continue living, not thinking about suicide, not having a suicide plan, and no stated intent to commit suicide. No homicidal thoughts, not thinking of a way to do it, and without a stated intent to kill. No frequent thoughts of death / morbid ideation and no impulsive behavior.

Physical findings**General Appearance:**

° Alert. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No disorientation was observed - oriented to place, person, time, and situation. ° No hallucinations. ° Memory was unimpaired. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Speech: ° Normal - regular rate, non-pressured. ° Rate was normal. ° Rate was not slowed. ° Not pressured. ° Tone was not a monotone. ° Volume was normal. ° No articulation abnormalities. ° No language abnormalities were demonstrated.

Psychiatric:

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Cooperative.

Mood: ° Anxious. ° Euthymic. ° Not depressed.

Affect: ° Normal. ° Not labile. ° Not flat. ° Not constricted. ° Showed no irritability. ° Congruent with the mood.

Thought Processes: ° Not impaired - they were linear, logical, and goal directed. ° Evaluation of connectedness showed no deficiency. ° Attention demonstrated no abnormalities. ° Attention span was not decreased.

Thought Content: ° Insight was intact. ° No delusions.

Tests**General:**

Test Results:	Value	
PHQ-9 Score	5	
Test Results:	Value	
Duke Health Profile Physical Health Score:	80	
Test Results:	Value	
GAD-7 Score	15	
Test Results:	Value	
Duke Health Profile Mental Health Score:	40	
Test Results:	Value	
DUKE HEALTH PROFILE TOTAL GENERAL HEALTH SCORE:		43
Tests:	Value	
Duke Health Profile Social Health Score:	10	

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

The patient completed the DUKE Health Profile, a 17-item measure of health-related quality of life. On this measure, scores range from 0 to 100, with higher scores indicating better health status.

Mental Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

Social Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

General Health score was 2 standard deviations or more below the mean indicating a lower score than about 98% of others of similar age and gender.

• DEPRESSION SCREENING / MONITORING (PHQ-9)

- [0] Little Interest or pleasure in doing things
 [1] Feeling down depressed or hopeless
 [2] Trouble sleeping or sleeping too much
 [0] Feeling tired or little energy
 [0] Poor appetite or overeating
 [0] Feeling bad about self
 [0] Trouble concentrating on things
 [2] Moving or speaking slowly or being restless (circled fidgety & restless)
 [0] Thoughts that you would be better off dead

Add point values from each response and document in the box below.

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

Thoughts that you would be better off dead: [] Yes [x] No

....

Generalized Anxiety Disorder Screening:

- [3] 1. Feeling nervous, anxious, or on edge
 [2] 2. Not being able to stop or control worrying
 [3] 3. Worrying too much about different things
 [3] 4. Trouble relaxing
 [1] 5. Being so restless that its hard to sit still
 [3] 6. Becoming easily annoyed or irritable
 [0] 7. Feeling afraid as if something awful might happen

Add point values from each response and document in the box below. 15

Difficulty doing work, taking care of things at home, or getting along with other people?

[] Not at all [x] Somewhat [] Very [] Extremely

....

Assessment

• Depression

PHQ-9 Score: 5 Date: 16 June 2014 Comments: Mild

....

• Anxiety disorder NOS

GAD-7 Score: 15 Date: 16 June 2014 Comments: Severe

....

Counseling/Education

Anxiety Recommendations for patient:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

Anxiety Recommendations for PCM Team: Support Pt in implementing above recommendations

....

A/P Last updated by JARRETT,ERICA M @ 20 Jun 2014 1414 EDT

1. GENERALIZED ANXIETY DISORDER: Pt was seen for a 30 minute initial consultation to address symptoms of anxiety. Pt meets diagnostic criteria for Generalized Anxiety Disorder: (inability to control excessive worry with restlessness, fatigue, difficulty concentrating, irritability, and sleep disturbance more days than not for longer than the past 6 months). Pt recalls times in his past that he self-isolated and avoided social encounters due to anxiety and feels his chronic worry negatively impacts his functioning. Pt is in the preparation stage of change in managing his anxiety, to include attending initial consultation with psychiatric and behavioral health providers for further treatment. In the meantime, Pt received education on relaxation techniques and agreed to implement the following interventions:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.
5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

2. NEUROTIC EXCORIATION: Per DSM-V, excoriation disorder is a separate diagnosis. Pt routinely picks his skin on the back of his scalp and has created a bald spot larger than the size of a quarter. Pt reported this behavior initially began with Folliculitis a few years ago, but has persisted and occurs whenever he feels anxious.

Disposition Last Updated by JARRETT,ERICA M @ 20 Jun 2014 1415 EDT

Released w/o Limitations

Follow up: as needed in 2 week(s) with PCM and/or in the HEALTH PROMOTION CL BE clinic or sooner if there are problems. - Comments: Follow up scheduled for 27 June 2014 at 1000 with Dr. York.

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By JARRETT, ERICA M (Clinical Health Psychologist, NNMC Bethesda, MD) @ 23 Jun 2014 0715

CHANGE HISTORY

The following Disposition Note Was Overwritten by JARRETT,ERICA M @ 20 Jun 2014 1415 EDT:

The Disposition section was last updated by JARRETT,ERICA M @ 20 Jun 2014 1415 EDT - see above. Previous Version of Disposition section was entered/updated by O'SULLIVAN,ROBIN R @ 17 Jun 2014 1320 EDT.

Released w/o Limitations

Follow up: as needed in 2 week(s) with PCM and/or in the HEALTH PROMOTION CL BE clinic or sooner if there are problems. - Comments: Follow up scheduled for 27 June 2014 at 1000 with Dr. York.

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.
30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following A/P Note Was Overwritten by JARRETT,ERICA M @ 20 Jun 2014 1413 EDT:

The A/P section was last updated by JARRETT,ERICA M @ 20 Jun 2014 1413 EDT - see above. Previous Version of A/P section was entered/updated by O'SULLIVAN,ROBIN R @ 19 Jun 2014 1212 EDT.

1. GENERALIZED ANXIETY DISORDER 300.02: Pt was seen for a 30 minute initial consultation to address symptoms of anxiety. Pt meets diagnostic criteria for Generalized Anxiety Disorder: (inability to control excessive worry with restlessness, fatigue, difficulty concentrating, irritability, and sleep disturbance more days than not for longer than the past 6 months). Pt recalls times in his past that he self-isolated and avoided social encounters due to anxiety and feels his chronic worry negatively impacts his functioning. Pt is in the preparation stage of change in managing his anxiety, to include attending initial consultation with psychiatric and behavioral health providers for further treatment. In the meantime, Pt received education on relaxation techniques and agreed to implement the following interventions:

1. Follow-up with individual psychotherapy and psychiatric consultation at Outpatient Adult Behavioral Health at WRNMMC.
2. Diaphragmatic breathing (3 x / day, 10 - 20 breathes)
3. Read handouts on anxiety, disputing cognitive distortions, and relaxation.
4. Read handout on sleep and download CBT-i Coach app.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page 768
AR 2755

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

5. Follow up in two weeks with IBHC (Dr. York, 27 June 2014, 10:00 a.m.)

Procedure(s): -(90791) Psychiatric Diagnostic Evaluation Initial x 1 ADDITIONAL PROVIDER(S): O'SULLIVAN,ROBIN R

2. NEUROTIC EXCORIATION 698.4: Per DSM-V, excoriation disorder is a separate diagnosis. Pt routinely picks his skin on the back of his scalp and has created a bald spot larger than the size of a quarter. Pt reported this behavior initially began with Folliculitis a few years ago, but has persisted and occurs whenever he feels anxious.

Procedure(s): -(90791) Psychiatric Diagnostic Evaluation Initial x 1 ADDITIONAL PROVIDER(S): O'SULLIVAN,ROBIN R

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

16 Jun 2014 at WRNMMC, Int Med CL A Medical Home BE by CLARK, THOMAS S

Encounter ID: BETH-17454981 Primary Dx: ANKLE SPRAIN LEFT

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED
 NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **16 Jun 2014 0930 EDT**
 Clinic: **INT MED MEDICAL HOME CL A
 BE**

Appt Type: **EST**
 Provider: **CLARK, THOMAS STEPHEN**

AutoCites Refreshed by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1003 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

f/u after sprained ankle

Appointment Comments:

kcm

Vitals**Vitals** Written by OWENS, ANGELA M @ 16 Jun 2014 0955 EDTBP: 137/84, HR: 80, RR: 18, T: 98.2 °F, HT: 69 in, WT: 155 lbs, SpO₂: 98%, BMI: 22.89,

BSA: 1.854 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: socially, Pain Scale: 2/10 Mild, Pain Scale Comments: left ankle

S/O Note Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1003 EDT**Chief complaint**

The Chief Complaint is: Limited Duty Chit.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 yo active duty male with 6 week old ankle sprain, consult to PT 12 days ago, he hasn't made appt, needs limited duty chit.

Redirecting to make PT appt. 30d limited duty chit provided.

Pain localized to one or more joints L ankle pain.

allergy to HPI [use for free text].

Pain Severity 2 / 10.

Review of systems**Systemic:** No systemic symptoms, no generalized pain, and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Cardiovascular:** No chest pain or discomfort.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Pulmonary: No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Eyes:

General/bilateral:

Pupils: ° PERRL.

External: ° Eyelids showed no abnormalities. ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

A/P Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1013 EDT**1. ANKLE SPRAIN LEFT**Medication(s): -DOXYCYCLINE--PO 100MG TAB - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS
#60 RF1**Disposition** Written by CLARK, THOMAS STEPHEN @ 16 Jun 2014 1014 EDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the INT MED MEDICAL HOME CL A BE clinic. - Comments: f/u with PT**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By CLARK, THOMAS STEPHEN** (Family Nurse Practitioner) @ 16 Jun 2014 1014

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Jun 2014 at WRNMMC, Int Med Cons/Spec Care Cl Be by DOUGHERTY, DIANA L

Encounter ID: BETH-17336631 Primary Dx: ANKLE SPRAIN LEFT

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **04 Jun 2014 0632 EDT**
 Clinic: **INT MED CONS/SPEC CARE CL**
BE

Appt Type: **ACUT**
 Provider: **DOUGHERTY, DIANA L**

Reason for Appointment: Written by PEREZ, DULCE C @ 04 Jun 2014 0632 EDT
 left ankle swelling

Vitals**Vitals** Written by PEREZ, DULCE C @ 04 Jun 2014 0633 EDT

BP: 119/82, HR: 81, T: 97.9 °F, HT: 69 in, WT: 155 lbs, SpO₂: 97%, BMI: 22.89, BSA: 1.854 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: occasional, Pain Scale: 4/10 Moderate, Pain Scale Comments:
 left ankle

SO Note Written by DOUGHERTY, DIANA L @ 04 Jun 2014 0855 EDT**Chief complaint**

The Chief Complaint is: L ankle swelling.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

Pt is 24 yo AD navy who presents with c/o L ankle swelling/pain that has persisted since injury 15 April 2014. He reports that while playing softball, he sustained injury that involved forward force of the foot into a hole while playing softball. At that time, he was evaluated in the ER, found to have no e/o fracture on XR, and given a brace and crutches. He used the brace for approx 2 weeks, and the crutches for approx 4 at which point he was able to bear weight with minimal pain. Repeat XR obtained by his PCM in early May continued to demonstrate no e/o fracture.

Today, he presents because of ongoing aching pain at the ankle joint and forefoot, associated with swelling localized to the ankle. He denies sharp pain or point tenderness, and is able to bear weight. However ROM is limited, and pain exacerbated particularly with dorsiflexion. He has been unable to obtain a timely appointment with his primary provider, and needs exemption from PT.

No localized joint pain and no localized joint swelling. No sensory disturbances.

Current medication

Ibuprofen prn

Past medical/surgical history**Reported:**

Medical: Reported medical history
 reviewed, noncontributory.

Review of systems**Musculoskeletal:** No knee symptoms.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Injuries: ° No evidence of a head injury.

Appearance: ° Head normocephalic.

Cardiovascular:

Arterial Pulses: ° Dorsalis pedis pulses were normal and PT pulses intact.

Musculoskeletal System:**Knee:**

Right Knee: ° No effusion. ° No tenderness on palpation.

Left Knee: ° No effusion. ° No tenderness on palpation.

Lower Leg:

Right Leg: ° Calf was not swollen. ° Leg exhibited no warmth. ° No erythema. ° No tenderness on palpation.

Left Leg: ° Calf was not swollen. ° Leg exhibited no warmth. ° No erythema. ° No tenderness on palpation.

Ankle:

Right Ankle: ° No swelling. ° No erythema. ° Ankle was not warm. ° No misalignment. ° No tenderness on palpation.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

° Motion was normal. ° No pain was elicited by motion. ° Ankle was not tender on ambulation.
 Left Ankle: • Swelling localized to ankle, both medial and lateral aspects. • Tenderness on palpation aching tenderness at both lateral and medial malleoli. No point tenderness. • Motion was abnormal decreased ROM with dorsiflexion, inversion, eversion. • Pain was elicited by motion. • Ankle was tender on ambulation. ° No erythema. ° Ankle was not warm. ° No misalignment.

Foot:

Right Foot: • Pes planus. ° No erythema. ° No tenderness on palpation.

Left Foot: • Examined resolving ecchymosis. Foot warm, well perfused with 2+ distal pulses. • Pes planus. • Tenderness on palpation aching tenderness of forefoot. No point tenderness. ° No erythema. ° No abnormal warmth. ° No deformity.

Functional Exam:

General/bilateral: • Mobility was limited.

Neurological:

Motor (Strength): ° No weakness of the right ankle was observed. ° No weakness of the left ankle was observed.

A/P Last Updated by DOUGHERTY, DIANA L @ 04 Jun 2014 0939 EDT

1. ANKLE SPRAIN LEFT: Residual ankle swelling and limited ROM 6 weeks s/p injury resulting in ankle sprain. It is not unexpected to have these residual symptoms, and XR imaging on 2 occasions has failed to demonstrate fracture. No e/o neurovascular compromise. Patient improving, but not yet back to baseline.

* chit provided for light duty/no PT/no running or prolonged standing walking x7 days

* pt instructed to follow-up with his primary for ongoing treatment and profile, if needed

* physical therapy consult for assistance with re-gaining ROM

* patient counseled to avoid activities which cause pain, and to elevate/ice ankle as needed

Consult(s): -Referred To: PHYSICAL THERAPY MTF BE (Routine) Specialty: THERAPY, PHYSICAL Clinic: PHYS THERAPY CL BE Provisional Diagnosis: ANKLE SPRAIN LEFT

Disposition Last Updated by DOUGHERTY, DIANA L @ 04 Jun 2014 0941 EDT

Released w/ Work/Duty Limitations

Follow up: 1 week(s) with PCM or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By DOUGHERTY, DIANA L (Physician) @ 04 Jun 2014 0941

Co-Signed By SALUJA, SHUCHI M (Physician, General Internal Medicine, WRAMC) @ 10 Jun 2014 1826

Note Written by SALUJA, SHUCHI M @ 10 Jun 2014 1826 EDT

(Added after encounter was signed.)

discussed pt with Dr Daugherty, agree with above

CHANGE HISTORY

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by SALUJA, SHUCHI M @ 10 Jun 2014 1825 EDT:

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 May 2014 at WRNMMC, AMH M01A Red Ki by COLEMAN, AUDREY G

Encounter ID: BETH-17298002 Primary Dx: Left ankle joint pain

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **30 May 2014 1141 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **T-CON***
 Provider: **COLEMAN,AUDREY G**

Call Back Phone: [REDACTED]

AutoCites Refreshed by COLEMAN,AUDREY G @ 30 May 2014 1410 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Reason for Telephone Consult: Written by ELLIS,KEISHA @ 30 May 2014 1141 EDT
 REFERRAL

Questionnaire AutoCites Refreshed by COLEMAN,AUDREY G @ 30 May 2014 1410 EDT
Questionnaires

Note Written by ELLIS,KEISHA @ 30 May 2014 1142 EDT

PATIENT STATES THAT HE WAS INSTRUCTED CALL BACK IN REGARDS TO HIS LEFT ANKLE HE IS STILL HAVING THE SAME PROBLEM.

PCM: UDE

CB#: (850)696-7239 (CELL)

Note Written by COLEMAN,AUDREY G @ 30 May 2014 1416 EDT

SPOKE WITH PT NAME AND DOB VERIFIED,PT STATES THAT LEFT FOOT SWOLLEN TODAY.HE HAS BEEN USING CRUTCHES OFO /ON FOR WEIGHT BEARING. HAVE NOT BEEN ABLE TO EVLEVATE FOOT AT WORK SITTING AT DESK. WILL DISCUSS WITH PROVIDER AND CALL THE THE PT BACK.

Note Written by COLEMAN,AUDREY G @ 30 May 2014 1458 EDT

SPOKE WITH PT NAME AND DOB VERIFIED, INFORMED PT THAT HE NEED TO MAKE A F/U APPT FOR LEFT ANKLE PER PROVIDER. PT STATED THAT HE WOULD RATHER CALL BACK TO SCHEDULE APPT. HE DON'T HAVE HIS SCHEDULE IN FRONT OF HIM.

A/P Last Updated by COLEMAN,AUDREY G @ 30 May 2014 1501 EDT

1. Left ankle joint pain

Disposition Last Updated by ELLIS,KEISHA @ 30 May 2014 1142 EDT

Signed By COLEMAN, AUDREY G (LPN,Family Practice Red Team, KACC,Ft. Meade Md) @ 30 May 2014 1502

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O

Encounter ID: BETH-17164995 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **19 May 2014 1150 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **EST**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by COLEMAN,AUDREY G @ 16 May 2014 0945 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- IMPAIRED FASTING GLUCOSE
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS

Family History

- family medical history (General FHx)
- family history of supplemental HPI [use for free text] (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- Other: OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

PHA/NAVY/NIOC

Appointment Comments:

eed [REDACTED]

Screening Written by SNOWDEN,HEATHER @ 19 May 2014 1142 EDT**Reason For Appointment:** PHA/NAVY/NIOC

Allergen information verified by SNOWDEN, HEATHER @ 19 May 2014 1142 EDT

Vitals**Vitals** Written by SNOWDEN,HEATHER @ 19 May 2014 1149 EDT

BP: 127/68 Right Arm, Adult Cuff, HR: 66, RR: 16, T: 98.3 °F, HT: 69 in Stated, Without Shoes,
 WT: 153.6 lbs Upright Scale, Actual, Without Shoes, Uncorr OD: 20/30, Uncorr OS: 20/50, Uncorr OU: 20/50, BMI:
 22.68, BSA: 1.846 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: 2-3 month, Pain Scale: 0 Pain Free

S/O Note Written by UDE,ASSUMPTA O @ 19 May 2014 1331 EDT**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O AD SM HERE FOR PHA-NO HEALTH CONCERNS EXCEPT FOR RESOVLING LT ANKLE SPRAIN

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Pain localized to one or more joints.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Visit is not deployment-related.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient is compliant with medications.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 19 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Annual Questions Date: 19 MAY 2014.

Social history reviewed single, no children

AD Navy

Non smoker

Occasional drinker.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 19MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info: [REDACTED]

PCM: UDE.

Family history

Family medical history

Father with DM, CAD.

Review of systems**Systemic:** No systemic symptoms, no fever, no chills, and no recent weight loss.**Head:** No head symptoms and no headache.**Neck:** No neck symptoms.**Eyes:** No eye symptoms.**Otolaryngeal:** No otolaryngeal symptoms, no earache, no nasal discharge, no nasal passage blockage (stiffness), and no sore throat.**Breasts:** No breast symptoms.**Cardiovascular:** No cardiovascular symptoms and no chest pain or discomfort.**Pulmonary:** No pulmonary symptoms, no dyspnea, and no cough.**Gastrointestinal:** No gastrointestinal symptoms, no nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No genitourinary symptoms, no change in urinary frequency, and no feelings of urinary urgency. No dysuria.**Endocrine:** No endocrine symptoms.**Hematologic:** No hematologic symptoms.**Musculoskeletal:** No musculoskeletal symptoms and no back pain.**Neurological:** No neurological symptoms and no lightheadedness.**Psychological:** No psychological symptoms.**Skin:** No skin symptoms.**Physical findings**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Head:

Appearance: ° Head normocephalic.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Pupils: ° PERRL.

External: ° Eyelids showed no abnormalities.

Ears:

General/bilateral:

Outer Ear: ° Normal.

External Auditory Canal: ° External auditory meatus normal.

Nose:

General/bilateral:

External Deformities: ° No external nose deformities.

Sinus Tenderness: ° No sinus tenderness.

Oral Cavity:

Lips: ° Showed no abnormalities.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation.

Musculoskeletal System:

Other:

General/bilateral: ° No muscle tenderness.

Neurological:

° Oriented to time, place, and person. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

° No skin lesions.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[X] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

.....

Tests:

Value

AUDIT-C Score

2

Practice Management

Patient's BMI < 30. Date: 19 MAY 2014.

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis - No

HIV Screen - APR 2014

Colonoscopy - 2012

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tetanus (Td/Tdap) - MAR 2013
 Influenza - NOV 2013
 Zoster - No record of titer or vaccine
 Pneumococcal -
 HPV -

Men:

Aortic Aneurysm Screen -
 G6pd- Nov 2005
 Sickle cell- nov 2005
 blood tye- O +
 hearing exam- march 2013
 vision exam - no record

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1210 EDT

Basic Metabolic Panel	Site/Specimen	04 Jun 2013 0925
Urea Nitrogen	SERUM	12
Carbon Dioxide	SERUM	30
Chloride	SERUM	102
Creatinine	SERUM	1.0
Glucose	SERUM	94 <i>
Potassium	SERUM	4.3
Sodium	SERUM	140
Calcium	SERUM	9.7
Anion Gap	SERUM	8
GFR Calculated Non-Black	SERUM	102.0
GFR Calculated Black	SERUM	117.9 <i>

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1208 EDT

HIV-1/O/2 Ab	Site/Specimen	10 Apr 2014 0951
HIV-1/O/2 Ab	SERUM	Negative <r>

Lab Result Cited by UDE,ASSUMPTA O @ 19 May 2014 1208 EDT

Lipid Panel	Site/Specimen	10 Apr 2014 0951
Cholesterol	SERUM	208 (H) <i>
Triglyceride	SERUM	158 (H) <i>
HDL Cholesterol	SERUM	64.0 (H)
LDL Cholesterol	SERUM	112 <i>
VLDL Cholesterol	SERUM	32
Cholesterol/HDL Cholesterol	SERUM	3.25

Lab Result Cited by COLEMAN,AUDREY G @ 16 May 2014 0944 EDT

HIV-1/O/2 Ab	Site/Specimen	10 Apr 2014 0951	Units	Ref Rng
HIV-1/O/2 Ab	SERUM	Negative <r>		

Lipid Panel	Site/Specimen	10 Apr 2014 0951	Units	Ref Rng
Cholesterol	SERUM	208 (H) <i>	mg/dL	(50-200)
Triglyceride	SERUM	158 (H) <i>	mg/dL	(40-150)
HDL Cholesterol	SERUM	64.0 (H)	mg/dL	(40-60)
LDL Cholesterol	SERUM	112 <i>	mg/dL	(0-129)
VLDL Cholesterol	SERUM	32	mg/dL	(2-49)
Cholesterol/HDL Cholesterol	SERUM	3.25		

A/P Last updated by UDE,ASSUMPTA O @ 19 May 2014 1334 EDT

1. Visit for: military services physical(PERIODIC PREVENTION EXAMINATION): AGE AND GENDER APPROPRIATE PREVENTIVE TASK FORCE REQUIRED COUNSELLING GIVEN, SEE MRRS AND NAVMED 6120/4 FOR READINESS AND VACCINE UPDATES

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

2. ESSENTIAL HYPERTRIGLYCERIDEMIA: SIG REDUCTION OF TRIG-CONTINUE lifestyle mod
Laboratory(ies): -GLUCOSE FASTING (Routine) Start Date: 06/01/2014

Disposition Written by UDE,ASSUMPTA O @ 19 May 2014 1334 EDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: MEDICATIONS RECONCILED, LIST GIVEN TO PATIENT, MASTER PROBLEM LIST REVIEWED AND RECONCILED WITH PATIENT.

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 19 May 2014 1334

CHANGE HISTORY

The following A/P Note Was Overwritten by UDE,ASSUMPTA O @ 19 May 2014 1316 EDT:

The A/P section was last updated by UDE,ASSUMPTA O @ 19 May 2014 1316 EDT - see above. Previous Version of A/P section was entered/updated by COLEMAN,AUDREY G @ 16 May 2014 0942 EDT.

The following S/O Note Was Overwritten by UDE,ASSUMPTA O @ 19 May 2014 1212 EDT:

S/O Note Written by SNOWDEN,HEATHER @ 19 May 2014 1144 EDT

Chief complaint

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O AD SM HERE FOR PHA

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Visit is not deployment-related.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Patient is compliant with medications.

Allergies

Current Allergies: Cats updated 19 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Annual Questions Date: 19 MAY 2014.

Social history reviewed single, no children

AD Navy

Non smoker

Occasional drinker.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 19MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info: [REDACTED]

PCM: UDE.

Family history

Family medical history

Father with DM, CAD.

Tests

ALCOHOL SCREENING

How often did you have a -

drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 780
AR 2767

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

[X] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

..... -

AUDIT-C Score

2

Practice Management

Patient's BMI < 30. Date: 19 MAY 2014.

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis - No

HIV Screen - APR 2014

Colonoscopy - 2012

Tetanus (Td/Tdap) - MAR 2013

Influenza - NOV 2013

Zoster - No record of titer or vaccine

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

G6pd- Nov 2005

Sickle cell- nov 2005

blood ty- O +

hearing exam- march 2013

vision exam - no record

Patient exercises for at least 30 minutes a day.

The following SO Note Was Overwritten by SNOWDEN,HEATHER @ 19 May 2014 1149 EDT:**SO Note** Written by COLEMAN,AUDREY G @ 16 May 2014 0942 EDT**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29 Y/O ADSM HERE FOR PHA

A PHA has been completed in past year. Date: 5/19/2014.

General overall feeling /health - Very Good.

Visit is not deployment-related.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 15 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? [X] Verbal [X] Written [X] Visual [] Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? [] Yes [X] No Specify:

Advance directives completed? [] Yes [X] No

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Is a copy of the Advance directive in the record? ☐ Yes ☒ No
 Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No
 Are you enrolled in EFMP? ☐ Yes ☒ No
 Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No
 Contact info:
 PCM: UDE.
 Annual Questions Date: 6 MAY 2014.

Family history

Family medical history
 Father with DM, CAD.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?
☒ 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?
☒ 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?
☒ 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)☒ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)**Tests:**

Value

AUDIT-C Score

2

Practice Management

Preventive medicine services

Lipid Screening - APR 2014

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - APR 2014

Colonoscopy -

Tetanus (Td/Tdap) - MAR 2013

Influenza - NOV 2013

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.
 Patient's BMI < 30. Date: 6 MAY 2014.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 May 2014 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O

Encounter ID: BETH-17036973 Primary Dx: ANKLE SPRAIN LEFT

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **06 May 2014 1430 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **EST**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by SMITH,PRISCILLA E @ 05 May 2014 1133 EDT**Problems**

- ESSENTIAL HYPERTRIGLYCERIDEMIA
- IMPAIRED FASTING GLUCOSE
- ANOMALIES OF SKIN
- Abdominal pain
- ASTHMA
- POSTSURGICAL STATE OF EYE AND ADNEXA
- Difficulty breathing (dyspnea)
- SKIN NEOPLASM UNCERTAIN BEHAVIOR
- Removal Of Sutures
- ASTHMA EXTRINSIC
- ROSACEA
- PERIPHERAL RETINAL DEGENERATION - LATTICE
- REFRACTIVE ERROR - MYOPIA
- ALLERGIC RHINITIS
- Visit for: military services physical

Family History

- family medical history (General FHx)
- no family history of malignant neoplasm of the large intestine (General FHx)
- no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- no family history of chronic liver disease (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

UDE-F/U FROM ER

Appointment Comments:

KLS/KACC

Screening Written by COLEMAN,AUDREY G @ 06 May 2014 1419 EDT**Reason For Appointment:** UDE-F/U FROM ER

Allergen information verified by COLEMAN, AUDREY G @ 06 May 2014 1419 EDT

Vitals**Vitals** Written by COLEMAN,AUDREY G @ 06 May 2014 1409 EDT

BP: 130/82 Left Arm, HR: 79, RR: 18, T: 97.5 °F, HT: 69 in Stated, WT: 153 lbs Upright Scale, Actual, With Shoes, SpO2: 97%, BMI: 22.59, BSA: 1.843 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 3/10 Mild, Pain Scale Comments: LEFT ANKLE

Comments: UNIFORM**S/O Note** Written by UDE,ASSUMPTA O @ 06 May 2014 1426 EDT**Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADSM FOR F/U ER VISIT while he was sprinting during softball game, and his foot went into the hole while he was running-2 weeks ago, Reports not using crutches currently. On morin pen, pain is 3/10.

Good general overall feeling /health.

Pain localized to one or more joints and joint swelling localized to one or more joints.

Visit is not deployment-related.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Pain assessment

Location: LEFT ANKLE

Duration:

Quality: AHARP/THROBBING

Factors that correlate with onset:

Frequency: CONSTANT

Average level: 3

Worst level: 7-8

Least level: 3

What makes it better: ELEVATION

What makes it worse: PRESSURE,STANDING,FULL EXSTENSION

Pain Severity 3 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic 19 APR 2014 BETHESDA.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Review of systems**Systemic:** No systemic symptoms.**Musculoskeletal:** No muscle aches and no limb pain.**Neurological:** No neurological symptoms.**Psychological:** No psychological symptoms.**Skin:** No skin symptoms.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Created: 16 Aug 2017

Musculoskeletal System:**Ankle:**

Left Ankle: • Swelling. • Tenderness on palpation. • Pain was elicited by motion. • Ankle was tender on ambulation. ° No erythema. ° Ankle was not warm. ° Motion was normal. ° No crepitus on motion was noted.

Foot:

Left Foot: • Tenderness on palpation. ° No erythema. ° No pain was elicited by motion.

Functional Exam:

General/bilateral: • Mobility was limited.

Other:

General/bilateral: • Muscle tenderness.

Neurological:

° Oriented to time, place, and person. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.

Motor (Strength): ° No weakness of the left ankle was observed.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SXSCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Tests:

AUDIT-C Score

Value

2

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Patient's BMI < 30. Date: 6 MAY 2014.

Rad Result Cited by UDE,ASSUMPTA O @ 06 May 2014 1443 EDT

MERWIN, DANIEL DENNIS 20 [REDACTED] **DoD ID: 1286180538 29yo** [REDACTED] **1985 M**

***** ANKLE, LT 3 VIEWS *****

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

POC Enc: #E4520771 POC Fac: WRNMMC
Status: Complete (Amended)

Procedure: ANKLE, LT 3 VIEWS
Event Date: 19-Apr-2014 15:38:00
Exam #: 14130312
Exam Date/Time: 19-Apr-2014 15:42:00
Transcription Date/Time: 20-Apr-2014 19:41:00
Provider: PIRRI, MICHAEL P
Requesting Location:
EMERGENCY RM BE WRNMMC BETHESDA, MD
Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: NIELSEN, NATHAN S
Supervised By: KENRIC T. ABAN, MD. LCDR, MC, USN.
Approved By: ABAN, KENRIC T
Approved Date: 20-Apr-2014 19:40:00
Supervised By:
122645 KENRIC T. ABAN, MD. LCDR, MC, USN.
Supervised By Date: 20-Apr-2014 19:40:00
Amended Report Text:

History:

Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique:

Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality. _____

Electronically signed by resident:

Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Electronically signed by:

Dr. Kenric T Aban Date: 04/20/14 Time:19:40

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Rad Result Cited by UDE,ASSUMPTA O @ 06 May 2014 1443 EDT**MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 29yo [REDACTED] 1985 M**

***** FOOT, LT 3 VIEWS *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: FOOT, LT 3 VIEWS
 Event Date: 19-Apr-2014 15:38:00
 Exam #: 14130311
 Exam Date/Time: 19-Apr-2014 15:42:00
 Transcription Date/Time: 20-Apr-2014 19:41:00
 Provider: PIRRI, MICHAEL P
 Requesting Location:
 EMERGENCY RM BE WRNMMC BETHESDA, MD
 Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: NIELSEN, NATHAN S
 Supervised By: KENRIC T. ABAN, MD. LCDR, MC, USN.
 Approved By: ABAN, KENRIC T
 Approved Date: 20-Apr-2014 19:40:00
 Supervised By:
 122645 KENRIC T. ABAN, MD. LCDR, MC, USN.
 Supervised By Date: 20-Apr-2014 19:40:00
 Amended Report Text:

History:

Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Technique:

Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available**Findings:**

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality. _____

Electronically signed by resident:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Dr. NATHAN S NIELSEN Date: 04/19/14 Time:19:41

Electronically signed by:

Dr. Kenric T Aban Date: 04/20/14 Time:19:40

A/P Written by UDE,ASSUMPTA O @ 06 May 2014 1448 EDT**1. ANKLE SPRAIN LEFT:** CONTINUE REST, ICE, MOIST HEAT, NSAID AND ELEVATE, USE CRUTCHES FOR LONG DISTANCE WALK PRNRadiology(ies): -ANKLE, LT 3 VIEWS (Routine) Impression: left lateral ankle pain and swelling 2 weeks following a spr
Comment: with weight bearing**2. Visit for: exam following treatment**Radiology(ies): -FOOT, LT WT BEARING 3 VIEWS (Routine) Impression: left foot pain x 2 weeks following a recent
injury, re-eval**3. ARMED FORCES FITNESS FOR DUTY EXAM(FITNESS FOR DUTY EXAMINATION):** NO JUMPING/RUNNING/CARDIO X
30DAYS-RECENT SPRAINED ANKLE-SEE DD689Disposition Written by UDE,ASSUMPTA O @ 06 May 2014 1448 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: MEDICATIONS RECONCILED, LIST GIVEN TO PATIENT, MASTER PROBLEM LIST REVIEWED AND
RECONCILED WITH PATIENT.Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER,FT MEADE, MD) @ 06 May 2014 1449**CHANGE HISTORY**The following S/O Note Was Overwritten by UDE,ASSUMPTA O @ 06 May 2014 1442 EDT:S/O Note Written by COLEMAN,AUDREY G @ 06 May 2014 1422 EDT**Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADSD FOR F/U ER VISIT.

Good general overall feeling /health.

Visit is not deployment-related.

Pain assessment

Location: LEFT ANKLE

Duration:

Quality: AHARP/THROBBING

Factors that correlate with onset:

Frequency: CONSTANT

Average level: 3

Worst level: 7-8

Least level: 3

What makes it better: ELEVATION

What makes it worse: PRESSURE,STANDING,FULL EXSTENSION

.....
Pain Severity 3 / 10.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has received other care since their last visit with this clinic 19 APR 2014 BETHESDA.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

IBUPROPHEN 800MG

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS
INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.**Page 788**
AR 2775

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease
 .
 Surgical / Procedural: Surgical / procedural history
 PRK eyes - 2011
 tonsillectomy - 2004
 colonoscopy 2012.

Personal history

Social history reviewed single, no children.
 Behavioral: No tobacco use in the last 10 years.
 Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.
 History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history
 Father with DM, CAD.

Tests**ALCOHOL SCREENING**

How often did you have a -

drink containing alcohol in the past year?

[2] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SXSCREENING for Alcohol Use (AUDIT-C)

[] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

..... -

AUDIT-C Score

2

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Patient's BMI < 30. Date: 6 MAY 2014.

The following SO Note Was Overwritten by COLEMAN,AUDREY G @ 06 May 2014 1422 EDT:**SO Note** Written by SMITH,PRISCILLA E @ 05 May 2014 1129 EDT**Chief complaint**

The Chief Complaint is: F/U ER VISIT.

History of present illness

The Patient is a 29 year old male.

<<Note accomplished in TSWF-CORE>>

29YO MALE, ADSM FOR F/U ER VISIT.

Good general overall feeling /health.

Visit is not deployment-related.

PHQ-2 Depression Screen Negative.

Patient IS NOT currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid.

Patient has NOT received other care since their last visit with this clinic.

Allergies

Current Allergies: Cats updated 6 MAY 2014.

Current medication

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

NONE

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.

Medical: Reported medical history

Asthma - last affected in 2005.

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history

PRK eyes - 2011

tonsillectomy - 2004

colonoscopy 2012.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 6 MAY 2014.

History

ANNUAL SCREENING DATE: 6 MAY 2014

What is your preferred method of learning? ☐ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM: UDE.

Annual Questions Date: 6 MAY 2014.

Family history

Family medical history

Father with DM, CAD.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient's BMI < 30. Date: 6 MAY 2014.

Patient exercises for at least 30 minutes a day.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

30 Dec 2013 at WRNMMC, GI Clinic Bethesda by COPSEY, HELEN C

Encounter ID: BETH-15820677 Primary Dx: Visit for: administrative purpose

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Outpatient**

Date: **30 Dec 2013 0802 EST**
 Clinic: **GI CL BE**

Appt Type: **T-CON***
 Provider: **COPSEY, HELEN C**

Call Back Phone: [REDACTED]

Reason for Telephone Consult: Written by COPSEY, HELEN C @ 30 Dec 2013 0802 EST
 Called pt

SO Note Written by COPSEY, HELEN C @ 30 Dec 2013 0803 EST**Subjective**

Called patient this morning- no answer. LM that if he has new issues, he should make a follow-up appointment in the GI clinic, as he was last seen by me well over a year ago. If he has any trouble getting an appointment or needs immediate attention he was given my direct phone number. From: Burleson, Ronald A CIV US WRNMMC Sent: Friday, December 27, 2013 12:14 PM To: Hopkins, Ida E CIV US WRNMMC Subject: RE: vmail msgs for your action Pls call mr merwin, [REDACTED] dob [REDACTED] 85, [REDACTED] f-up. Has some medical issues now.

A/P Last Updated by COPSEY, HELEN C @ 30 Dec 2013 0803 EST**1. visit for: administrative purpose****Disposition** Last Updated by COPSEY, HELEN C @ 30 Dec 2013 0803 EST

Signed By **COPSEY, HELEN C** (PA-C, MSHS, WRAMC- GI Clinic) @ 30 Dec 2013 0803

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Aug 2013 at WRNMMC, AMH M01A Red Ki by UDE, ASSUMPTA O

Encounter ID: BETH-14347968 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **12 Aug 2013 0930 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **EST**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI,OMOWUMI D @ 31 Jul 2013 1135 EDT**Problems****Chronic:**

- Essential hypertriglyceridemia
- Impaired fasting glucose
- Anomalies of the skin
- Visit for: ears/hearing exam
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to STD
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Vitals

No Vitals Found.

Reason for Appointment:

UDE PAPERWORK

Appointment Comments:

DJD/KACC

Screening Written by OLAWUMI,OMOWUMI D @ 31 Jul 2013 1136 EDT**Reason For Appointment:** UDE PAPERWORK

Allergen information verified by OLAWUMI, OMOWUMI D @ 31 Jul 2013 1136 EDT

SO Note Written by OLAWUMI,OMOWUMI D @ 31 Jul 2013 1136 EDT**Chief complaint**

The Chief Complaint is: PAPERWORK.

History of present illness

The Patient is a 28 year old male.

<<Note accomplished in TSWF-CORE>> 28 Y/O AD M HERE FOR PAPERWORK.

Currently on active duty. Visit is not deployment-related.
 Good general overall feeling.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Pain Severity 0/ 10.

PHQ-2 Depression Screen Negative.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Essential hypertriglyceridemia

Impaired fasting glucose

Anomalies of the skin

Postsurgical state of eye and adnexa

Dyspnea

Skin neoplasm of uncertain behavior

Extrinsic asthma

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to STD.

Personal history

Social history reviewed.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Family history

Family medical history.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Appointment Cancelled by Facility

Encounter Cancelled by KENNEY,RHENDA L @ 12 Aug 2013 0934 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Aug 2013 at WRNMMC, AMH M01A Red Ki by SLOAN, DAWN M

Encounter ID: BETH-14393823 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **07 Aug 2013 1450 EDT**
 Clinic: **AMHM01AREDKI**

Appt Type: **EST**
 Provider: **SLOAN,DAWN M**

Reason for Appointment:

TIO HIGH RISK MEDICAL SCREENING

Appointment Comments:

rar [REDACTED]

Screening Written by SMITH,PRISCILLA E @ 07 Aug 2013 1454 EDT**Reason For Appointment:** TIO HIGH RISK MEDICAL SCREENING

Allergen information verified by SMITH, PRISCILLA E @ 07 Aug 2013 1454 EDT

Vitals**Vitals** Written by SMITH,PRISCILLA E @ 07 Aug 2013 1449 EDT

BP: 106/60 Left Arm, Adult Cuff, HR: 88 Regular, Radial Artery, RR: 14, T: 98.1 °F Oral, HT: 69 in Stated,
 WT: 149 lbs Upright Scale, Actual, With Shoes, SpO2: 96%, BMI: 22, BSA: 1.823 square meters

Questionnaire AutoCites Refreshed by SLOAN,DAWN M @ 07 Aug 2013 1539 EDT**Questionnaires**

MEADE MEDCOM E774-I Version: 2 Completed On: 07 Aug 2013

1. SECTION I Feeling down, depressed, or hopeless.: No
2. Little interest or pleasure in doing things.: No
3. SECTION II Had any nightmares about it or thought about it when you did not want to?: No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?: No
5. Were constantly on guard, watchful, or easily startled?: No
6. Felt numb or detached from others, activities, or your surroundings?: No
7. PHQ-9 Severity Score or click Not Administered: NOT ADMINISTERED PHQ-9
8. Suicide Risk Score Item 1i or click Not Administered: NOT ADMINISTERED PHQ-9
9. PCL Severity Score or click Not Administered: Not Administered (PCL)
10. Risk Score Item #19 of PCL or click Not Administered.: Not Administered PCL
11. MEDCOM 774 Results: **SELECT ALL THAT APPLY-----IF NEGATIVE FOR BOTH -----STOP/DONE unless otherwise indicated. (CLICK DONE AND AUTOCITE): Negative for Both;**

SO Note Written by SLOAN,DAWN M @ 11 Aug 2013 2245 EDT**Chief complaint**

The Chief Complaint is: High Risk Medical Screening.

History of present illness

The Patient is a 28 year old male.

<<Note accomplished in TSWF-CORE>>

28yo Male presented for TIO High risk medical screening. Has form for review.

Does have hx of asthma as child, last episode in 2005 requiring albuterol. No episodes despite exposure to cats and dogs since, which were his trigger in the past. Notes hospitalization for 'bowel obstruction' last Oct with neg colonoscopy. No abdominal issues since stopping coffee and watching dairy.

Medication list reviewed, reconciled and list given to patient.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain assessment: denies.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: Cats updated 7 Aug 2013.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Current medication

NONE.

Past medical/surgical history**Reported:**

Medical: Reported medical history
 Asthma - last affected in 2005.
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease
 .
 Surgical / Procedural: Surgical / procedural history
 PRK eyes - 2011
 tonsillectomy - 2004
 colonoscopy 2012.
 Medications: No medication noncompliance.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Family history

Family medical history

Father with DM, CAD.

Review of systems**Systemic:** No fever, no chills, and no recent weight loss.**Head:** No headache.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage, and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No change in urinary frequency and no feelings of urinary urgency. No dysuria.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Eyes:

General/bilateral:

External: ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.

° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No S3 heard. ° No gallop was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Edema: ° Not present.

Neurological:

Balance: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Affect: ° Normal.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening - 5.4 June 2013

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

A/P Written by SLOAN,DAWN M @ 11 Aug 2013 2253 EDT**1. visit for: military services physical(OCCUPATIONAL EXAMINATION):** Pt in good condition currently. Has had health issues in the past which he seems to be managing well with diet changes and exercise. Signed off on form noting previous health issues and discussed with pt.**Disposition** Written by SLOAN,DAWN M @ 11 Aug 2013 2254 EDT**Released w/o Limitations****Follow up:** as needed with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
Comments: No medication reconciliation needed. Master problem List reconciled**Note** Written by JORDAN,TIMOTHY W @ 07 Aug 2013 1616 EDT**TIO High Risk Screening Form**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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TIO PROGRAM HIGH RISK MEDICAL SCREENING FORM			
Name: (Last, First Middle Initial)		Rate/Rank:	
MERWIN, DANIEL D		CTN1 / E-6	
Date:	Age:	Weight:	Unit:
07 Aug 13	28	150	NIOC MARYLAND
Rate your current health? (circle)			
Poor Good Excellent <u>Outstanding</u>			
List current medications:			
NONE			
PLEASE ANSWER THE FOLLOWING QUESTIONS (circle one answer)			
1. Do you have any fractures, sprains, splints or casts?	Yes	No	
2. Do you have a hernia?	Yes	No	
3. Do you have pneumonia, bronchitis, or asthma?	Yes	No	
4. Do you have nasal congestion or an ear/nose/throat condition?	Yes	No	
5. Do you have any allergies?	Yes	No	
6. Have you had high blood pressure, heart disease, stress related chest pains, or are you currently being treated or monitored for any of these?	Yes	No	
7. Have you had any surgery or post-operative procedure within the past 10-years?	Yes	No	
8. Do you have hypotension (low blood pressure) or hypoglycemia (low blood sugar)?	Yes	No	
9. Do you have a history of heat related illnesses/injuries?	Yes	No	
10. Have you had any cold weather related injuries?	Yes	No	
11. Have you tested positive for Sickle Cell or G6PD?	Yes	No	
12. Are you claustrophobic?	Yes	No	
13. Have you seen a Mental Health Professional for any reason?	Yes	No	
14. Do you have a history of heat related illnesses/injuries?	Yes	No	
15. Do you have any existing condition or injury that might preclude you from participating in high-risk training that may include temperature extremes, emotional and physical stress, or risk of death?	Yes	No	
Please explain any "YES" answers above in the space provided below.			
SCATS "ITOM" 7a. PRK "eyes, contact 2/20" 2011 7b. TONSILLECTOMY 2004			
I have completed this form to the best of my ability. I will notify the Detainer and TIO Recruiter of any changes in my medical standing.			
SIGNATURE		DATE	
		07 Aug 13	
MEDICAL OFFICER			
Comments:			
Hx of ASTHMA AS CHILD WITH LAST TREATMENT OR SHORTNESS OF BREATH IN 2005. NO RESPIRATORY ISSUES SINCE ADJUSTING DIET			
DAWN SLOAN, MD MAJ, MC, USA			
I have reviewed the medical record of individual [REDACTED] and am capable of entering the Tactical Information Operations (TIO) program.			
SIGNATURE		DATE	
		07 Aug 13	

Signed By SLOAN, DAWN M (Family Medicine Physician) @ 11 Aug 2013 2254

CHANGE HISTORY

The following SO Note Was Overwritten by SLOAN, DAWN M @ 07 Aug 2013 1545 EDT:

SO Note Written by SMITH, PRISCILLA E @ 07 Aug 2013 1454 EDT

Chief complaint

The Chief Complaint is: High Risk Medical Screening.

History of present illness

The Patient is a 28 year old male.

<<Note accomplished in TSWF-CORE>>

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28yo Male presented for High risk medical screening

Medication list reviewed, reconciled and list given to patient.
Currently on active duty. Visit is not deployment-related.
Good general overall feeling.

Pain Severity 0 / 10.

Pain assessment: denies.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: Cats updated 7 Aug 2013.

Current medication

NONE.

Past medical/surgical history**Reported:**

Recent Events: Medication compliance.
Medical: Reported medical history Asthma
Dyspnea
Skin neoplasm of uncertain behavior
Rosacea
Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Surgical / Procedural: Surgical / procedural history
PRK eyes - 2011
tonsillectomy - 2004.

Personal history

Social history reviewed single, no children.

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services
Lipid Screening - 19 MAR 2013
Blood Sugar Screening - 5.4 June 2013
Aspirin Prophylaxis -
HIV Screen - 19 MAR 2013.
Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 Aug 2013 at WRNMMC, Immunization Kimbrough by WRAY, KIM D

Encounter ID: BETH-14383762 Primary Dx: Vaccines Prophylactic Need Against Bacterial Diseases

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH
 AMBULATORY CARE CENTER**
 Patient Status: **Outpatient**

Date: **05 Aug 2013 0903 EDT**
 Clinic: **IMMUNIZATION KI**

Appt Type: **PROC**
 Provider: **WRAY,KIM D**

Reason for Appointment: Written by RYAN,LINDSEY O @ 05 Aug 2013 0903 EDT
 update imm

SO Note Written by WRAY,KIM D @ 05 Aug 2013 0917 EDT

Vaccinations

• Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Therapy

• Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record.

Practice Management

Patient information sheet: Given to _x_Patient___Parent___Guardian on Vaccination Information Statement(s)

A/P Last Updated by WRAY,KIM D @ 05 Aug 2013 0931 EDT

1. Vaccines Prophylactic Need Against Bacterial Diseases

Procedure(s):

-Meningococcal Oligosaccharide Diphtheria Toxoid Conjugate Vaccine x 1 - Meningococcal A,C,Y,W-135 Diphtheria Conj; Series #: 1; .5 mL; IM; Right Arm; Mfg: Sanofi Pasteur; Lot: U4575BA; VIS given (Ver: 10/14/11).
 -Immunization Administration One Vaccine x 1

Disposition Last Updated by WRAY,KIM D @ 05 Aug 2013 0931 EDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By **WRAY, KIM D** (LPN, Kimbrough Ambulatory Care Center, Ft Meade, MD) @ 05 Aug 2013 0932

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10 Apr 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-13259945 Primary Dx: Visit for: military services physical

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **10 Apr 2013 1130 EDT**
 Clinic: **AMHM01BBBLUEKI**

Appt Type: **WELL**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI,OMOWUMI D @ 09 Apr 2013 1620 EDT**Problems****Chronic:**

- Visit for: ears/hearing exam
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Visit for: follow-up exam
- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

navy pha

Appointment Comments:

rks 8506028501

Screening Written by OLAWUMI,OMOWUMI D @ 09 Apr 2013 1620 EDT**Reason For Appointment:** navy pha

Allergen information verified by OLAWUMI, OMOWUMI D @ 09 Apr 2013 1620 EDT

Vitals**Vitals** Written by OLAWUMI,OMOWUMI D @ 10 Apr 2013 1131 EDT

BP: 110/72 Left Arm, Adult Cuff, HR: 77 Regular, Radial Artery, RR: 16, T: 98.7 °F Oral, HT: 69 in Stated,
 WT: 153.4 lbs Upright Scale, Actual, With Shoes, SpO₂: 98%, BMI: 22.65, BSA: 1.845 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

SO Note Written by UDE,ASSUMPTA O @ 10 Apr 2013 1413 EDT**Chief complaint**

The Chief Complaint is: NAVY PHA.

History of present illness

The Patient is a 28 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

A PHA has been completed in past year. Date: 10 APR 2013.

<<Note accomplished in TSWF-CORE>> PRESENTS FOR ANNUAL PHA, NO HEALTH CONCERNS TODAY, FLAKINESS OF SCALP AND SOLE OF FEET, NON ITCHY BUT COMES AND GOES , HE HAS TRIED ANTIFUNGAL TOPICAL WITH NO IMPROVEMNT

In the Navy and currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Skin lesion:

Pain Severity 0 / 10.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma

Dyspnea

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems

Systemic: No systemic symptoms, no fever, no chills, and no recent weight loss.

Head: No head symptoms and no headache.

Neck: No neck symptoms.

Eyes: No eye symptoms.

Otolaryngeal: No otolaryngeal symptoms, no earache, no nasal discharge, no nasal passage blockage, and no sore throat.

Breasts: No breast symptoms.

Cardiovascular: No cardiovascular symptoms and no chest pain or discomfort.

Pulmonary: No pulmonary symptoms, no dyspnea, and no cough.

Gastrointestinal: No gastrointestinal symptoms, no nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No genitourinary symptoms, no change in urinary frequency, and no feelings of urinary urgency. No dysuria.

Endocrine: No endocrine symptoms.

Hematologic: No hematologic symptoms.

Musculoskeletal: No musculoskeletal symptoms and no back pain.

Neurological: No neurological symptoms and no lightheadedness.

Psychological: No psychological symptoms.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL.

Sclera: ° Normal.

Ears:

General/bilateral:

Outer Ear: ° Normal.

Right Ear:

Tympanic Membrane: ° No bulging tympanic membrane.

Left Ear:

Tympanic Membrane: ° No bulging tympanic membrane.

Nose:

General/bilateral:

Cavity: ° Nasal mucosa normal.

Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: ° Normal.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Breasts:

General/bilateral:

° Appearance of the breast was normal. ° Palpation of the breast revealed no abnormalities.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.

° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No S3 heard.

Murmurs: ° No murmurs were heard.

Edema: ° Not present.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: ° Bowel sounds were not diminished or absent.

Palpation: ° No abdominal tenderness. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Musculoskeletal System:

General/bilateral: ° Normal movement of all extremities.

Other:

General/bilateral: ° No muscle tenderness.

Neurological:

Sensation: ° No sensory exam abnormalities were noted. ° Monofilament wire test of the foot did not show decreased sensation.

Motor: ° Strength was normal.

Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.

Balance: ° Normal.

Gait And Stance: ° Normal.

Reflexes: ° Deep tendon reflexes were normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

• Skin: MILD SCALY REDNESS, SOLE OF FEET AND ONE SPOT ON THE SCALP, • Lesions. ° Showed no ecchymosis.

° Temperature was normal.

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Pneumococcal -
HPV -Men:
Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE,ASSUMPTA O @ 10 Apr 2013 1213 EDT

Lipid Panel	Site/Specimen	22 Feb 2012 1006 <o>
Cholesterol	PLASMA	207 (H) <i>
HDL Cholesterol	PLASMA	60 <i>
Triglyceride	PLASMA	183 (H) <i>
LDL Cholesterol	PLASMA	110 (H) <i>

Lab Result Cited by UDE,ASSUMPTA O @ 10 Apr 2013 1209 EDT

Basic Metabolic Panel	Site/Specimen	12 Oct 2012 0434
Urea Nitrogen	SERUM	5 (L)
Carbon Dioxide	SERUM	27
Chloride	SERUM	107
Creatinine	SERUM	0.80
Glucose	SERUM	113 (H)
Potassium	SERUM	4.0
Sodium	SERUM	141
Calcium	SERUM	9.2
Anion Gap	SERUM	8
GFR	SERUM	>60 <i>

Lab Result Cited by UDE,ASSUMPTA O @ 10 Apr 2013 1208 EDT

Lipid Panel	Site/Specimen	19 Mar 2013 1107
Cholesterol	SERUM	209 (H) <i>
Triglyceride	SERUM	265 (H) <i>
HDL Cholesterol	SERUM	63.0 (H)
LDL Cholesterol	SERUM	93 <i>
VLDL Cholesterol	SERUM	53 (H)
Cholesterol/HDL Cholesterol	SERUM	3.32

A/P Written by UDE,ASSUMPTA O @ 10 Apr 2013 1223 EDT

1. visit for: military services physical(PERIODIC PREVENTION EXAMINATION): I have reviewed all formatted and free text responses on the DD Form 2766. A review of age and gender appropriate preventive medicine task force items were discussed with SM. Included are cancer screening/prevention, CAD, and injury prevention. IN order to reduce TRIGLYCERIDE AND FBS in prediabetes, It was recommended to exercise 160 minutes per week at 80% of the Max heart rate minimum, this does not count warm up and cool down.

2. ANOMALIES OF SKIN: REFERRAL TO DERM

Consult(s): -Referred To: DERMATOLOGY MTF KI (Routine) Specialty: DERMATOLOGY Clinic: DERMATOLO CL
KI Primary Diagnosis: visit for: military services physical

3. IMPAIRED FASTING GLUCOSE: PER 10/12, SIG FAM HX OF T2DM, A1C AND FBG RECHECK

Laboratory(ies): -BASIC METABOLIC PANEL (Routine); HEMOGLOBIN A1C (Routine)

4. ESSENTIAL HYPERTRIGLYCERIDEMIA**Disposition** Written by UDE,ASSUMPTA O @ 10 Apr 2013 1416 EDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: MED REC NOT INDICATED

Administrative Options: Consultation requested

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 10 Apr 2013 1416**CHANGE HISTORY***The following SO Note Was Overwritten by UDE, ASSUMPTA O @ 10 Apr 2013 1214 EDT:***SO Note** Written by OLAWUMI, OMOWUMI D @ 10 Apr 2013 1134 EDT**Chief complaint**

The Chief Complaint is: NAVY PHA.

History of present illness

The Patient is a 28 year old male.

A PHA has been completed in past year. Date: 10 APR 2013.

In the Navy and currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma

Dyspnea

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services

Lipid Screening - 19 MAR 2013

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 19 MAR 2013.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13070095 Primary Dx: Visit for: follow-up exam

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Inpatient**

Date: **21 Mar 2013 0914 EDT**
 Clinic: **IMMUNIZATION KI**
 Inpatient Location: **ABAA**

Appt Type: **PROC**
 Provider: **MASON,HAZEL J**

AutoCites Refreshed by MASON,HAZEL J @ 21 Mar 2013 1042 EDT**Problems****Chronic:**

- Visit for: ears/hearing exam
- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:Written by RYAN,LINDSEY O @ 21 Mar 2013 0914 EDT
 ppd check

A/P Written by MASON,HAZEL J @ 21 Mar 2013 1157 EDT

1. visit for: follow-up exam: PPD check today, noted to be negative 0mm, reinforce to patient on the negative reaction versus the positive, verbalize understanding

Disposition Written by MASON,HAZEL J @ 21 Mar 2013 1201 EDT**Continued Stay**

Follow up: as needed with PCM. - Comments: PPD check today, noted to be negative 0mm, reinforce to patient on the negative reaction versus the positive, verbalize understanding

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By MASON, HAZEL J (LPN, NNMC Bethesda, MD) @ 21 Mar 2013 1201

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13046084 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH
AMBULATORY CARE CENTER**
Patient Status: **Inpatient**

Date: **19 Mar 2013 1226 EDT**
Clinic: **HEARING CONS KI**
Inpatient Location: **ABAA**

Appt Type: **SPEC**
Provider: **PERRY,CHARLES**

Reason for Appointment:Written by PERRY,CHARLES @ 19 Mar 2013 1226 EDT
ANNAUL HEARING EXAM

Appointment Cancelled by Facility

Encounter Cancelled by PERRY,CHARLES @ 19 Mar 2013 1256 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Mar 2013 at WRNMMC, Hearing Conservation Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13045263 Primary Dx: Visit for: occupational health / fitness exam

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH
 AMBULATORY CARE CENTER**
 Patient Status: **Inpatient**

Date: **19 Mar 2013 1225 EDT**
 Clinic: **HEARING CONS KI**
 Inpatient Location: **ABAA**

Appt Type: **SPEC**
 Provider: **PERRY,CHARLES**

AutoCites Refreshed by PERRY,CHARLES @ 19 Mar 2013 1357 EDT

Problems**Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Visit for: screening for pulmonary tuberculosis
- Need for DTP and TAB vaccination
- Need for typhoid vaccination

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:Written by PERRY,CHARLES @ 19 Mar 2013 1225 EDT
 ANNAUL HEARING EXAM

SO Note Written by PERRY,CHARLES @ 19 Mar 2013 1357 EDT

Reason for Visit

Visit for: occupational health/fitness exam

- ☐ New Hire
- ☐ Periodic Medical Surveillance
- ☒ Military hearing
- ☐ Deployment

Following tests were ordered:

- ☒ Audio exam
- ☐ DD 2215
- ☒ DD 2216
- ☐ 4700
- ☐ Termination

Results:

- ☒ No STS noted
- ☐ STS noted. Scheduled for a follow-up exam.
- ☐ Referred to audiologist.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

- ☐ New Hire
- ☐ Periodic Medical Surveillance
- ☒ Military hearing
- ☐ Deployment
- ☐ Post Deployment

Results:

- ☒ No STS noted
- ☐ STS noted. Scheduled for a follow-up exam- #1 ☐; #2 ☐
- ☐ Referred to audiologist

☐ Ear wax noted. Moderate amount of wax does not preclude testing. Patient advised to talk with his physician/pharmacist about cleaning of ear/s.

To continue annual job related medical surveillance.

DISCUSSED THE FOLLOWING:

- ☒ Counseled on symptoms of occupational illnesses, wearing of protective equipment and need for medical surveillance.
- ☒ Discussed effects of noise on hearing; hearing protection - its purpose, advantages, and disadvantages; various types of ear protection, sizes, uses, and care, testing and today's testing results, and hearing conservation.
- ☒ Employee verbalized understanding of above counseling.

A/P Written by PERRY, CHARLES @ 19 Mar 2013 1358 EDT

1. visit for: occupational health / fitness exam(PERIODIC PREVENTION EXAMINATION)

2. visit for: ears / hearing exam(OTHER EXAMINATION OF EARS AND HEARING, OTOSCOPIC EXAM DONE)

Procedure(s): -Threshold Audiogram (Pure Tone) x 1

Disposition Written by PERRY, CHARLES @ 19 Mar 2013 1358 EDT

Continued Stay

Signed By PERRY, CHARLES (Physician/Workstation) @ 19 Mar 2013 1358

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Mar 2013 at WRNMMC, Immunization Kimbrough by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-13039226 Primary Dx: Need For Vaccination Typhoid

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Inpatient**

Date: **19 Mar 2013 0852 EDT**
 Clinic: **IMMUNIZATION KI**
 Inpatient Location: **ABAA**

Appt Type: **PROC**
 Provider: **WRAY,KIM D**

AutoCites Refreshed by WRAY,KIM D @ 19 Mar 2013 0853 EDT**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Procedures

- CASE MANAGEMENT, EACH 15 MINUTES (12 Oct 2012)
- COORDINATED CARE FEE, MAINTENANCE RATE (12 Oct 2012)
- Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral (29 Mar 2011)
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) (24 Mar 2011)

Active Medications

No Active Medications Found.

Reason for Appointment: Written by WRAY,KIM D @ 19 Mar 2013 0852 EDT
 imm update

Questionnaire AutoCites Refreshed by WRAY,KIM D @ 19 Mar 2013 0853 EDT
Questionnaires

SO Note Written by WRAY,KIM D @ 19 Mar 2013 0855 EDT**Vaccinations**

- Received dose of vaccines: Vaccines/Immunizations recorded in Immunization Record of CHCS II includes details of vaccines given location dosage and adverse events

Therapy

- Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record.

Practice Management

Patient information sheet: Given to _x_Patient___Parent___Guardian on Vaccination Information Statement(s)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

A/P Last Updated by WRAY,KIM D @ 19 Mar 2013 0856 EDT

1. Need For Vaccination Typhoid

Procedure(s): -Typhoid Vaccine Vi Capsular Polysaccharide, For Intramus Use x 1 - Typhoid, ViCPs; Series #: 1; .5 mL; IM; Right Arm; Mfg: Sanofi Pasteur; Lot: H1481; VIS given (Ver: 05/29/12).
-Immunization Administration One Vaccine x 1

2. Need For Vaccination DTP + TAB

Procedure(s): -Tdap Vaccine x 1 - Tdap; Series #: 1; .5 mL; IM; Left Arm; Mfg: Sanofi Pasteur; Lot: U4422AA; VIS given (Ver: 01/24/12).
-Immunization Administration Each Additional Vaccine x 1

3. visit for: screening exam pulmonary tuberculosis

Procedure(s): -Skin Test Anergy Tuberculin Intradermal x 1 - IPPD; Series #: 1; .1 mL; ID; Left Arm; Mfg: Other; Lot: 293239; VIS given.

Disposition Last Updated by WRAY,KIM D @ 19 Mar 2013 0856 EDT

Continued Stay

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By WRAY, KIM D (LPN, Kimbrough Ambulatory Care Center, Ft Meade, MD) @ 19 Mar 2013 0908

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-12473998 Primary Dx: Visit for: screening exam STD

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **28 Jan 2013 1020 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **ROUT**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI,OMOWUMI D @ 23 Jan 2013 0904 EST**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

Ude Personal

Appointment Comments:

agm/kacc

Screening Written by OLAWUMI,OMOWUMI D @ 23 Jan 2013 0905 EST**Reason For Appointment:** Ude Personal

Allergen information verified by OLAWUMI, OMOWUMI D @ 23 Jan 2013 0905 EST

Vitals**Vitals** Written by OLAWUMI,OMOWUMI D @ 28 Jan 2013 1019 EST

BP: 124/72 Right Arm, Adult Cuff, HR: 73 Radial Artery, RR: 18, T: 97.3 °F Oral, HT: 69 in Stated,
 WT: 156.4 lbs Upright Scale, Actual, With Shoes, SpO₂: 97%, BMI: 23.1, BSA: 1.861 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

SO Note Written by UDE,ASSUMPTA O @ 28 Jan 2013 1049 EST**Chief complaint**

The Chief Complaint is: STD SCREENING.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF-CORE>> PRESENTS FOR STD SCREENING, POSSIBLE EXPOSURE TO HERPES, 15
 PARTNERS IN PAST 1 YR

Currently on active duty. Visit is not deployment-related.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

General overall feeling - Very Good.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma

Dyspnea

Skin neoplasm of uncertain behavior

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems**Systemic:** No generalized pain and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.**Head:** No headache.**Neck:** No neck pain and no swollen glands in the neck.**Otolaryngeal:** No earache, no nasal discharge, no nasal passage blockage, and no sore throat.**Cardiovascular:** No chest pain or discomfort.**Pulmonary:** No dyspnea, no cough, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.**Genitourinary:** No hematuria, no change in urinary frequency, and no feelings of urinary urgency. No urinary loss of control, no dysuria, and no pain in the flank. No abnormal urethral discharge.**Endocrine:** No inadequacy of penile erection.**Musculoskeletal:** No back pain.**Neurological:** No lightheadedness.**Skin:** No skin lesions and no rash.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Abdomen:

Visual Inspection: ° Abdomen was not distended.

Auscultation: • Bowel sounds were diminished or absent.

Palpation: ° No abdominal tenderness. ° No mass was palpated in the abdomen.

Liver: ° Normal to palpation.

Spleen: ° Normal to palpation.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Skin:

° Showed no ecchymosis. ° Temperature was normal. ° No skin lesions.

Practice Management

Preventive medicine services

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Lipid Screening - 22 FEB 2012.
 Blood Sugar Screening -
 Aspirin Prophylaxis -
 HIV Screen - 22 FEB 2012.
 Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005
 Influenza -
 Zoster -
 Pneumococcal -
 HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Lab Result Cited by UDE,ASSUMPTA O @ 28 Jan 2013 1037 EST

HIV-1/O/2 Ab

Site/Specimen

22 Feb 2012 1006

HIV-1/O/2 Ab

SERUM

Negative <o>

A/P Written by UDE,ASSUMPTA O @ 28 Jan 2013 1049 EST**1. visit for: screening exam venereal disease**

Laboratory(ies): -HIV-1/O/2 (Routine); URINALYSIS PANEL (Routine); RAPID PLASMA REAGIN (Routine);
 GC/CHLAMYDIA NAAT (Routine); HERPES SIMPLEX VIRUS IGG 1+2 (Routine)

2. Anticipatory Guidance: Unsafe Sexual Practices: MULTIPLE SEX PARTNERS IN 1 YR, INC RISK FOR STD, 100PERCENT USE OF CONDOM ADVISED**Disposition** Written by UDE,ASSUMPTA O @ 28 Jan 2013 1104 EST**Released w/o Limitations****Follow up:** with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -
 Comments: MED REC NOT INDICATED

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER,FT MEADE, MD) @ 28 Jan 2013 1104**CHANGE HISTORY***The following SO Note Was Overwritten by UDE,ASSUMPTA O @ 28 Jan 2013 1034 EST:***SO Note** Written by OLAWUMI,OMOWUMI D @ 28 Jan 2013 1026 EST**Chief complaint**

The Chief Complaint is: STD SCREENING.

History of present illness

The Patient is a 27 year old male.

He reported: Currently on active duty. Visit is not deployment-related.

General overall feeling - Very Good.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma
 Dyspnea
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 813
AR 2800

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

ANNUAL SCREENING DATE: 18 JAN 2013

What is your preferred method of learning? ☒ Verbal ☐ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services

Lipid Screening - 22 FEB 2012.

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 22 FEB 2012.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Jan 2013 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-12450007 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **22 Jan 2013 0800 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **ROUT**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI,OMOWUMI D @ 18 Jan 2013 1441 EST**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Reason for Appointment:

UDE. PERSONAL.

Appointment Comments:

DA/KACC

Screening Written by OLAWUMI,OMOWUMI D @ 18 Jan 2013 1439 EST**Reason For Appointment:** UDE. PERSONAL.

Allergen information verified by OLAWUMI, OMOWUMI D @ 18 Jan 2013 1439 EST

SO Note Written by OLAWUMI,OMOWUMI D @ 18 Jan 2013 1439 EST**History of present illness**

The Patient is a 27 year old male.
 He reported: Currently on active duty. Visit is not deployment-related.
 General overall feeling - Very Good.

Pain Severity 0/ 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history Asthma
 Dyspnea

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Skin neoplasm of uncertain behavior
Rosacea
Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 18 JAN 2013.

What is your preferred method of learning? ☒ Verbal ☐ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services

Lipid Screening - 22 FEB 2012.

Blood Sugar Screening -

Aspirin Prophylaxis -

HIV Screen - 22 FEB 2012.

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Appointment Cancelled by Facility

Encounter Cancelled by BLUE,TAHIS C @ 22 Jan 2013 0810 EST

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

30 Nov 2012 at WRNMMC, AMH M01B Blue Ki by UDE, ASSUMPTA O

Encounter ID: BETH-11987536 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **30 Nov 2012 0840 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **ACUT**
 Provider: **UDE,ASSUMPTA O**

AutoCites Refreshed by OLAWUMI,OMOWUMI D @ 29 Nov 2012 1403 EST**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Need for prophylactic measure

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

Reason for Appointment:

UDE: ACNE

Appointment Comments:

TCB

Screening Written by OLAWUMI,OMOWUMI D @ 29 Nov 2012 1353 EST**Reason For Appointment:** UDE: ACNE

Allergen information verified by OLAWUMI, OMOWUMI D @ 29 Nov 2012 1353 EST

Vitals**Vitals** Written by OLAWUMI,OMOWUMI D @ 30 Nov 2012 0830 EST

BP: 120/76 Left Arm, Adult Cuff, HR: 66 Radial Artery, RR: 18, T: 97.5 °F Oral, HT: 69 in Stated, WT: 145 lbs Stated,
 SpO₂: 100%, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,
 Pain Scale: 0 Pain Free

SO Note Written by UDE,ASSUMPTA O @ 30 Nov 2012 0845 EST**Chief complaint**

The Chief Complaint is: RASH.

History of present illness

The Patient is a 27 year old male.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

<<Note accomplished in TSWF-CORE>> ACTIVE DUTY PRESENTS FOR 2 WEEKS OF INFLAMED PUSTULAR FLUCTUANT RASHES ALONG THE BEARD THAT POPS OUT WITH HAIR FOLLICULES AND PUSSY DRAINAGE, HE SHAVES WITH SHAVING CREAM AND BLADE, NO OTHER AREA OF SKIN AFFECTED.

Currently on active duty. Visit is not deployment-related.
Good general overall feeling.
Rash:

Pain Severity 0 / 10.
PHQ-2 Depression Screen Negative.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Asthma
Dyspnea
Skin neoplasm of uncertain behavior
Rosacea
Lattice peripheral retinal degeneration
Myopia
Allergic rhinitis
Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/29/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, no night sweats, and no recent weight gain.

Endocrine: No flushing.

Skin: No pruritus. No skin lesions.

Physical findings**Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Well developed. ° Well nourished. ° In no acute distress.

Musculoskeletal System:

Other:

General/bilateral: • Muscle tenderness.

Skin:

• Skin: TENDER INFLAMED BUMP AND MULTIPLE OPEN SCARS FROM OLD PUSTULAR RASH ALONG THE BEARD.

• Showed ecchymosis. • Lesions. ° Temperature was normal.

Practice Management

Preventive medicine services
Lipid Screening - 22 FEB 2012.
Blood Sugar Screening -
Aspirin Prophylaxis -
HIV Screen - 22 FEB 2012.
Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Influenza -
 Zoster -
 Pneumococcal -
 HPV -

Men:
 Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

A/P Written by UDE, ASSUMPTA O @ 30 Nov 2012 1434 EST

1. FOLLICULITIS: Afebrile, PUSTULAR PER SELF REPORT, on exam non pustular nodular tender lesion- TOPICAL AND ORAL ANTIBIOTIC

Medication(s): -SKIN CLEANSING LOTION--TOP LOTN - USE INSTEAD OF SOAP UD #1 RF0 Qt: 1 Rf: 0
 -CLINDAMYCIN--TOP 1% GEL - APPLY TO RASH AREA ALONG THE BEARD BID X 7DAYS #1 RF0
 Qt: 1 Rf: 0
 -TRIMETHOPRIM/SULFAM--PO 160/800MG TAB - 1 TAB PO BID #20 RF0 Qt: 20 Rf: 0

Disposition Written by UDE, ASSUMPTA O @ 30 Nov 2012 1434 EST

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. -

Comments: MED REC DONE AND LIST GIVEN TO PT

Signed By UDE, ASSUMPTA O (NP, KIMBROUGH AMBULATORY CARE CENTER, FT MEADE, MD) @ 30 Nov 2012 1434

CHANGE HISTORY

The following SO Note Was Overwritten by UDE, ASSUMPTA O @ 30 Nov 2012 0848 EST:

SO Note Written by OLAWUMI, OMOWUMI D @ 30 Nov 2012 0837 EST

Chief complaint

The Chief Complaint is: RASH/ ACNE.

History of present illness

The Patient is a 27 year old male.
 He reported: Currently on active duty. Visit is not deployment-related.
 Good general overall feeling.

Pain Severity 0 / 10.
 PHQ-2 Depression Screen Negative.

Allergies

Current Allergies: NKDA.

Current medication

NO CURRENT MEDS.

Past medical/surgical history**Reported:**

Medical: Reported medical history

Asthma
 Dyspnea
 Skin neoplasm of uncertain behavior
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Exposure to venereal disease

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/29/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:

Advance directives completed? ☐ Yes ☒ No

Is a copy of the Advance directive in the record? ☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ No

Are you enrolled in EFMP? ☐ Yes ☒ No

Are you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Practice Management

Preventive medicine services
 Lipid Screening - 22 FEB 2012.
 Blood Sugar Screening -
 Aspirin Prophylaxis -
 HIV Screen - 22 FEB 2012.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page 819
AR 2806

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Colonoscopy -

Tetanus (Td/Tdap) - 08 NOV 2005

Influenza -

Zoster -

Pneumococcal -

HPV -

Men:

Aortic Aneurysm Screen -

Patient exercises for at least 30 minutes a day.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

05 Nov 2012 at WRNMMC, AMH M01B Blue Ki by DING, YIMING

Encounter ID: BETH-11743237 Primary Dx: Need For Prophylactic Measure

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
 Patient Status: **Outpatient**

Date: **05 Nov 2012 0820 EST**
 Clinic: **FAM PRACTICE KI**

Appt Type: **EST**
 Provider: **DING, YIMING**

AutoCites Refreshed by SPINKS,JEAN M @ 05 Nov 2012 0845 EST**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Nonspecific abnormal imaging findings

Family History

- No family history of malignant neoplasm of the large intestine (General FHx)
- No family history of malignant neoplasm of the gastrointestinal tract (General FHx)
- No family history of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

Reason for Appointment:

Ude Discuss Vasectomy

Appointment Comments:

agm/kacc

Screening Written by SPINKS,JEAN M @ 05 Nov 2012 0838 EST**Reason For Appointment:** Ude Discuss Vasectomy

Allergen information verified by SPINKS, JEAN M @ 05 Nov 2012 0838 EST

Vitals**Vitals** Written by SPINKS,JEAN M @ 05 Nov 2012 0842 ESTBP: 122/84 Right Arm, Adult Cuff, HR: 65, RR: 18, T: 97.7 °F, SpO₂: 97%**Vitals** Written by SPINKS,JEAN M @ 05 Nov 2012 0841 EST

HT: 69 in Stated, Without Shoes, WT: 152 lbs Upright Scale, Actual, With Shoes, BMI: 22.45, BSA: 1.838 square meters, Tobacco Use: No,

Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,

Have people Annoyed you by criticizing or complaining about your drinking? No,

Have you ever felt bad or Guilty about your drinking? No,

Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,

Alcohol Comments: 1 DRINK A DAY, Pain Scale: 0 Pain Free

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

SO Note Written by DING,YIMING @ 05 Nov 2012 1131 EST**Chief complaint**

The Chief Complaint is: DISCUSS VASECTOMY.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF-CORE>> 27 Y/O MALE IS HERE FOR REFERRAL. FOR VASECTOMY.

A PHA has been completed in past year. Date: FEB 2012.

Medication list reviewed with patient, reconciliation completed.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Current medication

NO CURRENT MEDS.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/05/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Review of systems**Systemic:** No fever and no chills.**Neck:** No neck pain and no swollen glands in the neck.**Cardiovascular:** No palpitations.**Pulmonary:** No paroxysmal nocturnal dyspnea, no orthopnea, and no wheezing.**Gastrointestinal:** No nausea, no vomiting, and no abdominal pain.**Musculoskeletal:** No limb swelling.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

• Oriented to time, place, and person.

Lungs:

• Clear to auscultation.

Cardiovascular:

Heart Rate And Rhythm: • Normal.

Abdomen:

Visual Inspection: • Abdomen was not distended.

Auscultation: • Bowel sounds were not diminished or absent.

Palpation: • No abdominal tenderness. • No mass was palpated in the abdomen.

Liver: • Normal to palpation.

Spleen: • Normal to palpation.

Psychiatric:

Mood: • Euthymic.

Affect: • Normal.

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

[4] 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[0] 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

How often did you have six or more drinks on one occasion in the past year?
☐ 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

AUDIT-C Score= 4 DATE ACCOMPLISHED: 11/05/2012

☒ Negative AUDIT-C☐ Positive AUDIT-C * >>Provider Alerted<<☐ Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

☐ Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Practice Management

Patient exercises for at least 30 minutes a day.

A/P Written by DING,YIMING @ 05 Nov 2012 0853 EST**1. Need For Prophylactic Measure**

Consult(s):

-Referred To: UROLOGY MTF KI (Routine) Specialty: UROLOGY Clinic: UROLOGY CL KI Primary
 Diagnosis: Need For Prophylactic Measure

Disposition Written by DING,YIMING @ 05 Nov 2012 1134 EST**Released w/o Limitations**

Follow up: as needed with PCM and/or in the FAM PRACTICE KI clinic. - Comments: Med rec not indicated, Master Problem list reconciliation completed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Signed By** DING, YIMING (MD, KACC) @ 05 Nov 2012 1134**CHANGE HISTORY***The following SO Note Was Overwritten by DING,YIMING @ 05 Nov 2012 1031 EST:**SO Note Written by SPINKS,JEAN M @ 05 Nov 2012 0838 EST***Chief complaint**

The Chief Complaint is: DISCUSS VASECTOMY.

History of present illness

The Patient is a 27 year old male.

A PHA has been completed in past year. Date: FEB 2012.

Medication list reviewed with patient, reconciliation completed.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Pain Severity 0 / 10.

PHQ-2 Depression Screen Negative.

Patient has NOT had specialty care, ER visit, or hospitalization since last visit.

Patient feels safe at home.

Current medication

NO CURRENT MEDS.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use AUDIT-C Date: 11/05/2012.

History

ANNUAL SCREENING DATE: 11/05/2012

What is your preferred method of learning? ☒ Verbal ☒ Written ☒ Visual ☐ Other (Specify):Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advance directives completed? ☐ Yes ☒ NoIs a copy of the Advance directive in the record? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoAre you registered for Relay Health/Secure Messaging? ☒ Yes ☐ No

Contact info:

PCM:

Tests**ALCOHOL SCREENING**

How often did you have a drink containing alcohol in the past year?

☐ 0=Never, 1=Monthly or less, 2=Two to four times a month, 3=Two to three times a week, 4=Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 0=1 to 2 or doesn't drink, 1=3 to 4, 2=5 to 6, 3=7 to 9, 4=10 or more

How often did you have six or more drinks on one occasion in the past year?

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

[0] 0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily

SCREENING for Alcohol Use (AUDIT-C)

AUDIT-C Score= 4 DATE ACCOMPLISHED: 11/05/2012

[X] Negative AUDIT-C

[] Positive AUDIT-C * >>Provider Alerted<<

[] Alcohol use exceeds maximum recommended limits

Men > 14 drinks/week or >4 drinks/occasion

Women > 7 drinks/week or >3 drinks/occasion

[] Past history of alcohol related treatment or counseling. (Consider Specialty Care if patient unable to abstain/reduce alcohol use after counseling OR AUDIT-C >= 8)

Practice Management

Patient exercises for at least 30 minutes a day.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page 824
AR 2811

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Oct 2012 at WRNMMC, SRP CI Ki by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-11655430 Primary Dx: Vaccines Prophylactic Need Against Influenza

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **HQS IMCOM G1**
ARMY SUBSTANCE ABUSE PROGRAM
 Patient Status: **Inpatient**

Date: **24 Oct 2012 0848 EDT**
 Clinic: **SRP CL KI**
 Inpatient Location: **ABAA**

Appt Type: **PROC**
 Provider: **JACOBS,MILLASENT J**

Reason for Appointment: FLU MIST**AutoCites** Refreshed by JACOBS,MILLASENT J @ 26 Oct 2012 1135 EDT**Problems****Chronic:**

- Abdominal pain
- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Nonspecific abnormal imaging findings

Family History

- No Family History of malignant neoplasm of the large intestine (General FHx)
- No Family History of malignant neoplasm of the gastrointestinal tract (General FHx)
- No Family History of chronic liver disease (General FHx)
- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Enoxaparin Sodium 40mg, Solution, Injection	New	Q DAY	NR	Not Recorded
Acetaminophen 10mg/mL Solution, Intravenous	New	PRNQ6H	NR	Not Recorded
Hydromorphone 1mg/mL, Syringe, Intravenous	New	PRNQ2H	NR	Not Recorded
Ondansetron 2mg/mL, Syringe, Intravenous	New	PRNQ4H	NR	Not Recorded

SO Note Written by RIKAS,MEGAN M @ 24 Oct 2012 0849 EDT**Reason for Visit**

Visit for: influenza vaccine.
 Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 27 year old male. Source of patient information was patient. Past medical history reviewed.

Allergies

Reviewed no allergies. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

- Received dose of influenza live virus vaccine, for intranasal use .FLUMIST
 MANUFACTURED BY: MEDIMMUNE LLC
 LOT #: AH2139 EXPIRATION DT: 3DEC2012
 DOSE GIVEN: 0.2ML (0.1ML PER NOSTRIL)
 INJECTION GIVEN INTRANASAL

Past medical/surgical history

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Reported History:

Recent events: No active illness.

Review of systems**Systemic symptoms:** No fever.**Counseling/Education**

- Patient education about adverse reactions to medication Patient instructed to remain in clinic for 20 minutes post vaccination. Patient educated regarding possible side effects: soreness\ redness\ or swelling at the site of injection\ Fever\

A/P Written by RIKAS,MEGAN M @ 24 Oct 2012 0850 EDT**1. Vaccines Prophylactic Need Against Influenza**

Procedure(s):
 -Influenza Virus Vaccine Live Intranasal x 1
 -Immunization Administration One Vaccine x 1
 -Immunization Admin By Intranasal / Oral Route One Vaccine x 1

Disposition Last updated by JACOBS,MILLASENT J @ 26 Oct 2012 1138 EDT**Continued Stay****Follow up:** as needed .**Discussed:** Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding.**Signed By JACOBS, MILLASENT J (Physician/Workstation) @ 26 Oct 2012 1138****CHANGE HISTORY*****The following Disposition Note Was Overwritten by JACOBS,MILLASENT J @ 26 Oct 2012 1137 EDT:***

The Disposition section was last updated by JACOBS,MILLASENT J @ 26 Oct 2012 1137 EDT - see above. Previous Version of Disposition section was entered/updated by RIKAS,MEGAN M @ 24 Oct 2012 0850 EDT.

Continued Stay**Follow up:** as needed with PCM.**Discussed:** Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

24 Oct 2012 at WRNMMC, SRP Cl Ki by AHLTA SYSTEM ADMINISTRATOR

Encounter ID: BETH-11655184 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **KIMBROUGH**
AMBULATORY CARE CENTER
Patient Status: **Inpatient**

Date: **24 Oct 2012 0840 EDT**
Clinic: **SRP CL KI**
Inpatient Location: **ABAA**

Appt Type: **PROC**
Provider: **JACOBS,MILLASENT J**

Reason for Appointment: FLU MIST

Appointment Cancelled by Facility

Encounter Cancelled by RIKAS,MEGAN M @ 24 Oct 2012 0841 EDT

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

23 Oct 2012 at WRNMMC, GI Inflam Bowel Dis Be by COPSEY, HELEN C

Encounter ID: BETH-11639690 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **WALTER REED
NATIONAL MILITARY MEDICAL CNTR**
Patient Status: **Outpatient**

Date: **23 Oct 2012 0815 EDT**
Clinic: **GI INFLAM BOWEL DIS BE**

Appt Type: **SPEC**
Provider: **COPSEY, HELEN C**

Reason for Appointment:

IBDvs mass

Appointment Comments:

ccb

Appointment Cancelled by Facility

Encounter Cancelled by BROWN,CANDICE C @ 23 Oct 2012 0845 EDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Oct 2012 at WRNMMC, GI Inflam Bowel Dis Be by COPSEY, HELEN C

Encounter ID: BETH-11637615 Primary Dx: Imaging Studies Nonspecific Abnormal Findings

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED NATIONAL MILITARY MEDICAL CNTR**
 Patient Status: **Outpatient**

Date: **23 Oct 2012 0800 EST**
 Clinic: **GI Inflam Bowel Dis Be**

Appt Type: **SPEC**
 Provider: **COPSEY, HELEN C**

AutoCites Refreshed by COPSEY, HELEN C @ 23 Oct 2012 0756 EST**Problems****Chronic:**

- Conditions influencing health status
- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals** Written by FARRINGTON, SHAUN C @ 23 Oct 2012 0739 EDT

BP: 114/66, HR: 79, T: 95.4 °F, HT: 5' 9", WT: 147 lbs, SpO₂: 97%, BMI: 21.71, BSA: 1.812 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking? No,
 Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No,
 Alcohol Comments: COUPLE DRINKS/WEEK, Pain Scale: 0 Pain Free

SO Note Written by COPSEY, HELEN C @ 24 Oct 2012 0936 EST**Reason for Visit**

Visit for: R/O of IBD.

History of present illness

The Patient is a 27 year old male.

This is a WM, AD PO2, who presents for R/O of IBD. He reports a long history of presumed IBS presenting with intermittent lower abdominal cramping that occurs several times per week, and is triggered by dairy intake, anxiety, and physical activity. This can be associated with looser stool and mild urgency, although in general he reports a soft stool each day. An evaluation for these symptoms along with isolated BRBPR in 2005 (IL) includes a CT scan showing moderate stool retention in the colon, and a flex sig that was reportedly limited d/t patient discomfort. He denies any rectal bleeding since that time. He does endorse occasional oral aphthi but otherwise denies any additional complaints. His weight has been stable.

Earlier this month he experienced worsening of his baseline abdominal pain, possibly precipitated by consuming a milk-shake. A CT in the ER showed focal colitis at the right colon (hepatic flexure) with fecalization of the small bowel, concerning for IBD. CRP was 1.2, labs otherwise nl. A follow-up colonoscopy with Dr. McNally showed cogested appearing mucosa in the left colon. Images of the right colon/ cecum are limited due to liquid stool, and the TI was not intubated per report. Biopsies are pending. The patient reports self-resolution of the pain, and has since been feeling back to baseline.

Allergies

ASA- (nausea).

Past medical/surgical history**Reported:**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical history

- Allergic asthma (cats); Headache, NOS

Surgical / Procedural: Prior surgery

- PRK, Tonsillectomy

Medications: Medication history

- Albuterol, Aleve prn (less than once per week)

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

Pre-op ASA class 1

Previous therapy

History of possible limitations and risks do not include complications from anesthesia

Personal history

Tob: (-)

Etoh: (2 drinks every other day)

Drug use: (-)

Family history

No chronic liver disease

No malignant neoplasm of the large intestine

No malignant neoplasm of the gastrointestinal tract

No known FH of IBD, autoimmune diseases.

Review of systems**Systemic:** Not feeling tired (fatigue). No fever, no chills, no night sweats, and no recent weight loss.**Head:** No headache.**Eyes:** No vision problems.**Otolaryngeal:** No hoarseness, no lump in the throat, and no mouth sores.**Cardiovascular:** No chest pain or discomfort and no palpitations.**Pulmonary:** No dyspnea and no cough.**Gastrointestinal:** No dysphagia, no pain on swallowing, no heartburn, no regurgitation, no early satiety, no nausea, no vomiting, no hematemesis, no hematemesis ('coffee grounds'), no abdominal swelling, no jaundice, no recent increase in bowel frequency, and not decrease. No tenesmus, no melena, no hematochezia, no acholic stools, no steatorrhea, and stool diameter is not smaller. No change in consistency of stool and no nocturnal diarrhea. No rectal pain.**Genitourinary:** No urinary symptoms.**Endocrine:** No endocrine symptoms.**Hematologic:** No tendency for easy bruising.**Musculoskeletal:** No arthralgias, new. No nonspecific pain, swelling, and stiffness.**Neurological:** No confusion and no memory lapses or loss.**Psychological:** Mood was euthymic and no sleep complaints.**Skin:** No pruritus, no change in skin texture, new, and no rash, new.**Physical findings****Vital Signs:**

° Current vital signs reviewed.

Standard Measurements:

° Patient was not observed to be obese.

General Appearance:

° Awake. ° Alert. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress. ° Patient did not appear uncomfortable. ° Not acutely ill. ° Not chronically ill.

Neck:

Appearance: ° Of the neck was normal.

Eyes:

General/bilateral:

Sclera: ° Showed no icterus.

Oral Cavity:

° Normal OP clear, Mallampati score = 1.

Chest:

° Visual inspection revealed no abnormalities.

Lungs:

° Normal CTA B.

Cardiovascular:

° System: normal RRR, no M or G.

Abdomen:

° Normal soft, NT/ND, +BS.

Neurological:

° Level of consciousness was normal.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Speech: ° Normal.

Gait And Stance: ° Normal.

Psychiatric:

Mood: ° Euthymic.

Affect: ° Normal.

Thought Processes: ° Not impaired.

Skin:

° General appearance was normal. ° No jaundice. ° No skin lesions.

Therapy

- Medical regimen review -- medication reconciliation performed.

Lab Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EST

ESR	Site/Specimen	12 Oct 2012 1209
ESR	BLOOD	10
C-Reactive Protein	Site/Specimen	12 Oct 2012 1209
C-Reactive Protein	SERUM	1.206 (H)
Magnesium	Site/Specimen	12 Oct 2012 0434
Magnesium	SERUM	2.1
Phosphorus	Site/Specimen	12 Oct 2012 0434
Phosphate	SERUM	3.5
Basic Metabolic Panel	Site/Specimen	12 Oct 2012 0434
Urea Nitrogen	SERUM	5 (L)
Carbon Dioxide	SERUM	27
Chloride	SERUM	107
Creatinine	SERUM	0.80
Glucose	SERUM	113 (H)
Potassium	SERUM	4.0
Sodium	SERUM	141
Calcium	SERUM	9.2
Anion Gap	SERUM	8
GFR	SERUM	>60 <i>
CBC W/o Diff	Site/Specimen	12 Oct 2012 0434
WBC	BLOOD	5.5
RBC	BLOOD	4.02 (L)
Hemoglobin	BLOOD	13.1
Hematocrit	BLOOD	38.1
MCV	BLOOD	94.9
MCH	BLOOD	32.6
MCHC	BLOOD	34.3
Platelets	BLOOD	264
RDW CV	BLOOD	13.1
MPV	BLOOD	7.8
Neutrophil Cytoplasmic Ab (ANCA)	Site/Specimen	11 Oct 2012 1147
Myeloperoxidase Ab	SERUM	<0.2 <i>
Proteinase 3 Ab	SERUM	<0.2 <i>
Neutrophil Cytoplasmic Ab (ANCA) Screen W/Reflex Titer	Site/Specimen	11 Oct 2012 1147
Neutrophil Cytoplasmic Ab Cytoplasmic	SERUM	Titer not indicated-ANCA screen Negative
Neutrophil Cytoplasmic Ab Perinuclear	SERUM	Titer not indicated-ANCA screen Negative
Neutrophil Cytoplasmic Ab	SERUM	Negative
Neutrophil Cytoplasmic Ab Perinuclear Atypical	SERUM	Titer not indicated-ANCA screen
Negative <r> <i>		
Carcinoembryonic Ag	Site/Specimen	11 Oct 2012 1147
Carcinoembryonic Ag	SERUM	0.9 <i>
Magnesium	Site/Specimen	11 Oct 2012 1147
Magnesium	SERUM	2.3
Amylase	Site/Specimen	11 Oct 2012 1147

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Amylase	SERUM	49
Comprehensive Metabolic Panel	Site/Specimen	11 Oct 2012 1147
Albumin	SERUM	4.7
Alkaline Phosphatase	SERUM	56
Alanine Aminotransferase	SERUM	33
Aspartate Aminotransferase	SERUM	29
Bilirubin	SERUM	0.5
Urea Nitrogen	SERUM	9
Calcium	SERUM	9.5
Carbon Dioxide	SERUM	29
Chloride	SERUM	101
Creatinine	SERUM	0.85
Glucose	SERUM	82
Potassium	SERUM	4.0
Protein	SERUM	7.3
Sodium	SERUM	139
Anion Gap	SERUM	9
GFR	SERUM	>60 <i>

Lipase	Site/Specimen	11 Oct 2012 1147
Triacylglycerol Lipase	SERUM	19

Phosphorus	Site/Specimen	11 Oct 2012 1147
Phosphate	SERUM	3.5

CBC W/Diff	Site/Specimen	11 Oct 2012 1147
WBC	BLOOD	6.4
RBC	BLOOD	4.30
Hemoglobin	BLOOD	14.1
Hematocrit	BLOOD	41.0
MCV	BLOOD	95.4
MCH	BLOOD	32.6
MCHC	BLOOD	34.2
RDW CV	BLOOD	13.1
Platelets	BLOOD	268
MPV	BLOOD	8.3
Neutrophils	BLOOD	72.7
Lymphocytes	BLOOD	18.1
Monocytes	BLOOD	7.1
Eosinophils	BLOOD	1.8
Basophils	BLOOD	0.3
Neutrophils	BLOOD	4.6
Lymphocytes	BLOOD	1.2
Monocytes	BLOOD	0.5
Eosinophils	BLOOD	0.1
Basophils	BLOOD	0.0
Differential Review	BLOOD	MANUAL DIFF NOT PERFORMED

Rad Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EST**MERWIN, DANIEL DENNIS** 20/[REDACTED] 27yo [REDACTED] 1985 M

***** CT, ABD/PELVIS W/ CONTRAST *****

POC Enc: #E923164 POC Fac: NH Great Lakes IL

Status: Complete

Procedure: CT, ABD/PELVIS W/ CONTRAST

Event Date: 22-Nov-2005 10:48:00

Order Comment: NO BRIEF COMMENT

Reason for Order:

20yo male dot 2-5 with intermittent abdominal pain x 4-5 years with rectal bleeding on 19th of NOV. Had normal sigmoidoscopy to proximal transverse colon

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

and mild int hemorrhoids done on Nov 21.

Exam #: 05050343

Exam Date/Time: 23-Nov-2005 09:26:00

Transcription Date/Time: 29-Nov-2005 10:02:00

Provider: ARTATES, NEMESIA F

Requesting Location:

COURAGE (WHITE) 1007 NBHC 1007/1017

Status: COMPLETE

Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MARINBERG, BORIS V

Approved By: MARINBERG, BORIS V

Approved Date: 29-Nov-2005 12:25:00

Report Text:

ba/DICTATION DATE: 23 November 2005

CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST:

Technique: 7.5 mm cross-sectional images of the abdomen and pelvis were obtained following oral and intravenous introduction of contrast.

Findings: There is a normal appearance of the liver, spleen, and pancreas. There is no gallstones. No dilatation of biliary ducts or pancreatic duct identified. There is no enlargement of the adrenal glands. There is no hydronephrosis. No renal stones are seen. There is no lymphadenopathy. No abnormal collection of fluid in the abdomen or pelvis identified. Moderate amount of fecal material noted throughout the colon. There is no changes of appendicitis. No aneurysmal dilatation of the abdominal aorta noted. There is no signs of bowel obstruction.

IMPRESSION: NORMAL COMPUTED TOMOGRAPHY OF THE ABDOMEN AND PELVIS.**MODERATE AMOUNT OF FECAL MATERIAL THROUGHOUT THE COLON.****Rad Result** Cited by COPSEY, HELEN C @ 24 Oct 2012 0956 EST**MERWIN, DANIEL DENNIS 20 [REDACTED] 27yo [REDACTED] 1985 M**

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)

Event Date: 11-Oct-2012 01:30:00

Exam #: 12343907

Exam Date/Time: 11-Oct-2012 00:30:00

Transcription Date/Time: 12-Oct-2012 07:00:00

Provider: HARDWARE, LESLIE

Requesting Location:

EMERGENCY RM BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Approved By: BERNARD, JACQUELINE M

Approved Date: 11-Oct-2012 08:16:00

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Supervised By Date: 11-Oct-2012 08:16:00

Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained from the level of the diaphragm to the level of the pubic symphysis after the intravenous administration of 110 mL Isovue 370 and oral contrast. Coronal and sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals, and kidneys are normal. No identifiable ureteral abnormalities. Fluid-filled urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal. There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal. There is a focal area of vascular prominence involving the mesentery at the level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450 hours on 10/11/12. _____

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12 Time:08:16

A/P Last Updated by COPSEY, HELEN C @ 24 Oct 2012 1002 EST

1. Imaging Studies Nonspecific Abnormal Findings: CT concerning for colitis and fecalization of SB ? radiographic artifact, constipation, acute vs. chronic inflammation, stenosis. Colonoscopy with limited evaluation of right colon, ICD, distal ileum. Recommend MRE for further evaluation of small bowel as d/w Dr. Kikendall. He may ultimately require repeat colonoscopy, however will await biopsy results prior to determining next steps. Patient voices understanding/ agreement.

2. abdominal pain: Patient with long history of intermittent abdominal pain ? due to IBS vs. dietary intolerance vs. inflammatory. Will proceed with evaluation to r/o IBD, however if negative encouraged patient to continue f/u with GI for management of chronic symptoms.

Disposition Last Updated by COPSEY, HELEN C @ 24 Oct 2012 1003 EST**Released w/o Limitations**

Follow up: in the GI INFLAM BOWEL DIS BE clinic. - Comments: Will call pt 850-602-8501 after obtaining pathology and discussing need for repeat colonoscopy with IBD staff.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments:

45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BROWN, CANDICE C @ 23 Oct 2012 0738 EST**Consult Order**

Referring Provider: SALTER, CAROLYN A

Date of Request: 12 Oct 2012

Priority: ASAP

Provisional Diagnosis:

IBD vs mass

Reason for Request:

27 y/o male w/ ascending colon inflammation s/p colonoscopy 12 OCT. Pt needs GI f/u to discuss results.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 24 Oct 2012 1003Note Written by COPSEY, HELEN C @ 24 Oct 2012 1004 EST

(Added after encounter was signed.)

PATH**PATH**

Spoke with Dr. Barner re: patient's pathology results- not yet placed into CHCS. Biopsies of left-colon show benign colonic mucosa, without active inflammation, chronicity or architectural distortion.

Note Written by COPSEY, HELEN C @ 08 Nov 2012 1503 EST

(Added after encounter was signed.)

MRE results

MRE d/w patient- essentially nl specifically right colon/T1, will review at IBD conference. Pt denies any continued pain. Will defer repeat COLO for now, however reconsider pending progress. Would re-check CRP, which should be down from hospitalization. Pt v/u.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

12 Oct 2012 at WRNMMC, Wounded Warrior GWOT by AGOSTO, ROBERT

Encounter ID: BETH-11525944 Primary Dx: Conditions influencing health status

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **WALTER REED**
NATIONAL MILITARY MEDICAL CNTR
 Patient Status: **Inpatient**

Date: **12 Oct 2012 0805 EDT**
 Clinic: **WOUNDED WARRIOR GWOT**
 Inpatient Location: **ABAA**

Appt Type: **ACUT**
 Provider: **AGOSTO,ROBERT**

Reason for Appointment: Written by AGOSTO,ROBERT @ 12 Oct 2012 0805 EDT
 Admission screening for CM services

A/P Last Updated by AGOSTO,ROBERT @ 12 Oct 2012 0808 EDT

1. Conditions influencing health status (OTHER SPECIFIED CONDITIONS INFLUENCING HEALTH STATUS OTHER):
 WRNMMC Case Management Department reviews active duty inpatient admissions to assess potential need for case management services. In reviewing this ADSM medical record we have determined case management services by WRNMMC staff are not indicated at this time because: Patient is enrolled to Kimbrough and we have contacted that MTF's NCM ms deborah Jolissaint, RN via email to advise of admission; .
 Robert Agosto, LPN
 Case Management Assistant, WRNMMC
 301-295-0657

Procedure(s): -COORDINATED CARE FEE, MAINTENANCE RATE x 1
 -CASE MANAGEMENT, EACH 15 MINUTES x 1

Disposition Last Updated by AGOSTO,ROBERT @ 12 Oct 2012 0809 EDT
Continued Stay

Signed By AGOSTO, ROBERT (LPN Case Management Assistant) @ 12 Oct 2012 0809

Co-Signed By MELENDEZ-WARREN, DORIS J (RN Case Manager, NMMC Bethesda) @ 12 Oct 2012 0920

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

14 May 2012 at NH Pensacola FL, Corry MHP by BRADLEY, RACHAEL NAOMI

Encounter ID: PENS-6872482 Primary Dx: VIRAL SYNDROME

Patient: **MERWIN, DANIEL DENNIS**Date: **14 May 2012 0855 CDT**Appt Type: **ACUT**Treatment Facility: **NBHC NTTC**Clinic: **CORRY MED HOME CLINIC**Provider: **BRADLEY, RACHAEL NAOMI****Pensacola**Patient Status: **Outpatient****AutoCites** Refreshed by BRADLEY, RACHAEL N @ 14 May 2012 0901 CDT**Problems****Chronic:**

- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Acute:

- Viral syndrome

Family History

- Family medical history (General FHx)

Allergies

- OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

cough/fever

Appointment Comments:

rmr

Vitals**Vitals** Written by GARZA, OMAR @ 14 May 2012 0844 CDT

BP: 120/76, HR: 90, RR: 14, T: 98.5 °F, HT: 69 in, WT: 146 lbs, BMI: 21.56, BSA: 1.807 square meters,

Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 0 Pain Free

Comments: NKDA

POC -8506028501

SO Note Written by BRADLEY, RACHAEL NAOMI @ 15 May 2012 1520 CDT**Chief complaint**

The Chief Complaint is: Cough/vomiting.

History of present illness

The Patient is a 27 year old male.

27 ADM presents to medical due to Cough/vomiting x 3 weeks. Pt is taking mucinex, is eating and drinking normally. Pt vomited at 0700 14MAY12 from coughing. Cough has been gradually worsening. No blood noted. Also has some nasal congestion. No ear pain, mild sore throat.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling, fever, and chills.

Cough.

Nausea and vomiting.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Current medication

Mucinex.

Past medical/surgical history**Reported:**

Medical: Reported medical history

none.

Surgical / Procedural: Surgical / procedural history

none.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Review of systems**Systemic:** No night sweats.**Head:** Headache.**Eyes:** No vision problems, no blurred vision, and no eye pain.**Otolaryngeal:** No hearing loss and no earache. Nasal discharge. No sore throat.**Pulmonary:** No dyspnea and no wheezing.**Gastrointestinal:** No abdominal pain, no bright red blood per rectum, and no diarrhea.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Normal. ° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Eyes:

General/bilateral:

Pupils: ° PERRL.

External: ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Tympanic Membrane: ° Normal.

Nose:

General/bilateral:

Cavity: ° Nasal mucosa normal.

Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: • Posterior pharyngeal wall was abnormal + PND. ° Tonsils showed no abnormalities.

Lymph Nodes:

° Cervical lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.

° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Lab Result Cited by BRADLEY,RACHAEL N @ 15 May 2012 1526 CDT**Throat Culture**

Order #	120510-04943 (NH Pensacola)
Filler #	120510 MI 3241 (NH Pensacola)
Status:	Final
Ordering Provider:	GUNTER, ROGER WILLIAM
Priority:	ASAP
Date Ordered:	10 May 2012 1652
Date Resulted:	11 May 2012 0845
COLLECT_SAMPLE:	PHARYNX
BACTERIOLOGY RESULT:	FINAL REPORT RESULTS: NORMAL FLORA
Specimen:	Pharynx
Collected:	10 May 2012 1248

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Results:

Final report

Lab Result Cited by BRADLEY,RACHAEL N @ 15 May 2012 1526 CDT**Streptococcus Group A Ag Rapid****Site/Specimen****10 May 2012 1248**

Streptococcus pyogenes Ag Rapid Strep

PHARYNX

NEGATIVE, INTERNAL CONTROL ACCEPTABLE

Lab Result Cited by BRADLEY,RACHAEL N @ 15 May 2012 1526 CDT**CBC****Site/Specimen****10 May 2012 1248**

WBC

BLOOD

6.3

RBC

BLOOD

4.73

Hemoglobin

BLOOD

14.8

Hematocrit

BLOOD

43.0

MCV

BLOOD

90.9

MCH

BLOOD

31.3

MCHC

BLOOD

34.4

RDW CV

BLOOD

12.5

Platelets

BLOOD

315

MPV

BLOOD

10.6

Neutrophils

BLOOD

63.9

Lymphocytes

BLOOD

23.9

Monocytes

BLOOD

10.5

Eosinophils

BLOOD

1.4

Basophils

BLOOD

0.3

Neutrophils

BLOOD

4.0

Lymphocytes

BLOOD

1.5

Monocytes

BLOOD

0.7

Eosinophils

BLOOD

0.1

Basophils

BLOOD

0.0

Lab Result Cited by BRADLEY,RACHAEL N @ 15 May 2012 1526 CDT**Infectious Mononucleosis Screen****Site/Specimen****10 May 2012 1248**

Heterophile Ab

SERUM

NEGATIVE, INTERNAL CONTROL ACCEPTABLE

A/P Written by BRADLEY,RACHAEL N @ 15 May 2012 1527 CDT

1. VIRAL SYNDROME: Labs drawn on 10 May all normal. Lungs sounds clear. Instructed to continue Mucinex PSE, hydrate and RTC if sx's persist or worsen.

Disposition Written by BRADLEY,RACHAEL N @ 15 May 2012 1527 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY MED HOME CLINIC clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By BRADLEY, RACHAEL N** (Independent Duty Corpsman) @ 15 May 2012 1527**CHANGE HISTORY***The following SO Note Was Overwritten by BRADLEY,RACHAEL N @ 14 May 2012 1011 CDT:***SO Note** Written by GARZA,OMAR @ 14 May 2012 0849 CDT**Chief complaint**

The Chief Complaint is: Cough/vomiting.

History of present illness

The Patient is a 27 year old male.

27 ADM presents to medical due to Cough/vomiting x 3 weeks. Pt is taking mucinex, is eating and drinking normally. Pt vomited at 0700 14MAY12, cough and fever have worsen in the past week.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling, fever, and chills.

Chest pain or discomfort.

Dyspnea and cough.

Nausea and vomiting.

No lightheadedness.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Mucinex.

Past medical/surgical history

Reported:

Medical: Reported medical history
none.
Surgical / Procedural: Surgical / procedural history
none.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:
History.

Review of systems

Otolaryngeal: No sore throat.

Gastrointestinal: No abdominal pain, no bright red blood per rectum, and no diarrhea.

Psychological: Not thinking about suicide. No homicidal thoughts.

Physical findings

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

◦ Well developed. ◦ Well nourished. ◦ In no acute distress.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

10 May 2012 at NH Pensacola FL, Corry MHP by GUNTER, ROGER WILLIAM

Encounter ID: PENS-6859398 Primary Dx: VIRAL SYNDROME

Patient: **MERWIN, DANIEL DENNIS**Date: **10 May 2012 1235 CDT**Appt Type: **EST**Treatment Facility: **NBHC NTTC**Clinic: **CORRY MED HOME CLINIC**Provider: **GUNTER, ROGER WILLIAM****Pensacola**Patient Status: **Outpatient****AutoCites** Refreshed by GUNTER, ROGER WILLIAM @ 10 May 2012 1238 CDT**Allergies**

•OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

chronic fever feelings

Appointment Comments:

aaw

Vitals**Vitals** Written by RATHBUN, TONYA @ 10 May 2012 1226 CDT

BP: 112/68, HR: 72, RR: 12, T: 98.4 °F, HT: 69 in, WT: 146 lbs, BMI: 21.56, BSA: 1.807 square meters,

Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 0 Pain Free

Comments: NKDA

POC: 850-602-8501

SO Note Written by GUNTER, ROGER WILLIAM @ 10 May 2012 1646 CDT**Chief complaint**

The Chief Complaint is: Viral malaise, fever.

History of present illness

The Patient is a 27 year old male.

27yo ADM reports to medical with a cough and hot flashes x 1 month. Symptoms began with hot flashes and a cough then recently about two weeks ago he began having congestion as well. Pt has taken Dayquil and Nyquil which he states was a minimally effective.

<<Note accomplished in TSWF CORE>>

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Currently on active duty. Visit is not deployment-related.

Good general overall feeling and chills.

Headache.

Nasal discharge, nasal passage blockage, and sore throat.

Cough.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Dayquil

Nyquil

Albuterol.

Past medical/surgical history**Reported:**

Medical: Reported medical history none

Surgical / Procedural: Surgical / procedural history none

Medications: No medication noncompliance.

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date:

History.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Review of systems**Systemic:** No fever.**Otolaryngeal:** No earache.**Gastrointestinal:** No nausea and no vomiting.**Psychological:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital Signs:**

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Ears:

General/bilateral:

Tympanic Membrane: ° Normal.

Nose:

General/bilateral:

Cavity: ° Nasal mucosa normal.

Pharynx:

Oropharynx: ° Posterior pharyngeal wall was normal.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.

° No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal S1 and S2. ° No S3 heard. ° No gallop was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Edema: ° Not present.

A/P Written by GUNTER,ROGER WILLIAM @ 10 May 2012 1649 CDT**1. VIRAL SYNDROME:** Exam is completely normal. No lymphadenopathy or objective findings on exam. Will continue on his OTC meds for symptom control as needed. I will obtain some basic labs to rule out Mono and strep but suspect he has a viral syndrome. HIV drawn in FEB this year was negative.

Laboratory(ies): -CBC PROFILE (Routine); MONONUCLEOSIS SCREEN (Routine); RAPID STREP A (Routine)

Disposition Written by GUNTER,ROGER WILLIAM @ 10 May 2012 1653 CDT**Released w/o Limitations****Follow up:** as needed in 1 week(s) with PCM and/or in the CORRY MED HOME CLINIC clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By GUNTER, ROGER WILLIAM** (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 10 May 2012 1654**CHANGE HISTORY***The following SO Note Was Overwritten by GUNTER,ROGER WILLIAM @ 10 May 2012 1648 CDT:**SO Note Written by RATHBUN,TONYA @ 10 May 2012 1228 CDT***History of present illness**

The Patient is a 27 year old male.

27yo ADM reports to medical with a cough and hot flashes x 1 month. Pt began condition with hot flashes and a cough then recently about two weeks ago he began having congestion. Pt has taken Dyquil and Nyquil which he states was a little effective.

<<Note accomplished in TSWF CORE>>

Currently on active duty. Visit is not deployment-related.

Good general overall feeling and chills.

Headache.

Nasal discharge, nasal passage blockage, and sore throat.

Cough.

PHQ-2 Depression Screen Negative.

Patient feels safe at home.

Current medication

Dyquil

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Nyquil
Albuterol.

Past medical/surgical history

Reported:

Medical: Reported medical history none

Surgical / Procedural: Surgical / procedural history none

Personal history

Behavioral: No tobacco use in the last 10 years.

Alcohol: Alcohol use: Screening Date:
History.

Review of systems

Systemic: No fever.

Otolaryngeal: No earache.

Gastrointestinal: No nausea and no vomiting.

Psychological: Not thinking about suicide. No homicidal thoughts.

Physical findings

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Well developed. ° Well nourished. ° In no acute distress.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Mar 2012 at NH Pensacola FL, Readiness Center by TREVEN, LAUREN A

Encounter ID: PENS-5802127

Primary Dx:

Visit for: occupational health / fitness exam

Patient: **MERWIN, DANIEL DENNIS**Date: **06 Mar 2012 1330 CDT**Appt Type: **WELL**Treatment Facility: **NH Pensacola**Clinic: **DEPLOYMENT HEALTH CLINIC**Provider: **TREVEN, LAUREN A**Patient Status: **Outpatient****Reason for Appointment:** PHA PART II / VA**Appointment Comments:**

CAC-DBM

AutoCites Refreshed by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1328 CDT**Allergies**

- OTHER: Unknown (SEE MED RECORD)

Screening Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1328 CDT**Reason For Appointment:** PHA PART II / VA**Reason(s) For Visit (Chief Complaint):** visit for: occupational health / fitness exam (New) : pha;**Vitals****Vitals** Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1337 CST

BP: 110/70 Left Arm, Adult Cuff, HR: 70 Regular, Radial Artery, RR: 17, HT: 69 in, WT: 151 lbs Upright Scale, Actual, With Shoes, BMI: 22.3,

BSA: 1.833 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by JOHNSONCRUTCHFIELD, ANDREA C @ 06 Mar 2012 1334 CDT**History of present illness**

The Patient is a 27 year old male.

He reported: Currently on active duty. Visit is not deployment-related.

Good general overall feeling.

Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

None.

Past medical/surgical history**Reported History:**

Medical: Reported medical history

-Diabetes- no

-Cancer- no

-HTN- no

-High Cholesterol- no

-Heart Disease- no

-Metal issues- no

-Kidney issue- no

-Seizures- no

Obesity - no

Heart attack - no

Asthma - self

Surgical / procedural: Surgical / procedural history none.

Personal history

Social history reviewed none.

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol Screening Date:

History ANNUAL SCREENING DATE:

What is your preferred method of learning? [] Verbal [] Written [x] Visual [] Other (Specify):

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Do you have a learning disability, language barrier, hearing/vision deficit? ☐ Yes ☒ No Specify:Advanced directives completed? ☐ Yes ☒ NoDo you have any cultural or religious beliefs that may affect your care? ☐ Yes ☒ NoAre you enrolled in EFMP? ☐ Yes ☒ NoDo you use a Personal Health Record (PHR)? ☒ Yes ☐ No Specify:

Contact info:

Family history

Family medical history

-Diabetics- father side of family

-Cancer- no

-HTN- no

-High Cholesterol- no

-Heart Disease- father side of family

-Metal issues- no

-Kidney issue- no

-Seizures- no

Obesity - side of family

Heart attack - no

Asthma - no

SO Note Written by TREVEN,LAUREN A @ 06 Mar 2012 1344 CDT**Chief complaint**

The Chief Complaint is: PHA, works at NIOC.

History of present illness

The Patient is a 27 year old male.

<<Note accomplished in TSWF CORE>>

Presents for PHA. Denies complaints or concerns.

Review of systems**Systemic symptoms:** No fever and no chills.**Head symptoms:** No headache.**Cardiovascular symptoms:** No chest pain or discomfort.**Pulmonary symptoms:** No cough.**Gastrointestinal symptoms:** No nausea, no vomiting, no abdominal pain, no diarrhea, and no constipation.**A/P** Written by TREVEN,LAUREN A @ 06 Mar 2012 1524 CDT**1. visit for: occupational health / fitness exam**(*PERIODIC PREVENTION EXAMINATION*): Annual TB risk assessment completed with responses determined to be minimal risk. No further testing recommended. See NAVMED 6224/8.

Record review completed. Reviewed deployment health history and individual medical readiness. Counseling on avoidable health risk factors and screening per clinical preventive service guidelines provided.

Member completed Fleet and Marine Corps Health Risk Assessment. Counseled on identified risks.

Counseled on lab results for PHA and discussed at length ways to improve through lifestyle changes; exercise, weight management, supplements and better nutrition. Teaching materials given. Encouraged follow-up with PCM for any health problems or concerns as needed.

Medically fit for full duty.

PHA complete

Disposition Written by TREVEN,LAUREN A @ 06 Mar 2012 1524 CDT**Released w/o Limitations****Follow up:** as needed with PCM.**Signed By** TREVEN, LAUREN A (Physician Assistant, Deployment Health Clinic) @ 06 Mar 2012 1524

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

02 Nov 2011 at NH Pensacola FL, Corry MHP by GRIMM, CHRISTOPHER T

Encounter ID: PENS-4417339

Primary Dx:

Vaccines Prophylactic Need Against
InfluenzaPatient: **MERWIN, DANIEL DENNIS**Date: **02 Nov 2011 1101 CST**Appt Type: **WELL**Treatment Facility: **NBHC NTTC**Clinic: **CORRY MED HOME CLINIC**Provider: **GRIMM, CHRISTOPHER TODD****Pensacola**Patient Status: **Outpatient****Reason for Appointment:** flu SHOT**Vitals****Vitals** Written by STANDLEY, CHAD J @ 02 Nov 2011 1424 CDT**Comments:** N/A**SO Note** Written by STANDLEY, CHAD J @ 02 Nov 2011 1424 CST**History of present illness**

The Patient is a 26 year old male.

Barriers to learning were identified as: None.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**

Reported medications: No medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Taking medication and no contraindications to live vaccine were noted on medication reconciliation.

Physical findings

Patient monitored 15 minutes for adverse reaction/complications.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by STANDLEY, CHAD J @ 02 Nov 2011 1425 CST**1. Vaccines Prophylactic Need Against Influenza**

Procedure(s):

-Immunization Administration One Vaccine x 1

-Influenza Split Virus Vacc Age 3+ Years IM Preservative Free x 1

Disposition Last Updated by STANDLEY, CHAD J @ 02 Nov 2011 1425 CST**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY MED HOME CLINIC clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Signed By GRIMM, CHRISTOPHER T** (Physician/Workstation) @ 02 Nov 2011 1518

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

07 Oct 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-4182237

Primary Dx:

POSTSURGICAL STATE OF EYE AND
ADNEXAPatient: **MERWIN, DANIEL DENNIS**Date: **07 Oct 2011 0800 CDT**Appt Type: **EST**Treatment Facility: **NH Pensacola**Clinic: **Ophthalmology Clinic**Provider: **ROPP, CORBY D**Patient Status: **Outpatient****Reason for Appointment:**A/P Last Updated by ROPP, CORBY D @ 07 Oct 2011 0836 CDT**1. Postsurgical state of eye and adnexa**

Procedure(s):

-Ophthalmological Prior Patient Start Comprehensive Care x 1

-Determination Of Refractive State x 1

2. Aftercare Following Surgery Of Sense OrgansDisposition Last Updated by ROPP, CORBY D @ 07 Oct 2011 0836 CDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 07 Oct 2011 0836

Note Written by CEPEDA, SERGIO JAVIER @ 10 Oct 2011 0517 CDT**(Added after encounter was signed.)**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: 1

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

USAF REFRACTIVE SURGERY (USAF-RS) POST-OP FORM									
This form and other USAF-RS Tools are available on AF Knowledge Exchange (DoDM) https://ss.afm.mil/USAF-RS or Public Access http://airforcemedicine.afm.mil/USAF-RS									
Examination Date: 7 Oct 2011									
PATIENT INFORMATION									
Last Name: MCCORMICK		First Name: DANIEL				MI: D			
Grade / Rank: P02		SSN (Last 4): 2489		Management Group: 		AASD: 		Warfighter: 	
SURGERY INFORMATION									
RS Treatment Location: Reaser		Post-Op Visit: 							
RS: OD		Surgery: OD		Date: MAR 11		OD: 		Weeks: 6	
Treatment: OS		Date: OS		Date: MAR 11		Post-Op Time: OS		Weeks: 6	
SUBJECTIVE INFORMATION									
Chief Complaint / Interval History: PRK (1) Retrobulbar HA 2 computer use						Post-Op Medication			
						If currently using, indicate name and dosage			
<input type="checkbox"/> OD OS <input type="checkbox"/> Steroid <input type="checkbox"/> IOP Control <input checked="" type="checkbox"/> Artificial Tear <input type="checkbox"/> Other						PRN Resc 415			
SYMPTOMS									
	NONE	MILD	MOD	SEVERE					
Glare / Halo	OD OS	OD OS	OD OS	OD OS					
Chasing/Spotting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hazy / Foggy Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Reduced Night Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Dry Eye Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>					
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Post-Op Use of Optical Correction					<input checked="" type="checkbox"/> None <input type="checkbox"/> Distance Only <input type="checkbox"/> Near Only <input type="checkbox"/> Both Distance & Near				
Specs: <input type="checkbox"/> 0% <input type="checkbox"/> <25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> >75% <input type="checkbox"/> CLX <input type="checkbox"/> 0% <input type="checkbox"/> <25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> >75%									
OBJECTIVE INFORMATION									
Uncorrected DVA		NVA		Manifest Refraction to BEST Visual Acuity				ADD	
OD 20/15-1	20/20	OD	pl.	- 0.25	x 015	20/15	+	20/	
OS 20/15	20/20	OS	pl.	- 0.0	x 015	20/15	+	20/	
AASD ONLY UNCORRECTED VISUAL ACUITY									
OD		OS		OD		OS			
PV (High Contrast)		PV (High Contrast)		PV (High Contrast)		PV (High Contrast)			
# letters: 20/xx		# letters: 20/xx		# letters: 20/xx		# letters: 20/xx			
20/		20/		20/		20/			
PV (5% Contrast)		PV (5% Contrast)		PV (5% Contrast)		PV (5% Contrast)			
# letters: 20/xx		# letters: 20/xx		# letters: 20/xx		# letters: 20/xx			
20/		20/		20/		20/			
PV Chart is Patient Distance		PV Chart is Patient Distance		PV Chart is Patient Distance		PV Chart is Patient Distance			
In meters: Typical		In meters: Typical		In meters: Typical		In meters: Typical			
4		4		4		4			
If word/line acuity is being recorded, cycloplegic refraction and dated function vision (DFV) are required. At least one post-ODS examination must be included with the commercial survey including MAUCOM values.									
Cycloplegic Refraction to BEST Visual Acuity									
Cyclopentolate 1%		Cyclopentolate 1%		Cyclopentolate 1%		Cyclopentolate 1%			
Drop 1 @		Drop 1 @		Drop 1 @		Drop 1 @			
OD		OS		OD		OS			
-		-		-		-			
20/		20/		20/		20/			
X		X		X		X			
20/		20/		20/		20/			

20/ [REDACTED]
7 Oct 2011, 0721

C.R. Lipp
 Learn me
 usual

Medical Record


Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Exam Date	Last Name	First Name	MI	Last 4
SLIT LAMP EXAM				
OD		OS		
Lids / Lashes / Lac	<input type="checkbox"/> NL <input type="checkbox"/> ABNL	Lids / Lashes / Lac	<input type="checkbox"/> NL <input type="checkbox"/> ABNL	FINDINGS
Conjunctiva	<input type="checkbox"/>	Conjunctiva	<input type="checkbox"/>	
Cornea	<input type="checkbox"/>	Cornea	<input type="checkbox"/>	
Haze <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		Haze <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
A/C	<input type="checkbox"/>	A/C	<input type="checkbox"/>	
Iris	<input type="checkbox"/>	Iris	<input type="checkbox"/>	
Lens	<input type="checkbox"/>	Lens	<input type="checkbox"/>	
IOP 11 mmHg	Must be Tx while on steroid eye drops	IOP 19 mmHg	Must be Tx while on steroid eye drops	
TOPOGRAPHY		IMPRESSION / PLAN		
Not Performed	<input type="checkbox"/>	<p>A) low post-op. mild DGS 2 migraine sx. P-) ↑ Refraction. Try OTC migraine Rx → file in PCN. F/L br at some pt</p>		
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
FUNDUS				
Not Performed	<input type="checkbox"/>			
DPE	<input type="checkbox"/>			
Non-DPE	<input type="checkbox"/>			
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
RECOMMENDATION		<p>Eye Care Provider: SR O'Connell, MD</p> <p>Aviator Meets AF Flight Vision Standards <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted</p> <p>Warfighter Meets AF Duty Vision Standards <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted</p> <p>Flight Surgeon Stamp/Signature: </p>		
<p>Eye Care Provider: SR O'Connell, MD</p> <p>Rank/Name: CAPT MC USN</p> <p>Base: Naval Hospital Pensacola</p> <p>OSN: FAX</p> <p>E-mail: stephen.oconnell@med.navy.mil</p>		<p>USAF-65 Post-Op, 20090603</p>		

MERWIN, DANIEL DENNIS
 20, [REDACTED]
 7 Oct 2011, 0721

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jul 2011 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-3154362 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL D**Treatment Facility: **NH Pensacola**Patient Status: **Outpatient**Date: **27 Jul 2011 0845 CDT**Clinic: **DERMATOLOGY CLINIC**Appt Type: **EST\$**Provider: **BRUMWELL, ERIC****Reason for Appointment:** f/u skin check**AutoCites** Refreshed by BRUMWELL, ERIC @ 27 Jul 2011 0851 CDT**Problems****Chronic:**

- Asthma
- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	INSTILL 1 DROP IN EACH 5 OF 6 EYE EVERY 5 TO 10 MINUTES AS NEEDED X 5 DAYS, THEN AS NEEDED		04 May 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3 RF3		14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	INS 1 G OU QID X 7 DAYS #1 RF1	1 of 1	14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010

Vitals**Vitals** Written by CONLEY, KARLA E @ 27 Jul 2011 0842 CDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by BRUMWELL,ERIC @ 27 Jul 2011 0852 CDT**Chief complaint**

The Chief Complaint is: F/U PHOT OR HEAT INDUCED FOLLICULITIS-- PT HAD PROBLEM LAST YEAR AND RECENTLY HAD RECURRENCE 2 WEEKS AGO AFTER WORKING IN YARD--TNTC SMALL PUSTULES ON FACE/NECK AND UPPER BACK THAT LASTED A FEW DAYS THEN WENT AWAY--NO TOPICALS USED OTHER THAN VASELINE LOTION, NO MEDS TAKEN.

Reason for Visit

Visit for: screening for dermatological disorders.

Referred here

From Primary Care.

History of present illness

The Patient is a 26 year old male.

He reported: Military service.

Concerns about cosmetic appearance.

Allergies

An allergy to drugs.

Current medication

current medication [Use for free text].

Past medical/surgical history**Reported History:**

Reviewed.

Reported medications: Taking medication MEDICINE RECONCILIATION PERFORMED.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings**Vital signs:**

• Pain level (0-10) 0.

Neurological:

Speech: ° Normal.

Psychiatric Exam:

Affect: ° Congruent with the mood.

Skin:

° Normal except as noted EXAM ESSENTIALLY NORMAL--NO ACTIVE SKIN DISEASE. ° No lesions on the scalp. ° No lesions on the ear. ° No lesions on the face. ° No lesions on the neck. ° No lesions on the shoulders. ° No lesions on the upper extremities.

A/P Written by BRUMWELL,ERIC @ 27 Jul 2011 0857 CDT

1. FOLLICULITIS: PREVIOUSLY BIOPSY AND DIAGNOSIS C/W PITYROSPORUM FOLLICULITIS HOWEVER HISTORY SEEMS MUCH BETTER FOR MILIARIA

ADVISED PT TO START TOPICAL KETOCONAZOLE AGAIN FOR PITYROSPORUM AND WILL ADD LAC HYDRIN AND CLINDA TOPICALLY TO TREAT CONCURRENTLY FOR MILIARIA AND BACTERIAL FOLLICULITIS. ADVISED PT TO WEAR LOOSE SUN PROTECTIVE CLOTHING AND TO COOL OFF IMMEDIATELY AFTER HOT ACTIVITY

WILL F/U W/ NEXT EPISODE FOR REPEAT BIOPSY/CULTURE WHEN ABLE

Medication(s):	-AMMONIUM LACTATE--TOP 12% LOTN - AAA TRUNK AND NECK DAILY #2 RF4 Qt: 2 Rf: 4 -CLINDAMYCIN--TOP 1% SOLN - APPLY TO UPPER TRUNK AND NECK DAILY-- THIS IS THE ANTIBIOTIC #2 RF3 Qt: 2 Rf: 3
Patient Instruction(s):	-Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure -Avoid Exposure Bright Sunlight -Education And Counseling -Instructions For Patient

Disposition Written by BRUMWELL,ERIC @ 27 Jul 2011 0857 CDT**Released w/o Limitations**

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Parent who indicated understanding.

Signed By BRUMWELL, ERIC (Department Head/Staff Physician, Dermatology Clinic, Naval Hospital Pensacola) @ 27 Jul 2011 0858

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

CHANGE HISTORY

The following SO Note Was Overwritten by BRUMWELL, ERIC @ 27 Jul 2011 0852 CDT:

SO Note Written by CONLEY, KARLA E @ 27 Jul 2011 0843 CDT

Chief complaint

The Chief Complaint is: F/u skin check.

Current medication

current medication [Use for free text].

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

26 Jul 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T

Encounter ID: PENS-3141764 Primary Dx: ASTHMA

Patient: MERWIN, DANIEL D

Date: 26 Jul 2011 1100 CDT

Appt Type: EST

Treatment Facility: NH Pensacola

Clinic: PULMONARY DISEASE CLINIC

Provider: LEWIS, CHRISTOPHER T

Patient Status: Outpatient

Reason for Appointment: PULM/LAB RESULTS/MEDS/20MIN**Appointment Comments:**

CAC BD

Screening Written by CURRY, JEREMY T @ 26 Jul 2011 1104 CDT**Reason For Appointment:** PULM/LAB RESULTS/MEDS/20MIN

Allergen information verified by CURRY, JEREMY T @ 26 Jul 2011 1103 CDT

Vitals**Vitals** Written by CURRY, JEREMY T @ 26 Jul 2011 1104 CDTBP: 104/64, HR: 72, RR: 16, T: 98.0 °F, HT: 68 in, WT: 150 lbs, SpO₂: 96%, BMI: 22.81,
BSA: 1.809 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free**SO Note** Written by LEWIS, CHRISTOPHER T @ 26 Jul 2011 1127 CDT**Chief complaint**

The Chief Complaint is: Follow up PFTs.

History of present illness

The Patient is a 26 year old male.

He reported: Feeling fine, Excellent, Very Good or Good.

Pain Severity 0 / 10.

Pt is a 26 yo male who presents for follow up of pulmonary function tests. He was last seen in March 2011. Since that time he has done well. He exercises regularly without difficulty. He will have occasional chest tightness when around cats, but otherwise is asymptomatic. He presents today for routine follow up.

Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

Advair diskus prn.

Past medical/surgical history**Reported History:**

Past medical history Past Medical History:

1) childhood asthma

2) allergies.

Personal history

-Tob: none

-EtOH: none.

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol Screening Date:

History ANNUAL SCREENING DATE:

What is Your Preferred Method of Learning?

(Specify):

☒ Verbal ☐ Written ☐ Visual ☐ Other

Learning Disability, Language or Learning Barriers?

☐ Yes ☒ No

Advanced Directives Completed?

☐ Yes ☒ No

Do you have any cultural or religious beliefs that may affect your care?

☐ Yes ☒ No

Are you enrolled in EFMP?

☐ Yes ☒ No

Contact Info:

Review of systems**Systemic symptoms:** Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.**Head symptoms:** No sinus pain.**Pulmonary symptoms:** No dyspnea, no cough, and no wheezing.**Physical findings****Vital signs:**

° Current vital signs reviewed.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

General appearance:

° Well-appearing. ° Awake. ° Alert. ° In no acute distress.

Tests**Laboratory studies:****Pulmonary Function Tests:**

Pulmonary function tests were performed on 17MAR11 and revealed normal spirometry, very mild decrease in TLC, and a normal DLCO. Following the administration of 16mg/ml of methacholine there was a significant decrease in FEV1 consistent with a positive methacholine challenge.

A/P Written by LEWIS,CHRISTOPHER T @ 26 Jul 2011 1135 CDT

1. ASTHMA(ASTHMA, UNSPECIFIED, MILD): Pt with a symptom complex and positive high dose methacholine challenge test consistent with mild intermittent asthma. Hls symptoms are confined to allergen exposure, particularly to cats. Given the mild intermittent nature of his disease, he does not require a controller medicine, and will be treated with prn albuterol alone. He was counseled on allergen avoidance. No further workup is required. He is FIT FOR FULL DUTY WITHOUT RESTRICTIONS, and FIT FOR WORLD WIDE DEPLOYMENT WITHOUT RESTRICTIONS. Follow up in 6 months.

Disposition Written by LEWIS,CHRISTOPHER T @ 26 Jul 2011 1135 CDT**Released w/o Limitations****Signed By** LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 26 Jul 2011 1135**CHANGE HISTORY***The following SO Note Was Overwritten by LEWIS,CHRISTOPHER T @ 26 Jul 2011 1127 CDT:***SO Note** Written by CURRY,JEREMY T @ 26 Jul 2011 1105 CDT**History of present illness**

The Patient is a 26 year old male.

He reported: Feeling fine, Excellent, Very Good or Good.

Pain Severity 0 / 10.

Patient feels safe at home.

Allergies

Current Allergies Reviewed.

Current medication

Advair diskus.

Personal history

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Not using alcohol Screening Date:

History ANNUAL SCREENING DATE:

What is Your Preferred Method of Learning?

Learning Disability, Language or Learning Barriers?

Advanced Directives Completed?

Do you have any cultural or religious beliefs that may affect your care?

Are you enrolled in EFMP?

Contact Info:

☒ Verbal ☐ Written ☐ Visual ☐ Other (Specify):☐ Yes ☒ No☐ Yes ☒ No☐ Yes ☒ No☐ Yes ☒ No

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-2275325

Primary Dx:

POSTSURGICAL STATE OF EYE AND
ADNEXAPatient: **MERWIN, DANIEL D**Treatment Facility: **NH Pensacola**Patient Status: **Outpatient**Date: **06 Jun 2011 0815 CDT**Clinic: **OPHTHALMOLOGY CLINIC**Appt Type: **EST**Provider: **ROPP, CORBY D****Reason for Appointment:** prk f/u**Appointment Comments:**

sjc

AutoCites Refreshed by ROPP, CORBY D @ 06 Jun 2011 0822 CDT**Problems****Chronic:**

- Postsurgical state of eye and adnexa
- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	INSTILL 1 DROP IN EACH 5 of 6 EYE EVERY 5 TO 10 MINUTES AS NEEDED X 5 DAYS, THEN AS NEEDED		04 May 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3 RF3		14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	INS 1 G OU QID X 7 1 of 1 DAYS #1 RF1		14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5 5 of 5		24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN 3 of 3 EACH NOSTRIL ONCE A DAY #1 RF3		24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY 0 of 1 BID #1 RF1		24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP 4 of 4 BID AS DIRECTED		13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% 4 of 4 SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4		13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR 1 of 1 WHEEZING #1 RF1		01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F 2 of 2		25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	ALLERGIES UD #30 RF2 INSTEAD OF SOAP UD 6 of 6 (BUT THE BEST SOAP IS		20 Jul 2010

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

NO SOAP) #2 RF6

A/P Written by ROPP,CORBY D @ 06 Jun 2011 0829 CDT

1. Postsurgical state of eye and adnexa

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Written by ROPP,CORBY D @ 06 Jun 2011 0829 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 06 Jun 2011 0829

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

06 Jun 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-2273083 Primary Dx: POSTSURGICAL STATE OF EYE AND ADNEXA

Patient: **MERWIN, DANIEL D**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**

Date: **06 Jun 2011 0757 CDT**
Clinic: **Ophthalmology Clinic**

Appt Type: **EST**
Provider: **ROPP, CORBY D**

Reason for Appointment:

A/P Last Updated by ROPP, CORBY D @ 06 Jun 2011 1243 CDT

1. Postsurgical state of eye and adnexa

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Last Updated by ROPP, CORBY D @ 06 Jun 2011 1243 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 06 Jun 2011 1243

Note Written by CEPEDA, SERGIO JAVIER @ 07 Jun 2011 1305 CDT
(Added after encounter was signed.)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

USAF REFRACTIVE SURGERY (USAF-RS) POST-OP FORM											
This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) https://ks.afma.mil/USAF-RS or Public Access http://airforcemedical.afma.mil/USAF-RS											
Examination Date: <u>6 Jun 11</u>											
PATIENT INFORMATION											
Last Name: <u>Merwin</u>				First Name: <u>Daniel</u>				MI: <u></u>			
Grade / Rank: <u>Po2</u>		SSN (Last 4): <u>2984</u>		Management Group: <u></u>		AASD: <u></u>		Warfighter: <u></u>			
SURGERY INFORMATION											
RS Treatment Location: <u>Reuter</u>				Post-Op Visit: <u></u>							
RS: <u>OD</u>		Surgery: <u>OD</u>		Date: <u>Apr</u>		Post-Op Time: <u>OD</u>		Weeks: <u>1</u>		Months: <u></u>	
Treatment: <u>OS</u>		Date: <u>Apr</u>		Post-Op Time: <u>OS</u>		Weeks: <u>1</u>		Months: <u></u>			
SUBJECTIVE INFORMATION											
Chief Complaint / Interval History: <u>PRK</u>				Post-Op Medication: <u>Prescribed Refresh</u>				If currently using, indicate name and dosage:			
Dry eye Sw.				<input type="checkbox"/> Steroid							
				<input type="checkbox"/> IOP Control							
				<input checked="" type="checkbox"/> Artificial Tear							
				<input type="checkbox"/> Other							
SYMPTOMS											
NONE		MILD		MOD		SEVERE		Post-Op Complications			
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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Exam Date	Last Name	First Name	MI	Last 4
SLIT LAMP EXAM				
OD		OS		
Lids / Lashes / Lac	<input checked="" type="checkbox"/> NL <input type="checkbox"/> ABNL	Lids / Lashes / Lac	<input checked="" type="checkbox"/> NL <input type="checkbox"/> ABNL	FINDINGS
Conjunctiva	<input checked="" type="checkbox"/>	Conjunctiva	<input checked="" type="checkbox"/>	
Cornea	<input checked="" type="checkbox"/>	Cornea	<input checked="" type="checkbox"/>	
Haze	<input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Haze	<input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
A/C	<input checked="" type="checkbox"/>	A/C	<input checked="" type="checkbox"/>	
Iris	<input checked="" type="checkbox"/>	Iris	<input checked="" type="checkbox"/>	
Lens	<input checked="" type="checkbox"/>	Lens	<input checked="" type="checkbox"/>	
IOP	10 mmHg	IOP	10 mmHg	Must be Tx while on steroid eye drops
TOPOGRAPHY		IMPRESSION / PLAN		
Not Performed	<input checked="" type="checkbox"/> OO <input checked="" type="checkbox"/> OS	<p>A) On target & expected</p> <p>Dry Eye Sr.</p> <p>P.) CAP.</p> <p>Continue U.V. protection</p> <p>Flu 2 mo for 3 mo.</p>		
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
FUNDUS				
Not Performed	<input checked="" type="checkbox"/> OO <input checked="" type="checkbox"/> OS			
DFE	<input type="checkbox"/>			
Non-DFE	<input type="checkbox"/>			
Normal	<input type="checkbox"/>			
Abnormal	<input type="checkbox"/>			
Eye Care Provider		Aviator Meets AF Flight Vision Standards		
RECOMMENDATION		Wartfighter Meets AF Duty Vision Standards		
SR O'Connell, MD		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted		
CAPT MC USN		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted		
Naval Hospital Pensacola		Flight Surgeon Stamp/Signature		
DSN		C. ROP		
E-mail: stephen.oconnell@med.navy.mil		[Signature]		

USAF-RS Post-Op. 20080603

MERWIN, DANIEL D
20/
6 Jun 2011, 0724

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

04 May 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1912953 Primary Dx: SUPERFICIAL INJURY - ABRASION OF CORNEA

Patient: **MERWIN, DANIEL D** Date: **04 May 2011 0817 CDT** Appt Type: **EST**
Treatment Facility: **NH Pensacola** Clinic: **OPHTHALMOLOGY CLINIC** Provider: **ROPP,CORBY D**
Patient Status: **Outpatient**

Reason for Appointment: prk f/u

A/P Last Updated by ROPP,CORBY D @ 04 May 2011 0859 CDT

1. SUPERFICIAL INJURY - ABRASION OF CORNEA

Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1

Disposition Last Updated by ROPP,CORBY D @ 04 May 2011 0900 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 04 May 2011 0900

Note Written by CEPEDA,SERGIO JAVIER @ 04 May 2011 1053 CDT
(Added after encounter was signed.)

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

MERWIN, DANIEL D
20/ [REDACTED]
4 May 2011, 0818

C. R. 2000
me 423

Medical Record


Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Exam Date	Last Name	First Name	MO	Last 4
SLIT LAMP EXAM				
OD		OS		
Lids / Lashes / Lac	NL ASNL	Lids / Lashes / Lac	NL ASNL	
Conjunctiva		Conjunctiva		
Cornea		Cornea		
Haze <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		Haze <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
A/C		A/C		
Iris		Iris		
Lens		Lens		
IOP 7 mmHg	Must be Tx while on steroid eye drops	IOP - mmHg	Must be Tx while on steroid eye drops	
TOPOGRAPHY		IMPRESSION / PLAN		
Not Performed	OD OS	A.) Healing abras. in (OS). P.) Vigamox QID (OS). Cm. mot. in every TID. Flu 1 day.		
Normal				
Abnormal				
FUNDUS				
Not Performed	OD OS			
DFE				
Non-DFE				
Normal				
Abnormal				
Eye Care Provider		Aviator Meets AF Flight Vision Standards		
RECOMMENDATION		Warfighter Meets AF Duty Vision Standards		
SR O'Connell, MD		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted		
Rank/Name CAPT MC USN		Flight Surgeon Stamp/Signature		
Base Naval Hospital Pensacola		 C. O'Connell		
DSN FAX				
E-mail stephen.oconnell@med.navy.mil				

USAF-RS Post-Op, 20080603

MERWIN, DANIEL D
20/[REDACTED]
4 May 2011, 0818

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

26 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1783025 Primary Dx: Aftercare Following Surgery Of Sense Organs

Patient: **MERWIN, DANIEL D**Date: **26 Apr 2011 0755 CDT**Appt Type: **EST**Treatment Facility: **NH Pensacola**Clinic: **OPHTHALMOLOGY CLINIC**Provider: **ROPP,CORBY D**Patient Status: **Outpatient****Reason for Appointment:** 1 WEEK PRK F/U**A/P** Last Updated by ROPP,CORBY D @ 26 Apr 2011 0819 CDT**1. Aftercare following surgery of the sense organs**

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Postsurgical state of eye and adnexa**Disposition** Last Updated by ROPP,CORBY D @ 26 Apr 2011 0819 CDT**Released w/o Limitations****Discussed:** Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 26 Apr 2011 0820

Note Written by CEPEDA,SERGIO JAVIER @ 26 Apr 2011 1518 CDT**(Added after encounter was signed.)**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Keesler Post Operative Form

SURGERY DATE: 21 APRIL		POD 1 Date:		POD 5 Date: 26 APRIL	
UCVA PH	OD 20/	OS 20/	OD 20/50+2	OS 20/30	
CHIEF COMPLAINT		1 week PKR F/U Blurriness 00			
Pain 0-10 (0 = None)		0-10			
MEDICATIONS					
Acular 4xDay NEJAVEL	Yes	No	Yes	No	Yes
Vigamox / Zymar 4xDay	Yes	No	Yes	No	Yes
PF 1% (FML)					QID
Artificial Tears					refresh Q 30 min PRN
Motrin					BID
Percocet					4
Phenergan					4
Other:					Restasis BID
SLE Lid Edema					4
Conj. Injection					4
Cornea					4
Edema					4
Immune Cells					4
Infection	Yes	No	Yes	No	Yes
A/C Reaction					4
BCL	Present	Removed	Present	Removed	Present
AV Oasys 8.4			AV Oasys 8.4		AV Oasys 8.4
ASSESSMENT / PLAN:					
Acular 4xDay	Continue	Stop	Continue	Stop	Continue 2 days then stop
PF / FML 4xDay	Continue	Taper/Stop	Continue	Taper/Stop	Continue 2 days then stop
Artificial Tears	Continue	Stop	Continue	Stop	Continue 2 days then stop
Oral Meds as directed	Continue	Stop	Continue	Stop	Continue 2 days then stop
Acular:	Continue	Stop	Continue	Stop	Continue 2 days then stop
Other: Restasis	Continue	Stop	Continue	Stop	Continue 2 days then stop
FOLLOW UP	1 2 3 4 5 6 9 12	6 Week Taper	1 2 3 4 5 6 9 12	6 Week Taper	4 Month Taper

MERWIN, DANIEL D
20 [REDACTED]
26 Apr 2011, 0756

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

22 Apr 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1748025 Primary Dx: POSTSURGICAL STATE OF EYE AND ADNEXA

Patient: **MERWIN, DANIEL D**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**

Date: **22 Apr 2011 0800 CDT**
Clinic: **Ophthalmology Clinic**

Appt Type: **EST**
Provider: **ROPP, CORBY D**

Reason for Appointment:

A/P Last Updated by ROPP, CORBY D @ 22 Apr 2011 0934 CDT

1. POSTSURGICAL STATE OF EYE AND ADNEXA

Procedure(s): -Postoperative Visit, Without Charge x 1

2. Aftercare Following Surgery Of Sense Organs

Disposition Last Updated by ROPP, CORBY D @ 22 Apr 2011 0934 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 22 Apr 2011 0935

Note Written by CEPEDA,SERGIO JAVIER @ 25 Apr 2011 1213 CDT
(Added after encounter was signed.)

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Keesler Post Operative Form

SURGERY DATE: 21 Apr 2011		PO D _1_ Date:		PO D _5_ Date:	
UCVA PH	OD 20/30+2	OS 20/40+1	OD 20/	OS 20/	
CHIEF COMPLAINT		Yucciness		Yucciness	
Pain 0-10 (0 = None)		0		0	
MEDICATIONS					
Acular 4xDay	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Zymar 4xDay	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
PF 10/ FML	QID				
Artificial Tears	Refresh FRT				
Motrin	CP				
Percocet	CP				
Phenergan	CP				
Other:	Rescudis				
SLE Lid Edema	CP		CP		
Conj. Injection	CP		CP		
Cornea	Re-Epithelialized		Re-Epithelialized		
	<input checked="" type="checkbox"/> 1/4	<input type="checkbox"/> 1/2	<input checked="" type="checkbox"/> 1/4	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/4
	<input type="checkbox"/> 1/2	<input type="checkbox"/> 3/4	<input type="checkbox"/> 1/2	<input type="checkbox"/> 3/4	<input type="checkbox"/> 3/4
	<input type="checkbox"/> Full	<input type="checkbox"/> Full	<input type="checkbox"/> Full	<input type="checkbox"/> Full	<input type="checkbox"/> Full
Edema	CP		CP		
Immune Cells	CP		CP		
Infection	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
A/C Reaction	CP		CP		
BCL	<input checked="" type="checkbox"/> Present	<input type="checkbox"/> Removed	<input checked="" type="checkbox"/> Present	<input type="checkbox"/> Removed	<input checked="" type="checkbox"/> Present
	Above	Replaced	Above	Replaced	Above
	AV Oasys 8.4	AV Oasys 8.4	AV Oasys 8.4	AV Oasys 8.4	AV Oasys 8.4
ASSESSMENT / PLAN:					
Zymar 4xDay	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
PF / FML 4xDay	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Taper/Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Taper/Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
Artificial Tears	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
Oral Meds as directed	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
Acular: N/A	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
Other:	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue	<input type="checkbox"/> Stop	<input checked="" type="checkbox"/> Continue 2 days then stop
FOLLOW UP	1 2 3 4 5 6 9 12	6 Week Taper	1 2 3 4 5 6 9 12	6 Week Taper	6 Week Taper
	Day Week Month	4 Month Taper	Day Week Month	4 Month Taper	4 Month Taper

MERWIN, DANIEL D
20/ [REDACTED]
22 Apr 2011, 0717

1 Day PRK FLU

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Apr 2011 at 81st Medical Group, Refractive Surgery by ROPP, CORBY D

Encounter ID: KSLR-874047 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL D**Treatment Facility: **81ST MEDICAL****GROUP**Patient Status: **Outpatient**Date: **21 Apr 2011 0928 CDT**Clinic: **REFRACTIVE SURGERY**Appt Type: **PROC**Provider: **ROPP, CORBY D****Reason for Appointment:** PRK Sx**AutoCites** Refreshed by SCHOEMANN, LINDA CIV @ 21 Apr 2011 1113 CDT**Problems****Chronic:**

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Acute:

- Visit for: preoperative exam

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Nepafenac 0.1%, Suspension, Ophthalmic	Active	INS 1 G OU TID - QID NR		14 Apr 2011
IBUPROFEN, 800 MG, TABLET, ORAL	Active	PRN SEVERE PAIN #1 RF0 T1 TAB PO Q8H PP #30 NR		14 Apr 2011
Cyclosporine 0.05%, Emulsion, Ophthalmic	Active	INS 1 GTT OU BID UD #2 3 of 3		14 Apr 2011
Polyvinyl Alcohol + Povidone, (Refresh), Solution, Ophthalmic	Active	RF3 INS 1 G OU EVERY 5-10 6 of 6		14 Apr 2011
Moxifloxacin Hydrochloride 0.5%, Solution, Ophthalmic	Active	MIN PRN X 5 DAYS, THEN PRN		14 Apr 2011
Fluorometholone 0.1%, Suspension, Ophthalmic	Active	INS 1 G OU QID X 7 1 of 1		14 Apr 2011
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	DAYS #1 RF1 INSTILL 1 DROP OU QID NR		14 Apr 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	X 1 WEEK, THEN TID X 1 WEEK, THEN BID X 2 WEEKS, THEN DAILY X 2 WEEKS AND STOP #2 RF0		24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	T1 TAB PO HS #30 RF5 5 of 5		24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	INHALE 2 SPRAYS IN 3 of 3		24 Jan 2011
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	DAY #1 RF3 INHALE 1 PUFF ORALLY 0 of 1		24 Jan 2011
		BID #1 RF1		
		USE ON TRUNK AND SCALP 4 of 4		13 Oct 2010
		BID AS DIRECTED		
		KETOCONAZOLE 2% 4 of 4		13 Oct 2010
		SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY		

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	AS DIRECTED #2 RF4 INH 2 PF PO Q4H FOR	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	WHEEZING #1 RF1 T1 TAB PO QD F	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	ALLERGIES UD #30 RF2 INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT**1. Myopia**

Procedure(s): -PHOTOREFRACTIVE KERATECTOMY (PRK) x 1 (50-BILATERAL PROCEDURE)

Disposition Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT**Released w/o Limitations****Note** Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1114 CDT

Medical Record

Merwin, Daniel Dennis

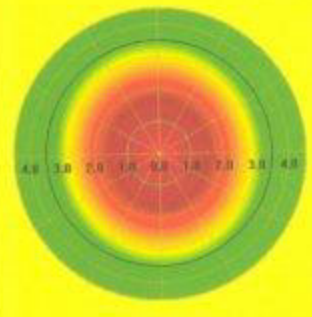
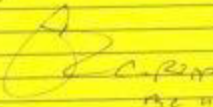
DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ALLEGRETTO		WaveLight®	
Treatment report			
MERWIN [REDACTED] DANIEL		OD	
[REDACTED] 985	ID: 125100386	Status: Finished	
Male			
Treatment Type: WFOptimized S 001 Date: 04-21-2011 Correction: -2.75 D -0.50 D @ 100° Clinical: -2.75 D ^ -0.50 D @ 100° Target Ref.: 0.00 D ^ 0.00 D @ 100° Optical Zone: 6.50 mm Transition Zone: 1.25 mm Ablation zone: 9.00 mm Vertex Distance: 12.0 mm K-reading (K1): 40.50 D @ 83° K-reading (K2): 40.75 D @ 173° Pupil Diameter: 7.00 mm Applied Drugs: Entry made by: BLG Surgeon: ROPP Confirmed by:		Ablation Profile  Maximum Depth: 49.14 µm Central Depth: 49.14 µm Corneal Thickness: 583 µm Device: Flap Thickness: 50 µm Stroma: 483 µm	
Memo and postOP-Comments S-PO CORDOVA L. BRIAN T-70 H-43 Minc 66274 applied 15 sec  M.C.			
WaveLight AG Am Wolfsmantel 5 D-91058 Erlangen - Germany Phone: ++49 (0)180 5526262			

Note Written by SCHOEMANN,LINDA CIV @ 21 Apr 2011 1115 CDT

Medical Record

Merwin, Daniel Dennis

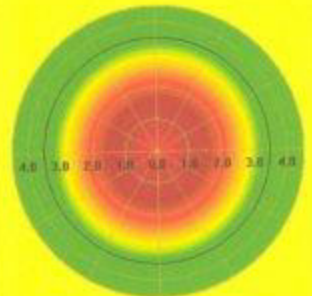
DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ALLEGRETTO		WaveLight®	
Treatment report			
MERWIN [REDACTED] DANIEL		OS	
[REDACTED] 985	ID: 125100386	Status: Finished	
Male			
Treatment Type: WFOptimized S 001 Date: 04-21-2011 Correction: -2.75 D -0.25 D @ 75° Clinical: -2.75 D ^ -0.25 D @ 75° Target Ref.: 0.00 D ^ 0.00 D @ 75° Optical Zone: 6.50 mm Transition Zone: 1.25 mm Ablation zone: 9.00 mm Vertex Distance: 12.0 mm K-reading (K1): 40.50 D @ 82° K-reading (K2): 40.75 D @ 172° Pupil Diameter: 7.00 mm Applied Drugs: Entry made by: BLG Surgeon: ROPP Confirmed by:		Ablation Profile  Maximum Depth: 45.47 µm Central Depth: 45.47 µm Corneal Thickness: 577 µm Device: Flap Thickness: 50 µm Stroma: 481 µm	
Memo and postOP-Comments S-PO CORDOVA L-BRIAN T-70 H-43 <i>mmc 0.02% X15 JCC</i> <i>[Signature]</i> <i>[Signature]</i>			
WaveLight AG Am Wolfsmantel 5 D-91058 Erlangen - Germany Phone: ++49 (0)180 5526262			

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 21 Apr 2011 1456

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Mar 2011 at NH Pensacola FL, Ophthalmology Clinic by ROPP, CORBY D

Encounter ID: PENS-1494230 Primary Dx: Visit for: preoperative exam

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **29 Mar 2011 1330 CDT**
 Clinic: **OPHTHALMOLOGY CLINIC**

Appt Type: **SPEC**
 Provider: **ROPP, CORBY D**

Reason for Appointment: PRK Screen**Appointment Comments:**
CJC**AutoCites** Refreshed by ROPP, CORBY D @ 29 Mar 2011 1335 CDT**Problems****Chronic:**

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by ROPP, CORBY D @ 29 Mar 2011 1446 CDT**1. visit for: preoperative exam:** The risks and benefits and CRS alternatives eligible for this patient were discussed including PRK/LASIK options.

PRK was discussed as use of a brush to create a large abrasion like defect which will take several days to heal with aid of a CL. Potential of pain/discomfort was mentioned. Risks of haze which may cause loss of best vision was discussed. Significantly slower visual recovery than LASIK (up to 6 months) worsening of dry eye or causing dry eye, and infection were discussed. Glare and

Merwin, Daniel Dennis

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1985 SSN: ***-**-****

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Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

halos, new dry eye that may persist for 6 months or longer was mentioned. The use of MMC as surgeon preference in order to minimize risk of corneal haze development was discussed as well as it's unknown long -term affects on the cornea and that it is not FDA approved for CRS. It was mentioned that the Navy has a long history of successful application of MMC with much less haze formation and minimal side effects.

The LASIK option was discussed as creation of a corneal flap which establishes a thinner corneal structure than PRK, but faster and less painful visual recovery. The lesser risk of haze was mentioned. The potential for re-lifting the flap if necessary for debri, folds, or re-treatment and risk for epithelial down-growth was discussed. The risk of flap dislocation although small was discussed. The risk for flap infection although small was discussed. The risk of worsening or creation of dry eye symptoms due to the corneal incision, as well as glare and halos at night during the healing process were discussed. The risk of worsened dry eye with age was also discussed, and that its long-term affects not known. The risk for multiple suction loss events, even during flap creation w/ potential for resultant aberrations was discussed.

It was mentioned that people who have either PRK or LASIK are generally happy and most would recommend to a friend w/ a few exceptions

After a discussion of the risks and benefits the patient elected to have PRK with MMC application.

Procedure(s):
 -Ophthalmological New Patient Start Comprehensive Care x 1
 -Determination Of Refractive State x 1
 -Corneal Pachymetry Both Eyes x 1
 -Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral x 2 (50-BILATERAL PROCEDURE) - Wavescan, low RMS, okay for Allegretto
 PentaCam - nl A/P floats and Belin-Ambrosio scans ou - Hard copy on file on system - no printer ink
 -Computerized Corneal Topography x 1

2. REFRACTIVE ERROR - MYOPIA

Disposition Written by ROPP,CORBY D @ 29 Mar 2011 1446 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by CORDOVA,CARLOS @ 29 Mar 2011 1219 CDT

Consult Order

Referring Provider: ZENT, JOHN W

Date of Request: 16 Mar 2011

Priority: Routine

Provisional Diagnosis:

Lattice peripheral retinal degeneration

Reason for Request:

Clinic will make appointment.CRS, please eval peripheral retinal lesion OD for correct diagnosis and possible laser retinopexy.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group, Refractive Surgery) @ 29 Mar 2011 1447

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 Mar 2011 at NH Pensacola FL, Pulmonary Function Lab by LEWIS, CHRISTOPHER T

Encounter ID: PENS-1447190 Primary Dx: Difficulty breathing (dyspnea)

Patient: **MERWIN, DANIEL DENNIS**Date: **17 Mar 2011 1300 CDT**Appt Type: **PROC\$**Treatment Facility: **NH Pensacola**Clinic: **PULMONARY FUNCTION LAB**Provider: **LEWIS, CHRISTOPHER T**Patient Status: **Outpatient****Reason for Appointment:** difficulty breathing (dyspnea)**Appointment Comments:**

LHM

A/P Last Updated by MCGEE, LINDA H @ 24 Mar 2011 1225 CDT**1. difficulty breathing (dyspnea)**

Procedure(s):

- Special Dr. Services Analysis Of Computerized Data x 1
- Pulse Oximetry x 1
- Pulmonary Function MVV x 1
- Pulmonary Function FRC (% Predicted Normal) x 1
- Pulmonary Function Carbon Monoxide Diffusion % (DLCO) x 1
- Bronchial Challenge With Methacholine x 1
- Spirometry Pre-bronchodilator x 1
- Spirometry Post-bronchodilator x 1

Disposition Last Updated by MCGEE, LINDA H @ 24 Mar 2011 1225 CDT**Released w/o Limitations****Note** Written by DAW, PAMELA J @ 17 Mar 2011 1300 CDT**Consult Order****Referring Provider:** LEWIS, CHRISTOPHER T**Date of Request:** 16 Feb 2011**Priority:** Routine**Provisional Diagnosis:**

difficulty breathing (dyspnea)

Reason for Request:

clinic will schedule. Per Ms Mcgee. Pt is a 26 yo male with chest tightness and dyspnea. Please evaluate with baseline PFTs and a methacholine challenge study if necessary to rule out asthma.

Note Written by MCGEE, LINDA H @ 24 Mar 2011 1224 CDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

PULMONARY LABORATORY
NAVY HOSPITAL PENSACOLA

Pulmonary Function Analysis

PF Reference: Morris/Pulgar

Patient: MERWIN, DANIEL

Id: [REDACTED]

Physician: LEWIS, CHRISTOPHER

Room: BAAA

Any Info: NAVY/AD

Diagnosis: Dyspnea

Date: 03/17/11

Age: 26
 Gender: Male
 Height(in): 69
 Weight(lb): 153
 Race: CAUCASIAN

Smoker: Yes
 How Long: 1
 Quit: Yes
 Stopped: 2

Spirometry

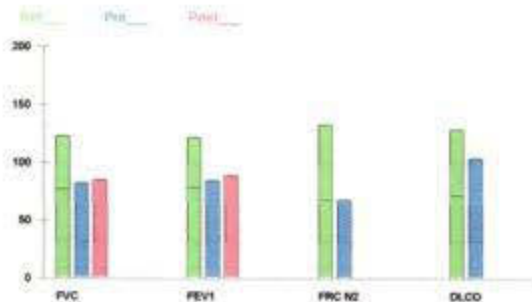
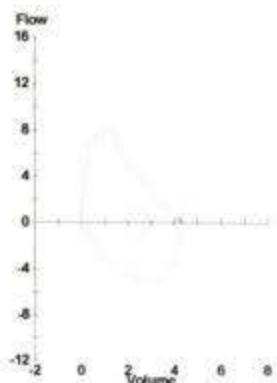
		Ref	Pre Meas	Pre % Ref
FVC	Liters	5.25	4.26	81
FEV1	Liters	4.21	3.53	84
FEV1/FVC	%	79	83	
FEF25-75%	L/sec	4.56	3.60	79
FEF50%	L/sec	5.41	4.71	87
PEF	L/sec	9.82	7.08	78
MVV	L/min	1.78	1.24	70

Lung Volumes

TLC	Liters	6.81	5.36	79
RV	Liters	1.69	1.10	65
RV/TLC	%	26	20	
FRC N2	Liters	3.72	2.50	67

Diffusion

DLCO	mL/minHg/min	29.0	30.0	103
DLCOVA	mL/minHg/min/L	4.79	5.23	109
DLVA Adj	mL/minHg/min/L		5.23	
VA	Liters	6.82	5.74	84



Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

PULMONARY LABORATORY
NAVY HOSPITAL PENSACOLA
 6000 Highway 98 West
 Pensacola Florida 32512 850 505-6560

Bronchochallenge Report

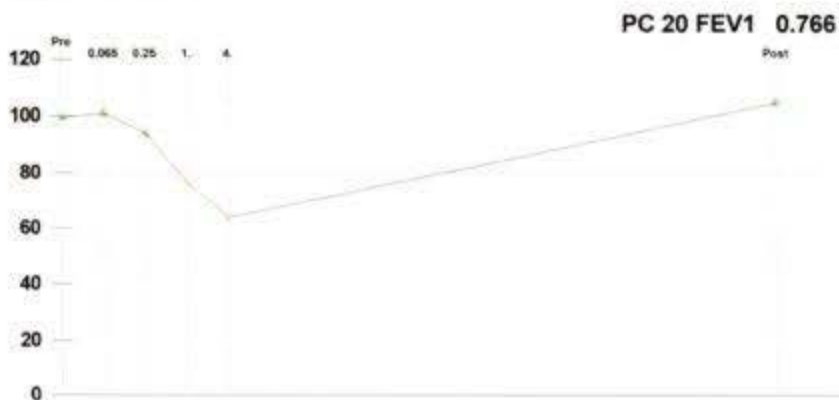
Date: 03/17/11

Protocol: Methacholinechal

ID: [REDACTED]
 Name: MERWIN, DANIEL
 Age: 26 Gender: Male
 Weight(lb): 153 Height(in): 69
 Race: CAUCASIAN
 Room: BAAA
 Technician: L.H. MCGEE
 Physician: LEWIS, CHRISTOPHER
 Diagnosis: Dyspnea

	Ref	Pre	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Post
Dose										
FVC Liters	5.25	4.26	4.40	4.38	4.06	3.54				4.42
% Ref		81	84	84	77	68				84
% Chg						-13				-4
Dose										
FEV1 Liters	4.21	3.53	3.58	3.34	2.71	2.26				3.71
% Ref		84	85	79	64	54				88
% Chg					-23	-36				6
Dose										
FEF25-75%	4.50	3.60	3.64	2.77	1.52	1.16				4.03
% Ref		79	80	61	33	26				88
% Chg					-58	-68				12
Dose										
PEF L/sec	9.82	7.68	6.21	6.84	7.51	7.10				7.99
% Ref		78	63	70	76	72				81
% Chg			-18	11	-2	-4				8

PC 20 FEV1: 0.766



Page 2

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Any Info: NAVY/AD ID: [REDACTED] Name: MERWIN, DANIEL

Comments:
 Patient is being evaluated for history of difficulty breathing. ATS standards met: initial SpO2 99% at rest and HR at 75 bpm. Good cooperation and good effort. Patient was initially given a control trial of 5 breaths of 0.9% NaCl with 0.4% Phenol solution via dosimeter nebulizer. Testing continued with administration of 5 breaths each of increasing dosages of ipratropium 0.065, 0.25, 1.0 mg/ml consecutively, using 0.9% NaCl with 0.4% Phenol as diluent. Test was discontinued due to decrease in FEV1 of 20% of predicted value or greater. Post bronchodilator administered via 0.5cc Albuterol in 0.2cc NaCl via nebulizer. Patient advised of possible side effects of ipratropium and albuterol. No known predisposition for hypersensitivities to these medications, no adverse reactions.

Interpretation:
 Pulmonary function test obtained to evaluate baseline lung functions. Normal baseline spirometry. The flow volume loop is normal. Lung Volumes are consistent with mild restrictive disease. The diffusing capacity for carbon monoxide is normal. Positive Methacholine Challenge.

Robert Merzies, CPT, MC, USN, Pulmonologist/ Internal Medicine
 Christopher Lewis, CDR, MC, USN, Pulmonologist
 Wendell Colberg, M.D. Allergist, Allergy Clinic

Page 3

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 25 Mar 2011 1117

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Mar 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-1434732 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC NAS Pensacola**
 Patient Status: **Outpatient**

Date: **16 Mar 2011 0900 CDT**
 Clinic: **NASP OPTOMETRY CLINIC**

Appt Type: **SPEC**
 Provider: **ZENT,JOHN W**

Reason for Appointment: NASP/EVAL PRK/NO CONTACTS 30 DAYS/20/UNIF/MED LIST**Appointment Comments:**

cac-mam

AutoCites Refreshed by ZENT,JOHN W @ 16 Mar 2011 1348 CDT**Problems****Chronic:**

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by SCHUSTER,ELIZABETH D @ 16 Mar 2011 0852 CDT**Reason For Appointment:** NASP/EVAL PRK/NO CONTACTS 30 DAYS/20/UNIF/MED LIST

Allergen information verified by SCHUSTER, ELIZABETH D @ 16 Mar 2011 0852 CDT

Vitals

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals Written by SCHUSTER,ELIZABETH D @ 16 Mar 2011 0852 CDT

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by SCHUSTER,ELIZABETH D @ 16 Mar 2011 0852 CDT**Reason for Visit**

Visit for: military services physical.

History of present illness

The Patient is a 26 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Reliability of source of patient information was good.

In the Navy and currently on active duty. Visit is not deployment-related. Paygrade E5.

Past medical/surgical history**Reported History:**

Surgical / procedural: Surgical / procedural history reviewed and updated in Patient's Problem List.

Reported medications: Medication history reviewed and updated in Medication module.

Physical trauma: No trauma to the eye.

Diagnosis History:

No glaucoma.

No hypertension.

No hyperlipidemia.

No diabetes mellitus

Family history

Family medical history: Reviewed in Problem List.

Review of systems**Cardiovascular symptoms:** No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Physical findings****Eyes:**

General/bilateral:

Visual Assessment: • Lensometry:

OD: -2.25 -0.50 x103

OS: -2.50 -0.25 x069.

Right eye:

Visual Assessment:

Value

Distance right acuity with current Rx: 20/

20

Left eye:

Visual Assessment:

Value

Distance left acuity with current Rx: 20/

20

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by ZENT,JOHN W @ 16 Mar 2011 1351 CDT**1. Myopia**

Procedure(s): -Ophthalmological Prior Patient Start Intermediate Level Care x 1

-Determination Of Refractive State x 1

2. Lattice peripheral retinal degeneration: Likely flat retinoschisis, difficulty observing today even with 3-mirror funduscopy. Best view with BIO/scleral depression.Consult(s): -Referred To: OPHTHALMOLOGY CONSULT (Routine) Specialty: OPHTHALMOLOGY Clinic:
OPHTHALMOLOGY CLINIC Primary Diagnosis: Lattice peripheral retinal degeneration**Disposition** Written by ZENT,JOHN W @ 16 Mar 2011 1404 CDT**Released w/o Limitations****Follow up:** as needed .**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Note** Written by SIMIEN,LATOSHA D @ 16 Mar 2011 1000 CDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

HEALTH RECORD		RECORD OF REFRACTIVE SURGERY PREOPERATIVE & TREATMENT PLAN			
C - Blurred Vision Pt Pref: PRK LASIK RefX C-Ref: S A DW NCL RGP CL Last Worn: 2010 Dominant Eye: R L		Right VAsc: 20/200 Habitual: -2.25 -0.50 X 103 20 Rx #1 2010: -2.25 -0.50 X 098 20 Rx #2: X 20 Auto Ref: -2.75 -0.50 X 095 Auto Ref K's: 40.25 @ 180 / 40.75 @ 178 Time: 0900 Tx: 15 min Paper: PERRLA EOM: Full & Smooth Manifest: -2.50 -0.25 X 095 20 Cycloplegic Rx: -2.50 -0.50 X 100 15 WAMR: X 20		Left VAsc: 20/200 Habitual: -2.50 -0.25 X 0109 20 Rx #1 2010: -2.50 -0.25 X 085 20 Rx #2: X 20 Auto Ref: -3.00 -0.25 X 0104 Auto Ref K's: 40.75 @ 163 / 41.00 @ 073 Time: 0900 Tx: 15 min Paper: PERRLA EOM: Full & Smooth Manifest: -2.75 DS X 20 Cycloplegic Rx: -2.75 -0.25 X 100 15 WAMR: X 20	
Medications: Dilated with Cyclo 1% Trop 1% Allergies: NKDA Schirmer - 2 min With 0.5% Prop: R: mm L: mm Pain: 0-10 (0 = none)		Notes/Plan: 1. Flap & Postop WNL 2. Discussed at length risks, limitations, expectations 3. All questions answered and patient elects to proceed 4. Acceptable Candidate 5. Schedule Procedure Y N Y N Y N Y N Y N Y N			
LT Zent, John W, OD USN		No Lamp Exam R Normal Normal L Normal Normal R Retina / Fundus L Retina / Fundus flat retinas, hems			
Right: K-Cal: CCT: Flap Thickness: CCT - Flap: Est Abl Depth: RSB: Left: K-Cal: CCT: Flap Thickness: CCT - Flap: Est Abl Depth: RSB:					
Planned Treatment: STANDARD or CUSTOM or MMC or PRK or LASIK or PRK or PRK or PRK Planned Surgery Date:					
Right: W to W: Name Adj: RSB: Left: W to W: Name Adj: RSB:					
Blind Zones Enabled Larger Zones Enabled					
Name: MERWIN, DANIEL D. SSN: [REDACTED] DOB: [REDACTED] 1985 Appt Date: 16 MAR 2011					
Occupation: Bartlett H. Hayes, Col, USAF, MC, FS 81 MSGS CC Commander, Surgical Operations Squadron Age: [REDACTED] Pn: [REDACTED] Race: Hoon Jung, Maj, USAF, MC 81 MSGS SGCXE Chief, Ophthalmology & Refractive Surgery Branch: [REDACTED] Rank: [REDACTED] Grade: [REDACTED] Notes: Jonathan Ellis, Capt, USAF, MC 81 MSGS SGCX Staff Ophthalmologist James C. Hartley, Capt, USAF, MC 81 MSGS SGCX Staff Ophthalmologist					

Created: 16 Aug 2017

Name:
Last 4:
DOB:

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017
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Page 880
AR 2867

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 Feb 2011 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-1189878 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC NAS Pensacola**
 Patient Status: **Outpatient**

Date: **17 Feb 2011 1000 CST**
 Clinic: **NASP OPTOMETRY CLINIC**

Appt Type: **SPEC**
 Provider: **ZENT,JOHN W**

Reason for Appointment: NASP 3600/ROUT EYE EXAM/ME DLIST/CTD/20/REC/UOD

Appointment Comments:
 CAC-EH

AutoCites Refreshed by KIRK,CAMERON P @ 17 Feb 2011 0947 CST**Problems****Chronic:**

- Dyspnea
- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Social History

No Social History Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Registry Items**Screening** Written by KIRK,CAMERON P @ 17 Feb 2011 0947 CST**Reason For Appointment:** NASP 3600/ROUT EYE EXAM/ME DLIST/CTD/20/REC/UOD

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Allergen information verified by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Vitals**Vitals** Written by KIRK, CAMERON P @ 17 Feb 2011 0947 CST

Tobacco Use: No, Pain Scale: 0 Pain Free

SO Note Written by KIRK, CAMERON P @ 17 Feb 2011 0947 CST**Reason for Visit**

Visit for: military services physical.

History of present illness

The Patient is a 26 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Reliability of source of patient information was good.

In the Navy and currently on active duty. Visit is not deployment-related. Paygrade E5.

Past medical/surgical history**Reported History:**

Surgical / procedural: Surgical / procedural history reviewed and updated in Patient's Problem List.

Reported medications: Medication history reviewed and updated in Medication module.

Physical trauma: No trauma to the eye.

Diagnosis History:

No cataract

No macular degeneration

No glaucoma.

No hypertension.

No hyperlipidemia.

No diabetes mellitus

Family history

Family medical history: Reviewed in Problem List.

Review of systems**Cardiovascular symptoms:** No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Physical findings****Eyes:**

General/bilateral:

Visual Assessment: • Lensometry:

OD: -2.25 -0.50 x096

OS: -2.50 -0.25 x080.

Right eye:

Visual Assessment:

Distance right acuity with current Rx: 20/

Right eye:

Intraocular Pressure:

Value

20

Value

15 mmHg

Left eye:

Visual Assessment:

Distance left acuity with current Rx: 20/

Left eye:

Intraocular Pressure:

Value

20

Value

16 mmHg

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by ZENT, JOHN W @ 17 Feb 2011 1043 CST**1. Myopia:** Pt. educated about CRS and its complications/benefits/alternatives. PRK and LASIK were discussed. Pt. K reading are near limit for CRS.

Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1
 -Corneal Pachymetry Both Eyes x 1

Disposition Written by ZENT, JOHN W @ 17 Feb 2011 1044 CST**Released w/o Limitations**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Follow up: 1 to 2 month(s) or sooner if there are problems. - Comments: complete screening after 30 days out of CLs**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by ZENT,JOHN W @ 17 Feb 2011 1042 CST

Chief Complaint:		Pt. here for CRS screening, no visual or astenopic complaints. 1.5 year retainability, wore CLs today						
Significant History:		(see above) -f/f, -dryness, -itch, -burn						
Confrontation Fields:		FTFC Central & Peripheral OD, OS		Cover Test:		cc	Ortho distance	Ortho' near
Extraocular Muscles:		Smooth, Accurate, Full, No Pain		Pupils:		Equal	Round	4+ Reactivity
auto		Sphere		Cylinder		Axis		DVA
OD	-2.50	-0.50	099	OD	20/20	20/20		
OS	-2.50	-0.50	070	OS	20/20			
Prism		Add		NVA				
OD				OD	20/20	20/20		
OS				OS	20/20			
						Drops: @		
						0.5% Proparacaine		
						0.5% Tropicamide		
						2.5% Phenylephrine		
						1% Cyclopentolate		
						0.25%/0.4% Fluress		
Slit Lamp:		90D		Undilated		Ancillary Testing		
L/L	OD	Clear		OS	Clear		PACHYMETRY: OD 586 OS 576	
Conj.	OD	Clear		OS	Clear		Auto Ks: OD 40.25 @ 084 40.75 @174	
Cornea	OD	Clear		OS	Clear		OS 40.75 sphere	
Tear Layer	OD	Clear		OS	Clear			
A/C	D & Q	4X4	4X4	D & Q			Final Spec Rx	
Iris	Clear			Clear	OD	-2.50	-0.50	099
Lens	Clear		Clear		OS	-2.50	-0.50	070
Vitreous	Clear		Clear					pl
C/D	.3/.3		.3/.3					pl
Margins	Pink/Distinct		Pink/Distinct					PD
Macula	+FR, Clear		+FR, Clear					
A/V	2/3		2/3					
Periphery	Not Assessed		Not Assessed					
Notes		-Medication reconciliation was performed. However, no new medications were added and no old medications have been discontinued by the provider. Pt was offered a copy of med list.						
		Pt ed @ S/S ret tear/detach						

Signed By ZENT, JOHN W (Physician/Workstation) @ 17 Feb 2011 1044

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

16 Feb 2011 at NH Pensacola FL, Pulmonary Disease Clinic by LEWIS, CHRISTOPHER T

Encounter ID: PENS-1168201 Primary Dx: Difficulty breathing (dyspnea)

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**Date: **16 Feb 2011 0830 CST**
Clinic: **PULMONARY DISEASE CLINIC**Appt Type: **SPEC**
Provider: **LEWIS, CHRISTOPHER T****Reason for Appointment:** ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN**Appointment Comments:**
CAC-CN**Screening** Written by LEE, BRANDON G @ 16 Feb 2011 0803 CST**Reason For Appointment:** ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN

Allergen information verified by LEE, BRANDON G @ 16 Feb 2011 0803 CST

Vitals**Vitals** Written by LEE, BRANDON G @ 16 Feb 2011 0803 CSTBP: 123/74, HR: 85, RR: 15, HT: 69 in, WT: 157 lbs, SpO₂: 98%, BMI: 23.18, BSA: 1.864 square meters,
Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free**SO Note** Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0905 CST**Chief complaint**

The Chief Complaint is: Chest tightness.

History of present illnessThe Patient is a 26 year old male.
He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression Screen: Negative PHQ-2 (Score < 3).
Pt is a 26 yo male with a history of allergies and childhood asthma. He notes a history of asthma in childhood which was associated with allergic symptoms. He remarks on 1 hospitalization for his asthma as a child but none since. Since the age of 8 he has been doing well and was not maintained on any inhalers. He is very active and is an active marathoner. Recently he has noted increased symptoms of chest tightness associated with exposure to cats and dogs. He was briefly treated with advair, but is currently being maintained on zyrtec and flonase as well as allergen avoidance with excellent control of his symptoms. He will have one weekly chest tightness and albuterol use, but is otherwise doing well, and recently completed a marathon. He presents for routine follow up.

Pain Severity 0 / 10.

Past medical/surgical history**Reported History:**

Past Medical History:

- 1) childhood asthma
- 2) allergies.

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history 1) T&A.

Reported medications: Medication history Zyrtec t1 tab po qd

Flonase.

Personal history

-Tob: none

-EtOH: none

Originally from California. Lived in PA and NJ. USN for 5 years. Works as a cryptologist. Deployed to Japan recently, but no other travel or occupational exposure.

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Review of systems**Military service:** Visit is not deployment-related Location:

Date:

Systemic symptoms: Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.**Pulmonary symptoms:** No dyspnea, not coughing up sputum, no hemoptysis, and no wheezing.**Gastrointestinal symptoms:** No heartburn, no nausea, and no vomiting.**Physical findings**

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vital signs:

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Awake. ° Alert. ° In no acute distress.

Neck:

Palpation: ° Of the neck revealed no abnormalities.

Nose:

General/bilateral:

Nasal Discharge: ° No nasal discharge seen.

Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: ° Uvula was not enlarged. ° Tonsils were not enlarged.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° No wheezing was heard. ° No rhonchi were heard. ° No prolonged expiratory time. ° No rales/crackles were heard.

Cardiovascular system:

Jugular Venous Pressure: ° JVP was normal.

Jugular Venous Distention: ° JVD not increased.

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° S1 normal. ° S2 normal. ° No S3 heard. ° No S4 heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Palpation: • Abdomen was not soft. ° No abdominal tenderness.

Skin:

° No generalized cyanosis.

A/P Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0930 CST

1. difficulty breathing (dyspnea): Pt is a 26 yo male with a history of childhood asthma and allergy type symptoms. His clinical history is suggestive of mild intermittent asthma, and his symptoms are under excellent control with control of his allergies with zyrtec and flonase. He will continue on these medications and prn albuterol for now, and will be referred for baseline PFTs and methacholine challenge study to definitive rule in/out asthma. Even with a positive study, his symptoms are under excellent control on his current therapy, and if needed he can be successful controlled with an inhaled steroid. He is highly functional, and even if a diagnosis of asthma is established this in no way should impact upon his fitness for duty. He is currently fit for duty and fit for world wide deployment. He will follow up in 3-4 weeks to review the results of his PFTs.

Consult(s): -Referred To: PULMONARY FUNCTION STUDIES (Routine) Specialty: PULMONARY DISEASE Clinic:
PULMONARY FUNCTION LAB Primary Diagnosis: difficulty breathing (dyspnea)

Disposition Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0931 CST**Released w/o Limitations****Administrative Options:** Consultation requested**Note Written by AEPPLI, CAROL @ 16 Feb 2011 0755 CST****Consult Order****Referring Provider:** BROWN, TRAVIS S**Date of Request:** 08 Feb 2011**Priority:** Routine**Provisional Diagnosis:**

ASTHMA EXTRINSIC

Reason for Request:

LVM ON CELL PHONE 25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment. thank you. contact phone # 850 292 7149

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 16 Feb 2011 0931**CHANGE HISTORY**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

The following SO Note Was Overwritten by LEWIS,CHRISTOPHER T @ 16 Feb 2011 0905 CST:

SO Note Written by LEE,BRANDON G @ 16 Feb 2011 0806 CST

Chief complaint

The Chief Complaint is: ASTHMA.

History of present illness

The Patient is a 26 year old male.

He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression Screen: Negative PHQ-2 (Score < 3).

Pain Severity 0 / 10.

Past medical/surgical history**Reported History:**

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history N/A.

Reported medications: Medication history Zrytec t1 tab po qd

Flonase.

Personal history

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Review of systems

Military service: Visit is not deployment-related Location:

Date:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Page 886
AR 2873

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Feb 2011 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S

Encounter ID: PENS-1057895

Primary Dx:

Visit for: occupational health / fitness exam

Patient: **MERWIN, DANIEL DENNIS**Date: **08 Feb 2011 0830 CST**Appt Type: **WELL**Treatment Facility: **NH Pensacola**Clinic: **DEPLOYMENT HEALTH CLINIC**Provider: **BROWN, TRAVIS SCOTT**Patient Status: **Outpatient****Reason for Appointment:** pha/jacc/15 min/rec/rx/ct**Appointment Comments:**

cac-cjm

AutoCites Refreshed by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST**Problems****Chronic:**

- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST**Reason For Appointment:** pha/jacc/15 min/rec/rx/ct

Allergen information verified by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : pha;**Vitals**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals Written by JOHNSONCRUTCHFIELD,ANDREA C @ 08 Feb 2011 0835 CST

BP: 120/74 Left Arm, Adult Cuff, HR: 58 Regular, Radial Artery, RR: 20, HT: 69 in Actual, With Shoes,

WT: 156 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/25, Corr OS: 20/25, Corr OU: 20/25, BMI: 23.04, BSA: 1.859 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by BROWN,TRAVIS SCOTT @ 08 Feb 2011 1027 CST**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 25 year old male.

Barriers to learning were identified as: None

Barriers considered were, social, cultural, emotional, motivational, physical, religious, cognitive and language.

Problem list reviewed.

Member has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results.

Current medication

Albuterol HFA inhaler prn

Advair prn

Zyrtec

Flonase

Past medical/surgical history**Reported History:**

Past Medical History:

Fracture of right 5th phalanx 2008 - resolved.

Surgical / procedural: Surgical / procedural history Past Surgical History: noncontributory.

Review of systems**Cardiovascular symptoms:** No cardiovascular symptoms.**Gastrointestinal symptoms:** No gastrointestinal symptoms.**Genitourinary symptoms:** No genitourinary symptoms.**Musculoskeletal symptoms:** No musculoskeletal symptoms.**Psychological symptoms:** No psychological symptoms.**A/P** Written by BROWN,TRAVIS S @ 08 Feb 2011 1031 CST**1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION):** Annual TB risk assessment completed with responses determined to be minimal risk. No further testing recommended. See NAVMED 6224/8.

Record review completed. Reviewed deployment health history and individual medical readiness. Counseling on avoidable health risk factors and screening per clinical preventive service guidelines provided.

Counseled on triglyceride results from PHA and discussed at length ways to improve through lifestyle changes; exercise, weight management, supplements and better nutrition. Teaching materials given.

No recent fasting glucose done, will repeat lipids in 2 months after he makes lifestyle modifications and get fasting glucose at that time.

Contact phone # 850 292 7149

Medically fit for full duty.

Laboratory(ies): -GLUCOSE FASTING (Routine) Ordered By: BROWN,TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT; LIPID PANEL (HDL,LDL,CHOL,TRIG (Routine) Ordered By: BROWN,TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

2. ASTHMA EXTRINSIC (EXTRINSIC ASTHMA, UNSPECIFIED, MILD): Pulmonary consult placed to determine diagnosis, treatment recommendations and any deployment limiting concerns.

Consult(s): -Referred To: PULMONARY DISEASES CONSULT (Routine) Specialty: PULMONARY DISEASE Clinic: PULMONARY DISEASE CLINIC Primary Diagnosis: ASTHMA EXTRINSIC

Disposition Written by BROWN,TRAVIS S @ 08 Feb 2011 1032 CST**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By BROWN, TRAVIS S (NP-C, NH Pensacola FL) @ 08 Feb 2011 1032

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Jan 2011 at NH Pensacola FL, Corry Prime Care by WIEDL, ERICA KITCHELL

Encounter ID: PENS-927132 Primary Dx: ALLERGIC RHINITIS

Patient: MERWIN, DANIEL DENNIS

Date: 24 Jan 2011 1250 CST

Appt Type: ACUT

Treatment Facility: NBHC NTTC

Clinic: CORRY PRIME CARE

Provider: MILLER, ERICA KITCHELL

Pensacola

Patient Status: Outpatient

Reason for Appointment: MED REFILL

Appointment Comments:

CSW

AutoCites Refreshed by MILLER, ERICA K @ 24 Jan 2011 1312 CST**Problems****Chronic:**

- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP 4 of 4 BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

VitalsVitals Written by STANDLEY, CHAD J @ 24 Jan 2011 1313 CST

BP: 120/60, HR: 64, RR: 14, T: 98.3 °F, HT: 69 in, WT: 147 lbs, BMI: 21.71, BSA: 1.812 square meters, Tobacco Use: No, Alcohol Use: No,
Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by MILLER, ERICA K @ 24 Jan 2011 1312 CST**Questionnaires**SO Note Written by STANDLEY, CHAD J @ 24 Jan 2011 1320 CST**Chief complaint**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

The Chief Complaint is: Med refill.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical for a refill on advair. pt states that he has no negative reactions to the medication. pt states that he only uses advair once a day.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Advair, albuterol

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergies, asthma. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

Behavioral history: No tobacco use.

Alcohol: Not using alcohol.

Family history

Family medical history: Reviewed

Review of systems**Systemic symptoms:** No fever and no chills.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

° Normal. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

° No learning disability was noted (barriers to learning).

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by MILLER,ERICA K @ 24 Jan 2011 1341 CST**1. ALLERGIC RHINITIS**

Medication(s):

-FLONASE (TYPE)--NAS 0.05% SPRA - INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3

Qt: 1 Rf: 3 Ordered By: MILLER,ERICA K Ordering Provider: MILLER, ERICA KITCHELL

-CETIRIZINE (ZYRTEC)--PO 10MG TAB - T1 TAB PO HS #30 RF5 Qt: 30 Rf: 5 Ordered By:

MILLER,ERICA K Ordering Provider: MILLER, ERICA KITCHELL

Disposition Last updated by MILLER,ERICA K @ 24 Jan 2011 1352 CST**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 25 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**Note** Written by MILLER,ERICA K @ 24 Jan 2011 1344 CST

Pt is a 25 yo AD WM with a hx of childhood SAR/possible asthma sx. His congestion and breathing troubles are triggered by proximity of cats and dogs. Pt had no asthma/SAR sx while overseas for 3 years and not exposed to animals. Pt had return of sx

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

when dating and individual with cats and recently a roommate attained a dog. Pt was aggressively tx with albuterol and high dose advair for resp sx. At the time he was on antihistamines for a dermatologic condition. Over time he was only using one puff of advair daily for sx that occurred only when reclining for the evening. Pt denies any wheezing sx. Pt is s/p tonsilectomy (has adenoids) as a child.

Alert AF NAD VSS

Heent sinus nt tms wnl nares pale boggy clear drainage

OP healed tonsilectomy no edema

neck supple

skin type one red hair/blue eyes.

Described constellation and continuum of allergy, atopy, asthma. Pt seems to have very good control of sx when not around critters. To rule out severe asthma and possible medical DQ pt will be managed on oral antihistamines and intranasal steroids. If there is further difficulty breathing, pt had albuterol and should report to medical. Consider methacholine challenge and allergen testing if sx are not controlled. Consider Adenoidectomy as sx are worst when reclining. Pt understands and agrees with plan. Pt will f/u as needed.

Signed By MILLER, ERICA K (Physician, NBHC Cherry Point) @ 24 Jan 2011 1352

CHANGE HISTORY

The following Disposition Note Was Overwritten by MILLER, ERICA K @ 24 Jan 2011 1352 CST:

The Disposition section was last updated by MILLER, ERICA K @ 24 Jan 2011 1352 CST - see above. Previous Version of Disposition section was entered/updated by STANDLEY, CHAD J @ 24 Jan 2011 1312 CST.

Released w/o Limitations

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.

No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Nov 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-807839

Primary Dx:

SKIN NEOPLASM UNCERTAIN
BEHAVIORPatient: **MERWIN, DANIEL DENNIS**Treatment Facility: **NH Pensacola**Patient Status: **Outpatient**Date: **24 Nov 2010 0830 CST**Clinic: **DERMATOLOGY CLINIC**Appt Type: **EST\$**Provider: **BRUMWELL, ERIC****Reason for Appointment:** f/u skin check**Appointment Comments:**

kec

AutoCites Refreshed by BRUMWELL, ERIC @ 24 Nov 2010 0834 CST**Problems****Chronic:**

- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP 4 of 4 BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

SO Note Written by BRUMWELL, ERIC @ 24 Nov 2010 0834 CST**Chief complaint**

The Chief Complaint is: PT KNOWN TO ME-- RED HEAD, NUMEROUS EPHILIDES AND H/O SEVERE PROLONGED SUN EXPOSURE W/ NEW DARK LESION ON LOWER MUCOSAL LIP.

Reason for Visit

Visit for: follow-up exam (Noise Free F/U 1 or F/U2). Visit for: screening for dermatological disorders.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Military service.

Allergies

An allergy to drugs.

Current medication

No meds.

Past medical/surgical history**Reported History:**

Reviewed.

Reported medications: Taking medication MEDICINE RECONCILIATION PERFORMED.

Diagnosis History:

No malignant melanoma of the skin

No basal cell carcinoma of the skin

No squamous cell carcinoma of the skin

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems**Systemic symptoms:** No systemic symptoms and not feeling tired (fatigue). No chills.**Head symptoms:** No concerns about cosmetic appearance.**Gastrointestinal symptoms:** No nausea and no vomiting.**Physical findings****Vital signs:**

• Pain level (0-10): Reviewed.

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Alert. ° Oriented to time, place, and person. ° Well nourished. ° Well hydrated.

Oral cavity:

Lips: • Lower lip was abnormal 3MM DARK BROWN MACULE.

Pharynx:

Oropharynx: ° Normal.

Lymph Nodes:

° No adenopathy IN H/N.

Neurological:

Speech: ° Normal.

Psychiatric Exam:

Affect: ° Congruent with the mood.

Skin:

° Normal except as noted EXAM LIMITED TO HEAD/NECK-- SEE MUCOSAL LIP FINDING.

Tests

UNIVERSAL PROTOCOL REQUIREMENTS WERE MET

Shave Biopsy ~

site verified with patient: Time <0830 >~site labeled with surgical marking pen~consent signed~area cleansed/prepped~anesthesia-
 1% lidocaine with epi~hemostasis with drysol~closure: < >~bandage applied~wound care discussed~Estimated Blood Loss: <2 ml
 ~pt educated on wound care.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient voices
 understanding and all questions were answered.

A/P Last Updated by BRUMWELL, ERIC @ 24 Nov 2010 0840 CST

1. SKIN NEOPLASM UNCERTAIN BEHAVIOR: LIP LESION APPEARS TO BE AN EPILIDE/SOLAR LENTIGO HOWEVER H/O
 CHANGE WARRANTS BX

Procedure(s):	-Biopsy Skin x 1
Laboratory(ies):	-TISSUE EXAM (Routine)
Patient Instruction(s):	-Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure
	-Avoid Exposure Bright Sunlight
	-Change Dressing Daily As Instructed
	-Clean Incision As Instructed
	-Education And Counseling
	-Instructions For Patient

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

-Post-Op Teaching About Wound Care

2. visit for: screening exam malignant neoplasm skin: D/W PT ABCDS,MSE, SUN AVOIDANCE, NEW/CHANGING LESIONS**Disposition** Written by BRUMWELL,ERIC @ 24 Nov 2010 0840 CST**Released w/o Limitations****Follow up:** 1 to 2 week(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by KENT,AHMAD J @ 24 Nov 2010 0840 CST

MEDICAL RECORD		REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES	
A. IDENTIFICATION			
1a. (Check all applicable boxes)		1b. DESCRIBE	
<input checked="" type="checkbox"/> OPERATION OR PROCEDURE	<input type="checkbox"/> SEDATION	Shave biopsy	
<input checked="" type="checkbox"/> ANESTHESIA	<input type="checkbox"/> TRANSFUSION	↓ mucous Lip	
B. STATEMENT OF REQUEST			
2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be described (operation or procedure in layman's language)			
After cleaning and local anesthesia, a piece of tissue will be sliced off with a surgical blade, either scooped out below surface or shaved flush with skin surface. A scar will form. Risks also include bleeding, infection and recurrence.			
which is to be performed by or under the direction of Dr. Smith			
3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.			
4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.			
5. Exceptions to surgery or anesthesia, if any are: none			
6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.			
7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by a authorized personnel, subject to the following conditions:			
a. The name of the patient and his/her family is not used to identify said pictures.			
b. Said pictures be used only for purposes for medical/dental study or research.			
8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.			
(Cross out any parts above which are not appropriate)			
C. SIGNATURES			
(Appropriate items in parts A and B must be completed before signing)			
9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment and significant alternative therapies.			
(Signature of Counseling Physician/Dentist)			
10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.			
(Signature of Patient)		24 NOV 10	
HA CONLEY		x [Signature]	
11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)			
Sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.			
(Signature of Sponsor, Legal Guardian)		(Date and Time)	
PATIENT'S IDENTIFICATION (For typed or written entries, give Name - last first middle, (Initials) (State or other Hospital)		REGISTERING (WARD NO)	
MERWIN, DANIEL DENNIS		20/ [REDACTED]	
24 Nov 2010, 0837			
OPTIONAL FORM 522 (REV 7/2008)			
Prescribed by CDA, 15881 NR 441 (FR) 102-114-1003			
DoD Exception to OF 522 approved by CDA			

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

PRE-PROCEDURE CHECKLIST
UNIVERSAL PROTOCOL

I. PHYSICIAN'S PRE-PROCEDURE ASSESSMENT

Procedure: Stare

II. UNIVERSAL PROTOCOL TIMEOUT: Verifying the Correct Patient - Correct Procedure - Correct Procedure Site Checklist.

1. **Pre-procedural verification:** Patient states name and DOB which is compared to the following (as appropriate):
- Documents- History & Physical, Nursing Assessment
 - Consent Form
 - Diagnostic Test Results
 - Blood Products, implants, devices, Special Equipment

YES ☒

2. **Site Marking:** (patient involvement if possible)
- By provider doing the procedure

YES ☒ N/A ☒

"TIME OUT" CONDUCTED AUDIBLY w/team

YES ☒ N/A ☒

Antibiotics/fluid for irrigation (if needed)

☒

Patient- 2 identifiers (name and DOB)

☒

Procedure- correct procedure documented on consent

☒

Laterality- Surgical site marked

☒

Equipment- if needed

☒

Position- Verified

☒

Implants- if needed

☒

Exams- Diagnostic tests (radiographs etc.)

☒

Safety Precautions- Based upon outpatient history and profile

☒

Comments (optional)

Provider Signature: [Signature]Date/Time: 11/24/10

Pat Info:

Signed By **BRUMWELL, ERIC** (Physician/Workstation) @ 24 Nov 2010 1124

CHANGE HISTORY

The following SO Note Was Overwritten by BRUMWELL, ERIC @ 24 Nov 2010 0834 CST:

SO Note Written by BUROKER, JONATHAN G @ 24 Nov 2010 0827 CST

Chief complaint

The Chief Complaint is: Chick check.

Reason for Visit

Visit for: follow-up exam (Noise Free F/U 1 or F/U2).

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Current medication

No meds.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**- [REDACTED] DoD ID: 1286180538 Created: 16 Aug 2017

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

- Pain level (0-10): Reviewed.

- Current vital signs reviewed.

General appearance:

- Well-appearing. ◦ Alert. ◦ Oriented to time, place, and person. ◦ Well nourished. ◦ Well hydrated.

Therapy

- No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

15 Nov 2010 at NH Pensacola FL, Corry Prime Care by WILLIAMS, TREVOR MICHAEL

Encounter ID: PENS-791398

Primary Dx:

Vaccines Prophylactic Need Against
InfluenzaPatient: **MERWIN, DANIEL DENNIS**Date: **15 Nov 2010 1336 CST**Appt Type: **WELL**Treatment Facility: **NBHC NTTC**Clinic: **CORRY PRIME CARE**Provider: **WILLIAMS, TREVOR M****Pensacola**Patient Status: **Outpatient****Reason for Appointment:** flumist**Appointment Comments:** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1336 CST

lwc

Vitals**Vitals** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1339 CST**Comments:** n/a**SO Note** Written by CRUMPTON, LATAIJA W @ 15 Nov 2010 1339 CST**Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 25 year old male.

He reported: Past medical history reviewed.

Allergies

Reviewed an allergy. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

: up to date.

- Received dose of influenza live virus vaccine, for intranasal use Vaccine lot #, manufacturer, and location given recorded in Immunization module. Patient provided and reviewed current CDC Vaccine Information Sheet. Vaccine inspected for discoloration/particulates and Exp Date verified

Past medical/surgical history**Reported History:**

Recent events: No active illness.

Review of systems**Systemic symptoms:** No fever.**A/P** Last Updated by CRUMPTON, LATAIJA W @ 15 Nov 2010 1340 CST**1. Vaccines Prophylactic Need Against Influenza****2. Parent Education: Immunizations (MEDICATION EDUCATION)**

Procedure(s): -Influenza Virus Vaccine Live Intranasal x 1

-Immunization Administration One Vaccine x 1

Disposition Last Updated by CRUMPTON, LATAIJA W @ 15 Nov 2010 1341 CST**Released w/o Limitations**

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By WILLIAMS, TREVOR M** (Physician/Workstation) @ 15 Nov 2010 1401

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

13 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-731275 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **13 Oct 2010 0845 CDT**
 Clinic: **DERMATOLOGY CLINIC**

Appt Type: **EST\$**
 Provider: **BRUMWELL, ERIC**

Reason for Appointment: F/u biopsy**Appointment Comments:**

tjn

AutoCites Refreshed by BRUMWELL, ERIC @ 13 Oct 2010 0838 CDT**Problems****Chronic:**

- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEFOXENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

SO Note Written by BRUMWELL, ERIC @ 13 Oct 2010 0854 CDT**Chief complaint**

The Chief Complaint is: FOLLICULITIS--NO NEW EPISODES BUT HAS NBOT BEEN OUT IN SUN OR IN WATER LATELY.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

Military service in the Navy, currently on active duty, and paygrade E5.

Concerns about cosmetic appearance.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

An allergy to drugs.

Current medication

Allegra
 albuterol
 advair.

Past medical/surgical history

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Reported History:

Reported medications: Including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Currently taking medication MEDICINE RECONCILIATION PERFORMED.

Personal history

-Tob:n

-EtOH:y

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems

Systemic symptoms: No systemic symptoms and not feeling tired (fatigue). No chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Physical findings**Vital signs:**

- Pain level (0-10): Reviewed.

- Current vital signs reviewed.

General appearance:

- Well-appearing.
- Alert.
- Oriented to time, place, and person.
- Well nourished.
- Well hydrated.

Neurological:

- Speech: Normal.

Psychiatric Exam:

- Affect: Congruent with the mood.

Skin:

- Normal except as noted NO ACTIVE SKIN LESIONS.

Therapy

- Herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Lab Result Cited by BRUMWELL,ERIC @ 13 Oct 2010 0839 CDT**Tissue Exam**

Date Collected:	28 Sep 2010 0821	
POC Enc:	E847233	
Enc Fac:	NH Pensacola FL	
Clinician:	BRUMWELL, ERIC	
Status:	Certify	
Procedure:	TISSUE EXAM	
Order #:	101005-04215	
Provider:	BRUMWELL, ERIC	
Ordered Date:	05 Oct 2010 1421	
Priority:	ROUTINE	
Specimen:	TISSUE	
Resulted Date:	05 Oct 2010 1421.1-0500	
100929 SP 2595	Col: 28Sep10@0821	TISSUE (TISSUE)
Hcp:	BRUMWELL, ERIC	Req Loc: DERMATOL
TISSUE E	C: DMR05Oct10@1421	
	CoPath Report	
Patient:	MERWIN, DANIEL DENNIS	Specimen #:
S10-2595		
Accessioned:	09/29/10	
Pathologist:	DAVID M ROGERS, LT MC USN	
SPECIMEN:		
	A: SKIN, CHEST, PUNCH BX B: SKIN, BACK, PUNCH BX	
CLINICAL DIAGNOSIS AND HISTORY:		
AFTER EXPOSURE TO WATER	A/B- PUSTULES ON A-CHEST AND B-BACK THAT DEVELOP	
TRUNK AND FACE--HAS	AND SUN AT BEACH--PT HAS THESE LESIONS ON UPPER	
AREAS	HISTORY OF SEVERE SUNBURN AS A CHILD IN THESE	
PRE-OPERATIVE DIAGNOSIS:		

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

FUNGAL STAINS AS WELL

POST-OPERATIVE DIAGNOSIS:

GROSS DESCRIPTION:

patient's name "Merwin," and

skin excised to a depth

0.3cm creamy-white lesion.

patient's name "Merwin," and

tan skin excised to a

a 0.3cm white-tan area.

FINAL DIAGNOSIS:

A) SKIN, "CHEST," PUNCH BIOPSY:

CONSISTENT WITH ACUTE

B) SKIN, "RIGHT BACK," PUNCH BIOPSY:

CONSISTENT WITH ACUTE

Electronically Signed **

Comment:

Langerhans' cells with

microabscess cavities is

biopsies from both the

units. These findings are

stains are

MILIARIA PUSTULOSA VS FOLLICULITIS--PLEASE DO

Operative Findings: SAA

Post-operative Diagnosis: SAA

A) Received in Formalin, labeled with the

designated "Chest" is a 0.4cm punch biopsy of tan

of 0.5cm. The skin surface is remarkable for a

Bisected. 2/1/NG hh

B) Received in Formalin, labeled with the

designated "Right Back" is a 0.5cm punch biopsy of

depth of 0.6cm. The skin surface is remarkable for

Bisected. 2/1/NG hh

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES,

FOLLICULITIS.

- SEE COMMENT.

- SKIN WITH INTRAFOLLICULAR MICROABSCESSES,

FOLLICULITIS.

- SEE COMMENT.

dmr/10/05/10

** Report

DAVID M ROGERS, LT MC USN

A mixture of acute inflammatory cells and

associated necroinflammatory debris forming

present within the infundibulum of follicles in

chest and back, extending into the sebaceous

consistent with an acute folliculitis. Fungal

non-contributory.

SNOMED CODES

1. P1148; T02424

2. M41780; M47401; T01000

3. E4000

4. P1148; T02450

5. M41780; M47401; T01000

6. E4000

CPT Codes:

; 88305 ; TISSUE LEVEL IV

; 88305 ; TISSUE LEVEL IV

; 88313 ; SPECIAL STAINS OTHER

; 88313 ; SPECIAL STAINS OTHER

Lab Result Cited by BRUMWELL, ERIC @ 13 Oct 2010 0839 CDT**Tissue Culture+Smear**

Order # 100928-00627 (NH Pensacola)

Filler # 100928 MI 3893 (NH Pensacola)

Status: Final

Ordering Provider: BRUMWELL, ERIC

Priority: ROUTINE

Date Ordered: 28 Sep 2010 0827

Date Resulted: 01 Oct 2010 0918

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

COLLECT_SAMPLE: TISSUE
 Order Comment: PLEASE DO FUNGAL, AFB AND BACTERIAL

BACTERIOLOGY RESULT (CULT TISSUE -- Final): NO GROWTH IN 24 HOURS
 BACTERIOLOGY RESULT (CULT TISSUE -- Final): NO GROWTH IN 48 HOURS
 BACTERIOLOGY RESULT (CULT TISSUE -- Final): FINAL REPORT RESULTS: NO GROWTH AT 72

HOURS

GRAM STAIN (GRAM STAIN -- Final): NO WBCs OR ORGANISMS NOTED

Specimen: Tissue
 Collected: 28 Sep 2010 0851

Results: Final report

Lab Result Cited by BRUMWELL,ERIC @ 13 Oct 2010 0839 CDT**Acid Fast Bacilli Culture**

Order # 100928-00798 (NH Pensacola)
 Filler # 100928 STB 48 (NH Pensacola)
 Status: Intermediate
 Ordering Provider: BRUMWELL, ERIC
 Priority: ROUTINE
 Date Ordered: 28 Sep 2010 0847
 Date Resulted: 30 Sep 2010 0938
 COLLECT_SAMPLE: TISSUE
 Order Comment: left back

MYCOBACTERIUM: Negative for M. tuberculosis complex rRNA
 MYCOBACTERIUM: Performed by Fl. Dept. of Health Lab. Jacksonville
 ACID FAST STAIN: No Acid Fast Bacilli seen on smear.
 ACID FAST STAIN: Performed by Fl. Dept. of Health Lab. Jacksonville

Specimen: Tissue
 Collected: 28 Sep 2010 0851

Results: I

Lab Result Cited by BRUMWELL,ERIC @ 13 Oct 2010 0839 CDT**Wound Culture+Smear**

Order # 100928-00865 (NH Pensacola)
 Filler # 100928 MI 3904 (NH Pensacola)
 Status: Final
 Ordering Provider: BRUMWELL, ERIC
 Priority: ROUTINE
 Date Ordered: 28 Sep 2010 0854
 Date Resulted: 28 Sep 2010 1134
 COLLECT_SAMPLE: SKIN LESION
 Order Comment: FROM PUSTULE OF BACK

GRAM STAIN (GRAM STAIN -- Final): NO WBCs OR ORGANISMS NOTED

BACTERIOLOGY RESULT (CULT AEROBIC WOUND -- Final): NO GROWTH IN 24 HOURS
 BACTERIOLOGY RESULT (CULT AEROBIC WOUND -- Final): FINAL REPORT RESULTS: NO

GROWTH IN 48 HOURS

Specimen: Skin
 Collected: 28 Sep 2010 0954

Results: Final report

A/P Written by BRUMWELL,ERIC @ 13 Oct 2010 0901 CDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

1. FOLLICULITIS: PATH/LABS SHOW ONLY STERILE FOLLICULITIS-- SUSPECT PITYROSPORUM DUE TO LOCATION

WILL UNDERGO TRIAL OF TOPICAL KETOCONAZOLE SHAMPOO AND HAVE PT F/U FOR FURTHER EVAL AFTER THE HOLIDAYS

Medication(s): -NON-FORMULARY DRUG REQUEST (NFDR)--MISC - KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4 Qt: 2 Rf: 4 Start Date: 10/12/2010
 Comment: DERM REQUIRES

Patient Instruction(s): -Instructions For Patient
 -Education And Counseling

Disposition Written by BRUMWELL,ERIC @ 13 Oct 2010 0901 CDT**Released w/o Limitations****Follow up:** 3 month(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** BRUMWELL, ERIC (Physician/Workstation) @ 13 Oct 2010 0901**CHANGE HISTORY***The following SO Note Was Overwritten by BRUMWELL,ERIC @ 13 Oct 2010 0854 CDT:**SO Note Written by GIBSON,CHARLES A @ 13 Oct 2010 0842 CDT***Chief complaint**

The Chief Complaint is: Fu biopsy.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy, currently on active duty, and paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medicationAllegra
albuterol
advair.**Personal history**

-Tob:n

-EtOH:y

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Alert. ° Oriented to time, place, and person. ° Well nourished. ° Well hydrated.

Therapy

• Herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Oct 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-715986 Primary Dx: Removal Of Sutures

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **04 Oct 2010 0755 CDT**
 Clinic: **DERMATOLOGY CLINIC**

Appt Type: **EST\$**
 Provider: **BRUMWELL, ERIC**

Reason for Appointment: Suture Removal**AutoCites** Refreshed by BRUMWELL, ERIC @ 04 Oct 2010 0837 CDT**Problems****Chronic:**

- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

A/P Written by BRUMWELL, ERIC @ 04 Oct 2010 0838 CDT**1. Removal Of Sutures****Disposition** Written by BRUMWELL, ERIC @ 04 Oct 2010 0838 CDT**Released w/o Limitations****Follow up:** 2 week(s) or sooner if there are problems. - Comments: TO REVIEW ALL LABS WHEN BACK**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** BRUMWELL, ERIC (Physician/Workstation) @ 04 Oct 2010 0838

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

28 Sep 2010 at NH Pensacola FL, Dermatology Clinic by BRUMWELL, ERIC P

Encounter ID: PENS-706703 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **28 Sep 2010 0815 CDT**
 Clinic: **DERMATOLOGY CLINIC**

Appt Type: **EST\$**
 Provider: **BRUMWELL, ERIC**

Reason for Appointment: f/u skin check**AutoCites** Refreshed by BRUMWELL, ERIC @ 28 Sep 2010 0755 CDT**Problems****Chronic:**

- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	1 of 1	01 Sep 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by WEST, ALEXANDER D @ 28 Sep 2010 0800 CDT**Reason For Appointment:** f/u skin check

Allergen information verified by WEST, ALEXANDER D @ 28 Sep 2010 0800 CDT

SO Note Written by BRUMWELL, ERIC @ 28 Sep 2010 0817 CDT**Chief complaint**

The Chief Complaint is: RECURRENT PUSTULES AND UPPER TRUNK AFTER SWIMMING AT BEACH/BEING IN SUN--DOES NOT OCCUR W/ ONLY SUN EXPOSURE.

Reason for Visit

Visit for: screening for dermatological disorders.

Referred here

Referred by: from Primary Care.

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

Military service in the Navy, currently on active duty, and paygrade E5.

Concerns about cosmetic appearance.

Allergies

An allergy to drugs.

Current medication

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Cetaphil
allegra
triamcinolone
albuterol
advair.

Past medical/surgical history**Reported History:**

Reviewed.

Reported medications: Including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

. Taking medication MEDICINE RECONCILIATION PERFORMED.

Personal history

-Tob:n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Review of systems**Systemic symptoms:** No systemic symptoms and not feeling tired (fatigue). No chills.**Gastrointestinal symptoms:** No nausea and no vomiting.**Physical findings****Vital signs:**

• Pain level (0-10): Reviewed.

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Alert. ° Oriented to time, place, and person. ° Well nourished. ° Well hydrated.

Neurological:

Speech: ° Normal.

Psychiatric Exam:

Affect: ° Congruent with the mood.

Skin:

• Lesions on the face. ° Normal except as noted <1MM PUSTULES ON FOREHEAD AND UPPER BACK/CHEST--MANY IN VARIOUS STAGES OF EVOLUTION/BEING EXCORIATED.

Tests

UNIVERSAL PROTOCOL REQUIREMENTS WERE MET

Shave Biopsy ~

site verified with patient:Time 0815 >~site labeled with surgical marking pen~consent signed~area cleansed/prepped~anesthesia-2% lidocaine with epi~hemostasis with drysol~closure: < 4-0PROL >~bandage applied~wound care discussed~Estimated Blood Loss: <2 ml~suture removal 10 days~pt educated on wound care.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by BRUMWELL,ERIC @ 28 Sep 2010 0854 CDT**1. FOLLICULITIS:** PER PT ONLY W/ COMBINATION OF HEAT/SUN AND WATER AT BEACH

SUSPECT FOLLICULITIS VS MILIARIA PUSTULOSA- PT TO AVOID SUN/BEACH ENVIRONMENT UNTIL RESULTS DISCUSSED W/ HIM

BIOPSIES PERFORMED FOR H&E AS WELL AS TRIPLE CULTURE

Procedure(s):	-Biopsy Skin x 1 -Biopsy Skin Each Additional Lesion x 1
Laboratory(ies):	-TISSUE EXAM (Routine); CULTURE TISSUE PANEL (Routine): PLEASE DO FUNGAL, AFB AND BACTERIAL Start Date: 09/27/2010; CULTURE AEROBIC WOUND PANEL (Routine): FROM PUSTULE OF BACK Start Date: 09/27/2010
Patient Instruction(s):	-Clean Incision As Instructed -Education And Counseling -Instructions For Patient -Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure -Post-Op Teaching About Wound Care

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 906
AR 2893

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Disposition Written by BRUMWELL,ERIC @ 28 Sep 2010 0855 CDT**Released w/o Limitations****Follow up:** 10 day(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** BRUMWELL, ERIC (Physician/Workstation) @ 28 Sep 2010 0855**CHANGE HISTORY***The following SO Note Was Overwritten by BRUMWELL,ERIC @ 28 Sep 2010 0817 CDT:**SO Note Written by WEST,ALEXANDER D @ 28 Sep 2010 0803 CDT***Chief complaint**

The Chief Complaint is: Skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

In the Navy, currently on active duty, and paygrade E5.

Current medication

Cetaphil

allegria

triamcinolone

albuterol

advair.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tob:n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Alert. ° Oriented to time, place, and person. ° Well nourished. ° Well hydrated.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

01 Sep 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-665023 Primary Dx: ASTHMA EXTRINSIC

Patient: MERWIN, DANIEL DENNIS

Date: 01 Sep 2010 0850 CDT

Appt Type: ACUT

Treatment Facility: NBHC NTTC

Clinic: CORRY PRIME CARE

Provider: GUNTER, ROGER WILLIAM

Pensacola

Patient Status: Outpatient

Reason for Appointment: poss. allergic reaction**Appointment Comments:**

mr.

AutoCites Refreshed by GUNTER, ROGER WILLIAM @ 01 Sep 2010 0848 CDT**Allergies**

- OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals Written by STANDLEY, CHAD J @ 01 Sep 2010 0839 CDT**

BP: 120/84, HR: 76, RR: 16, T: 98.0 °F, HT: 69 in, WT: 145 lbs, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 0 Pain Free

Comments: 850-292-7149**SO Note Written by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1423 CDT****Chief complaint**

The Chief Complaint is: Possible allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with allergies to cats and dogs which makes it hard for the pt to breathe. If he's in the same room with these animals, the pt feels tightness in chest. and becomes short of breath. He has to remove him self and uses an OTC epinephrine inhaler. pt states that when he does have an onset it can take up to 2days for the symptoms to go away completely. He had severe childhood asthma but no symptoms for years since 11 or 12.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Itching of the eyes.

Dyspnea, paroxysmal nocturnal dyspnea, orthopnea: sleeping upright or with extra pillows, and wheezing.

Current medication

Current medications reviewed and reconciled.

fexofenadine HCL 100mg, ceraphil/aquanil.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

childhood asthma. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Taking OTC medications. Not taking dietary supplements and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

° Normal. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Palpation: ° No tenderness of the neck.

Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: ° PERRL.

External Eye: ° Conjunctiva exhibited no abnormalities.

Sclera: ° Normal.

Ears:

General/bilateral:

Tympanic Membrane: ° Normal.

Pharynx:

Oropharynx: ° Posterior pharyngeal wall was normal.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed.

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° S1 normal. ° S2 normal. ° No S3 heard. ° No S4 heard. ° No gallop was heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Neurological:

° No learning disability was noted (barriers to learning).

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by GUNTER,ROGER WILLIAM @ 01 Sep 2010 1438 CDT

1. ASTHMA EXTRINSIC (EXTRINSIC ASTHMA, UNSPECIFIED, MILD PERSISTENT): exposure to cats and dogs. DC Primatine Mist. Patient is already on daily Claritin per Dermatology for skin rash - 1 week so far. Is supposed to follow up with Derm after 1 month and if no improvement will get skin biopsies. He's to continue on the Claritin. Will add a long acting B agonist and Albuterol for rescue inhaler in case he has any acute exacerbations of his symptoms. I have advised him to practice avoidance - not be around cats and dogs as much as possible. he has none in his home but does visit with people that have pets. If the Claritin, avoidance and Advair are not effective will refer to Allergist.

Medication(s): -ALBUTEROL *HFA* MDI--INH 90MCG/PUFF AERP - INH 2 PF PO Q4H FOR WHEEZING #1 RF1 Qt: 1 Rf: 1
-ADVAIR 250-50MCG--PO INHA - INHALE 1 PUFF ORALLY BID #1 RF1 Qt: 1 Rf: 1

Disposition Last updated by GUNTER,ROGER WILLIAM @ 01 Sep 2010 1439 CDT**Released w/o Limitations**

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 01 Sep 2010 1439**CHANGE HISTORY****The following Disposition Note Was Overwritten by** GUNTER,ROGER WILLIAM @ 01 Sep 2010 1439 CDT:

The Disposition section was last updated by GUNTER,ROGER WILLIAM @ 01 Sep 2010 1439 CDT - see above. Previous Version of Disposition section was entered/updated by STANDLEY, CHAD J @ 01 Sep 2010 0913 CDT.

Released w/o Limitations

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Follow up: as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.
No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 01 Sep 2010 1423 CDT:

SO Note Written by STANDLEY, CHAD J @ 01 Sep 2010 1002 CDT

Chief complaint

The Chief Complaint is: Possible allergic reaction.

History of present illness

The Patient is a 25 year old male.
25yo ADM arrived to medical with complaints of allergic reaction. pt has allergies to cats and dogs which makes it hard for the pt to breath. pt feels tightness in chest. when this happens the pt has to remove him self and use a epinephrine inhaler. pt states that when he does have an onset it can take up to 2days for the symptoms to go away. pt also mentioned that he also gets headaches.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Itching of the eyes.

Dyspnea, paroxysmal nocturnal dyspnea, orthopnea: sleeping upright or with extra pillows, and wheezing.

Current medication

Current medications reviewed and reconciled.

fexofenadine HCL 100mg, ceraphil/aquanil.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed
childhood asthma. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Taking OTC medications. Not taking dietary supplements and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems

Systemic symptoms: No fever and no chills.

Gastrointestinal symptoms: No nausea and no vomiting.

Psychological symptoms: Not thinking about suicide. No homicidal thoughts.

Physical findings**Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

° Normal. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Lungs:

° Respiration rhythm and depth was normal. ° Exaggerated use of accessory muscles for inspiration was not observed. ° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard: ° No rales/crackles were heard.

Neurological:

° No learning disability was noted (barriers to learning).

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page 910
AR 2897

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Aug 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P

Encounter ID: PENS-653628 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **25 Aug 2010 0830 CDT**
 Clinic: **DERMATOLOGY CLINIC**

Appt Type: **EST\$**
 Provider: **SMITH, ERIC P**

Reason for Appointment: f/u skin check**AutoCites** Refreshed by SMITH, ERIC P @ 25 Aug 2010 0850 CDT**Problems****Chronic:**

- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by WEST, ALEXANDER D @ 25 Aug 2010 0842 CDT**Reason For Appointment:** f/u skin check

Allergen information verified by WEST, ALEXANDER D @ 25 Aug 2010 0842 CDT

SO Note Written by SMITH, ERIC P @ 25 Aug 2010 0908 CDT**Chief complaint**

The Chief Complaint is: Fu skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.
 Barriers to learning were identified as: None
 Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.
 In the Navy, currently on active duty, and paygrade E5.

Presents in follow-up. He was seen for a papular follicular-based rash that appeared to occur when exposed to sunlight, primarily on the weekends. After his last visit he stopped using his soaps and use Cetaphil for two weeks. He also switched to a nonchemical sunscreen but did not notice any improvement in his symptoms overall. He has subsequently returned to using his antibacterial soap or old spice, and has used a chemical sunscreen (baby sunscreen SPF 70) and states that this weekend he did not have a breakout at all, in spite of being in the sun 11 to two.
 He states that the rash has characteristically only lasted for about two to 3 days before going away without sequelae. It is tender but not necessarily itchy. He has pictures of his breakout which occurred primarily on his neck face and upper chest.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Claritan.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tob: n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

• Pain level (0-10): Reviewed.

• Current vital signs reviewed.

General appearance:

• Well-appearing. • Alert. • Oriented to time, place, and person. • Well nourished. • Well hydrated.

Skin:

• Lesions: No rash today. No evidence of scarring.

Photographs showed demonstrate raised erythematous papules on his chest with several that appear to be pustular.

• General appearance was normal.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Written by SMITH,ERIC P @ 25 Aug 2010 0911 CDT

1. FOLLICULITIS: Recurrent short-lived folliculitis. Discussed that switching to Cetaphil for only two weeks may not have been long enough to reduce chemical exposure from other soaps. There is still no clear etiology for his rash although it does appear to be sun related. Discussed trying to avoid histamine release as well symptomatically treatment.

Plan:

Start Allegra one tablet daily for 30 days.

Triamcinolone cream two to 3 times a day for two to 3 days at onset of his rash.

Return in one month, sooner as needed.

Medication(s): -FEXOFENADINE (ALLEGRA) --PO 180MG TAB - T1 TAB PO QD F ALLERGIES UD #30 RF2 Qt: 30
Rf: 2
-TRIAMCINOLONE 0.025%--TOP 80GM CREA - AAA BID TO TID FOR 2-3 DAYS AT ONSET OF
RASH UD #1 RF0 Qt: 1 Rf: 0

Disposition Written by SMITH,ERIC P @ 25 Aug 2010 0912 CDT**Released w/o Limitations****Follow up:** 1 month(s) in the DERMATOLOGY CLINIC clinic or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** SMITH, ERIC P (Physician, NH Pensacola FL) @ 25 Aug 2010 0912**CHANGE HISTORY***The following SO Note Was Overwritten by SMITH,ERIC P @ 25 Aug 2010 0908 CDT:**SO Note Written by WEST,ALEXANDER D @ 25 Aug 2010 0843 CDT***Chief complaint**

The Chief Complaint is: Fu skin check.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None

Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.

In the Navy, currently on active duty, and paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Claritan.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Past medical/surgical history

Reported History:

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

-Tob: n

-EtOH: y.

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

• Pain level (0-10): Reviewed.

° Current vital signs reviewed.

General appearance:

° Well-appearing. ° Alert. ° Oriented to time, place, and person. ° Well nourished. ° Well hydrated.

Therapy

• No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

20 Jul 2010 at NH Pensacola FL, Dermatology Clinic by SMITH, ERIC P

Encounter ID: PENS-597452 Primary Dx: FOLLICULITIS

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **20 Jul 2010 0920 CDT**
 Clinic: **DERMATOLOGY CLINIC**

Appt Type: **SPEC**
 Provider: **SMITH, ERIC P**

Reason for Appointment: ROSACEA/DERM-NHP/MED LIST/CTD/20/RECORDS/UNIFORM**Appointment Comments:**
CAC-EH**AutoCites** Refreshed by SMITH, ERIC P @ 20 Jul 2010 0948 CDT**Problems****Chronic:**

- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

SO Note Written by SMITH, ERIC P @ 20 Jul 2010 1115 CDT**Chief complaint**

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related /deployment-related. Paygrade E5.

Presents for evaluation of her recurrent rash that has been occurring over the past two summers. He states that when he spends time in the sun and especially in the water he will develop crops of pustules across his forehead, cheeks, and somewhat on his back and chest. These are typically painful and he tends to puncture these or pick them. He did that this morning and does not have any significant acute lesions. He denies breakouts on other sun exposed areas of his skin.

He has tried many different types of sunscreens, but most recently used a baby sunscreen that one time helped prevent a breakout and the other time did not.

He does not take medications regularly, though occasionally takes Aleve.

He does relate that he had MRSA 3 times, and has been using an antibacterial soap on all of his skin since April of 2009.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

- Pain level (0-10): Reviewed.
- ° Current vital signs reviewed.

General appearance:

- ° Well-appearing.
- ° Alert.
- ° Oriented to time, place, and person.
- ° Well nourished.
- ° Well hydrated.

Skin:

- Lesions: See add note for details.

Also noted to have very fair skin and fairly moderate photo damage with hundreds of ephelids. ° General appearance was normal.

Therapy

- No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by SMITH,ERIC P @ 20 Jul 2010 1643 CDT

1. FOLLICULITIS: Appears to developing pustules of unclear etiology. The sudden onset following sun exposure may point towards a photosensitive reaction which could be photo drug or photo toxic or photoallergic. He only takes Aleve occasionally, and this could be a potential cause of pseudo-porphyrria though he has no lesions on the back of his hands and no milia. It would be atypical for acne, even though he complains of blackheads, as the sun tends to be more immunosuppressive rather than causing acne breakouts.

He may have a reaction to sunscreen products, though states that he is broken out even when not wearing sunscreen. There does not appear to be a likely interaction between water in his skin. These lesions are not urticarial.

There may be a relationship to him starting his antibacterial soap and the onset of this rash. Discussed the importance of good skin care without damaging the surface.

Pityrosporum folliculitis is also in the differential diagnosis.

Recommended:

Stop antibacterial soap.

Start Dove or Cetaphil for washing his body.

They tried different sunscreens on his skin to see if there is a relationship between outbreaks.

Return 3 to 6 weeks for reevaluation

Medication(s): -CETAPHIL (AQUANIL)CLNSR 240ML --TOP SOAP - INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6 Qt: 2 Rf: 6

Disposition Written by SMITH,ERIC P @ 20 Jul 2010 1645 CDT**Released w/o Limitations**

Follow up: 2 to 6 week(s) in the DERMATOLOGY CLINIC clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by NEWTON,TYLER JEROME @ 20 Jul 2010 0916 CDT**Consult Order**

Referring Provider: GUNTER, ROGER WILLIAM

Date of Request: 14 Jun 2010

Priority: Routine

Provisional Diagnosis:

ROSACEA

Reason for Request:

1ST L/M ON VM25 yo male active duty member with 9 months of facial break outs - pustules, papules on forehead, nose and cheeks with any sun exposure. Patient has tried every sun screen he knows but every time he goes out to the beach or has any outdoor time for 4 or more hours he'll break out. Clears after about 2-4 days but comes back every time he gets sun exposure. It has some features of Rosacea but a very unusual onset and resolution. Please evaluate and treat definitively.

Note Written by NEWTON,TYLER JEROME @ 20 Jul 2010 1154 CDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

FORM 7240-00-030-0170 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE: 07/20/10 SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

DERMATOLOGY CLINIC, NH PENSACOLA FL

Doctor: Smith

Appointment time: 0900

Time in: [REDACTED]

Drug allergies: None/Other

Visit today related to deployment? Yes/No

ASSESSMENT: Is Pain Present? Y/N

Intensity: 1 2 3 4 5 6 7 8 9 10

Location: [REDACTED]


Duration: [REDACTED]


Onset: [REDACTED]

Time of onset: [REDACTED]

Is it a new or recurrent problem? Y/N

It has a reaction whenever goes to the beach a break out appears on his face, chest, and back. White head pimples, last 3-4 days.





Glycimerous papules ≤ 1 mm.

Acne vulgaris

④ from Autocite pictures

HOSPITAL OR MEDICAL FACILITY STATUS DEPARTMENT SERVICE (INITIALS MAINTAINED AT)

SPONSOR'S NAME SSN-ID NO. RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name, last, first, middle; if file or SSN, SSN; Date of Birth, Rank/Grade.) REGISTER NO. WARD NO.

20 Jul 2010@0920 SPEC PO2

CHRONOLOGICAL RECORD OF MEDICAL CARE

SMITH, ERIC P

STANDARD FORM 600 (REV. 8-97)

Prescribed by GSA/ICM

FPMR (41 CFR) 201.9.202-1

Signed By SMITH, ERIC P (Physician, NH Pensacola FL) @ 20 Jul 2010 1646

CHANGE HISTORY

The following SO Note Was Overwritten by SMITH, ERIC P @ 20 Jul 2010 1115 CDT:

SO Note Written by MATTHEWS, KARLA M @ 20 Jul 2010 0923 CDT

Chief complaint

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related /deployment-related. Paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 916
AR 2903

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Past medical/surgical history

Reported History:

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

- Pain level (0-10): Reviewed.

- Current vital signs reviewed.

General appearance:

- Well-appearing. ◦ Alert. ◦ Oriented to time, place, and person. ◦ Well nourished. ◦ Well hydrated.

Therapy

- No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

14 Jun 2010 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-547172 Primary Dx: ROSACEA

Patient: MERWIN, DANIEL DENNIS

Treatment Facility: NBHC NTTC

Pensacola

Patient Status: Outpatient

Date: 14 Jun 2010 1010 CDT

Clinic: CORRY PRIME CARE

Appt Type: ACUT

Provider: GUNTER,ROGER WILLIAM

Reason for Appointment: allergic reaction**Appointment Comments:**

mso

AutoCites Refreshed by GUNTER,ROGER WILLIAM @ 14 Jun 2010 1012 CDT**Allergies**

• OTHER: Unknown (SEE MED RECORD)

Vitals**Vitals Written by STANDLEY,CHAD J @ 14 Jun 2010 0953 CDT**

BP: 114/68, HR: 72, RR: 16, T: 98.5 °F, HT: 69 in, WT: 145 lbs, BMI: 21.41, BSA: 1.802 square meters, Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 5/10 Moderate, Pain Scale Comments: forehead

Comments: 850-292-7149**SO Note** Written by GUNTER,ROGER WILLIAM @ 14 Jun 2010 1236 CDT**Chief complaint**

The Chief Complaint is: Allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with complaints of allergic reaction x1year. pt stated that when he first arrived to florida he was fine for x2months. now every time he goes outside he breaks out with pustules all over his face. pt has tried using sunscreen with no success. pt denies taking any medication to treat the reaction.pt does notice more pustules when in the sun but he still gets them when its cloudy outside. No problems with alcohol or hot beverages. No history of Rosacea though he's had acne since he was a teen - that's cleared for the most part and hasn't had any problems of this kind until he got to floriday about 9 months ago. Originally from California and has spent his whole life out doors in the sun.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Current medications reviewed and reconciled.

none.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergic all outdoor items and pets. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Pulmonary symptoms:** No dyspnea, no cough, and no wheezing.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings**

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vital signs:

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:• General appearance: • Not oriented to time, place, and person pustules all over pt face. ° Well developed. ° Well nourished.
° In no acute distress.**Neurological:**

° No learning disability was noted (barriers to learning).

Skin:

• Showed erythema entire face is red and dusky. Three hours of sun exposure with sun screen. • Pustules were seen on forehead and nose primarily.

Therapy

• No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

A/P Written by GUNTER,ROGER WILLIAM @ 14 Jun 2010 1239 CDT**1. ROSACEA:** Some features of Rosacea but may just be an acneiform eruption. Patient insists there are no triggers other than prolonged sun exposure. Will refer to Dermatology for evaluation and treatment.

Consult(s):

-Referred To: DERMATOLOGY CONSULT (Routine) Specialty: DERMATOLOGY Clinic: UTILIZATION
MANAGEMENT OFFICE Primary Diagnosis: ROSACEA**Disposition** Written by GUNTER,ROGER WILLIAM @ 14 Jun 2010 1239 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Administrative Options:** Consultation requested**Signed By GUNTER, ROGER WILLIAM** (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 14 Jun 2010 1240**CHANGE HISTORY***The following SO Note Was Overwritten by GUNTER,ROGER WILLIAM @ 14 Jun 2010 1228 CDT:**SO Note Written by STANDLEY,CHAD J @ 14 Jun 2010 0957 CDT***Chief complaint**

The Chief Complaint is: Allergic reaction.

History of present illness

The Patient is a 25 year old male.

25yo ADM arrived to medical with complaints of allergic reaction x1year. pt stated that when he first arrived to florida he was fine for x2months. now every time he goes outside he breaks out with pustules all over his face. pt has tried using sunscreen with no success. pt denies taking any medication to treat the reaction.pt does notice more pustules when in the sun but he still gets them when its cloudy outside.

In the Navy and currently on active duty. Visit is not deployment-related and visit is not GWOT-related.

Current medication

Current medications reviewed and reconciled.

none.

Past medical/surgical history**Reported History:**

Medical: Reported medical history: Reviewed

allergic all outdoor items and pets. No previous hospitalizations that are associated with the reason for this encounter: and no previous emergency room visit that are associated with the reason for this encounter:

Surgical / procedural: Surgical / procedural history: Reviewed

none.

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Reported prior tests: No prior tests were performed at non-MHS facility that relate to this encounter includes:

Personal history

Social history: Reviewed

none.

Behavioral history: No tobacco use.

Alcohol: Alcohol use.

Family history

Family medical history: Reviewed

none.

Review of systems**Systemic symptoms:** No fever and no chills.**Pulmonary symptoms:** No dyspnea, no cough, and no wheezing.**Gastrointestinal symptoms:** No nausea and no vomiting.**Psychological symptoms:** Not thinking about suicide. No homicidal thoughts.**Physical findings****Vital signs:**

Vital Signs/Measurements

Value

Blood pressure: Reviewed

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:

• General appearance: • Not oriented to time, place, and person pustules all over pt face. ° Well developed. ° Well nourished. ° In no acute distress.

Neurological:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

° No learning disability was noted (barriers to learning).

Skin:

- Pustules were seen.

Therapy

- No herbal medicines.

Counseling/Education

Patient verbalized understanding and accepted instructions.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

21 Apr 2010 at NH Pensacola FL, NASP Optometry by ZENT, JOHN W

Encounter ID: PENS-468299 Primary Dx: REFRACTIVE ERROR - MYOPIA

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC NAS Pensacola**
 Patient Status: **Outpatient**

Date: **21 Apr 2010 0800 CDT**
 Clinic: **NASP OPTOMETRY CLINIC**

Appt Type: **SPEC**
 Provider: **ZENT,JOHN W**

Reason for Appointment: EYE EXAM-CONSULT FOR PRK/BLD 3600/UOD/REC/MEDS/GLASSES/CDT/20MINS**Appointment Comments:**
CAC-ANT**AutoCites** Refreshed by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Problems****Chronic:**

- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Visit for: administrative purposes
- Inquiry and counseling about contraceptive practices

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
LORATADINE, 10 MG, TABLET, ORAL	Active	T 1 TABLET PO QD PRN NR FOR ALLERGIES #100 RF0		17 Mar 2010
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Reason For Appointment:** EYE EXAM-CONSULT FOR PRK/BLD 3600/UOD/REC/MEDS/GLASSES/CDT/20MINS

Allergen information verified by MERRELL, SHAUNTE T @ 21 Apr 2010 0806 CDT

Vitals**Vitals** Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT

Pain Scale: 0 Pain Free

SO Note Written by MERRELL,SHAUNTE T @ 21 Apr 2010 0806 CDT**Reason for Visit**

Visit for: routine eye exam.

Referred here

referred here.

History of present illness

The Patient is a 25 year old male. Source of patient information was patient.
 Barriers to learning were identified as: None
 Possible barriers include cultural; religious; emotional; motivational; physical; and cognitive.
 Reliability of source of patient information was good.
 In the Navy, currently on active duty, and paygrade E5.
 No eye pain.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Physical trauma: No trauma to the eye.

Diagnosis History:

No iritis / Uveitis
 No cataract

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

No macular degeneration
 No glaucoma.
 No hypertension.
 No hyperlipidemia.
 No diabetes mellitus

Review of systems**Cardiovascular symptoms:** No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Physical findings****Eyes:**

General/bilateral:

Visual Assessment: • Lensometry:

OD:-2.00-0.25x090

OS:-1.75sph.

Intraocular Pressure: ° Normal NCT IOP.

Visual Fields Exam: • A limited visual fields exam was performed. ° Peripheral vision was full to confrontation.

Right eye:

Visual Assessment:

Value

Distance right acuity with current Rx: 20/

20

Right eye:

Intraocular Pressure:

Value

12 mmHg

Left eye:

Visual Assessment:

Value

Distance left acuity with current Rx: 20/

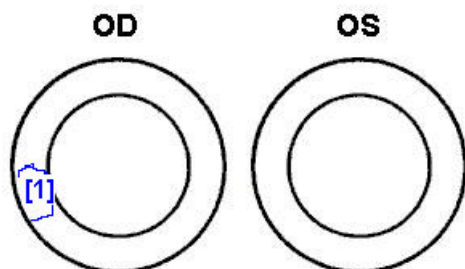
30

Left eye:

Intraocular Pressure:

Value

13 mmHg

Drawing/Image Written by ZENT,JOHN W @ 23 Apr 2010 1644 CDT**1. pigmented crescent with no holes or tears****A/P** Written by ZENT,JOHN W @ 23 Apr 2010 1644 CDT**1. REFRACTIVE ERROR - MYOPIA**

Procedure(s):

-Ophthalmological New Patient Start Comprehensive Care x 1

-Spectacles Services Fitting Monofocals (Not For Aphakia) x 1

-Determination Of Refractive State x 1

-Prescription & Fitting Bilateral Corneal Lenses (Not Aphakia) x 1

2. PERIPHERAL RETINAL DEGENERATION - LATTICE: abnormal appearance OS, possibly lattice, or very flat typical retinoschisis.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

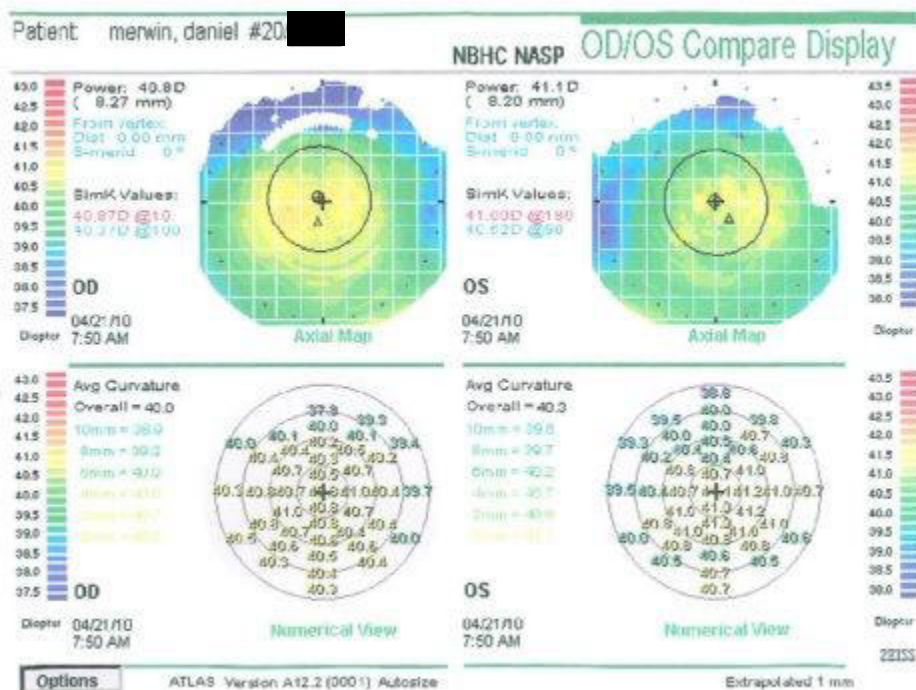
Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Disposition Written by ZENT,JOHN W @ 23 Apr 2010 1645 CDT**Released w/o Limitations****Follow up:** 12 month(s) or sooner if there are problems.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Note** Written by SIMIEN,LATOSHA D @ 21 Apr 2010 1301 CDT**Note** Written by ZENT,JOHN W @ 23 Apr 2010 1642 CDT

Chief Complaint:		Pt. here for CRS screening, no visual or asthenopic complaints			
Significant History:		(see above) -f/f, -dryness, -itch, -burn			
Confrontation Fields:		FTFC Central & Peripheral OD, OS		Cover Test:	cc Ortho distance Ortho' near
Extraocular Muscles:		Smooth, Accurate, Full, No Pain		Pupils:	Equal Round 4+ Reactivity -APD
MRx	Sphere	Cylinder	Axis	DVA	Drops: @ 0820
OD	-2.25	-0.50	098	OD 20/20	0.5% Proparacaine
OS	-2.50	-0.25	083	OS 20/20	1gt OU 0.5% Tropicamide
	Prism	Add	NVA		1gt OU 2.5% Phenylephrine
OD			OD 20/20	20/20	1% Cyclopentolate
OS			OS 20/20	20/20	0.25%/0.4% Fluress
Slit Lamp:		78D & 20D Dilated		Ancillary Testing	
	OD	OS		Pt. educated that too large of an Rx change for CRS	
L/L	Clear	Clear			
Conj.	Clear	Clear			
Cornea	Clear	Clear			
Tear Layer	Clear	Clear			
A/C	D & Q	4X4	4X4	Final Spec Rx	Full Time Wear
Iris	Clear		Clear	OD -2.25	-0.50 098
					Add pl

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

17 Mar 2010 at NH Pensacola FL, Readiness Center by BROWN, TRAVIS S

Encounter ID: PENS-413309

Primary Dx:

Visit for: occupational health / fitness exam

Patient: **MERWIN, DANIEL DENNIS**Treatment Facility: **NH Pensacola**Patient Status: **Outpatient**Date: **17 Mar 2010 0730 CDT**Clinic: **DEPLOYMENT HEALTH CLINIC**Appt Type: **WELL**Provider: **BROWN, TRAVIS SCOTT****Reason for Appointment:** PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD**Appointment Comments:**

cac-jab

AutoCites Refreshed by WHITE, PAMELA J @ 17 Mar 2010 0727 CDT**Allergies**

• OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Screening Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT**Reason For Appointment:** PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD

Allergen information verified by WHITE, PAMELA J. @ 17 Mar 2010 0730 CDT

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : PHA PART 2;**Vitals****Vitals** Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT

BP: 102/60, HR: 72, RR: 20, HT: 69.5 in Actual, With Shoes, WT: 150 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/30, Corr OS: 20/20, Corr OU: 20/20, BMI: 21.83, BSA: 1.838 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: OCC., Pain Scale: 0 Pain Free

SO Note Written by BROWN, TRAVIS SCOTT @ 17 Mar 2010 0807 CDT**Chief complaint**

The Chief Complaint is: PHA.

History of present illness

The Patient is a 25 year old male.

Barriers to learning were identified as: None

Barriers considered were, social, cultural, emotional, motivational, physical, religious, cognitive and language.

Problem list reviewed.

Head symptoms States he has a history of allergy to dogs and cats. Approximately 3 weeks ago he was at a friend's house who had a dog. since that time, he has had problems with head and nasal congestion and sneezing. Also reports one episode of shortness of breath when running approximately 2 weeks ago. States he has been using Primatene OTC. No other meds. On exam today the pharynx and nasal septum with mild erythema, no inflammation or drainage. Lungs clear to auscultation over all fields bilaterally. No wheezing noted.

Current medication

Primatene - OTC

Past medical/surgical history**Reported History:**

Past Medical History:

Fracture of right 5th phalanx - 2008 -Resolved

Surgical / procedural: Surgical / procedural history Past Surgical History: noncontributory.

Review of systems**Neck symptoms:** No neck symptoms.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Eye symptoms: No eye symptoms.**Otolaryngeal symptoms:** No otolaryngeal symptoms.**Cardiovascular symptoms:** No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Gastrointestinal symptoms:** No gastrointestinal symptoms.**Genitourinary symptoms:** No genitourinary symptoms.**Musculoskeletal symptoms:** No musculoskeletal symptoms.**Psychological symptoms:** No psychological symptoms.**A/P** Written by BROWN, TRAVIS S @ 17 Mar 2010 0815 CDT**1. visit for: occupational health / fitness exam**(*PERIODIC PREVENTION EXAMINATION*): Annual TB risk assessment completed. He has been in Asia over the past year. Recommend placing PPD today. See NAVMED 6224/8.

Counseled on lab results, triglycerides and discussed at length ways to improve through lifestyle changes; exercise, supplements and better nutrition. Teaching materials given.
Medically fit for full duty.

2. ALLERGIC RHINITIS: Place him on claratin and mucinex. f/u with PCM if symptoms not improved in 3-4 days. member states he was treated by an allergist as a child. Explained he could discuss this with his PCM if symptoms remain persistent.

Medication(s):

-LORATADINE (CLARITIN)--PO 10MG TAB - T 1 TABLET PO QD PRN FOR ALLERGIES #100 RF0

Qt: 100 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

-GUAIFENESIN PSE --PO 600MG-60MG TAB - TAKE ONE TABLET TWICE DAILY **MAX 50 TABS

PER FILL ** #40 RF0 Qt: 40 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

Disposition Written by BROWN, TRAVIS S @ 17 Mar 2010 0817 CDT**Released w/o Limitations****Follow up:** with PCM.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** BROWN, TRAVIS S (NP-C, NH Pensacola FL) @ 17 Mar 2010 0817

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

09 Mar 2010 at NH Pensacola FL, Corry Prime Care by THOMAS, JOSHUA L

Encounter ID: PENS-400052

Primary Dx:

Vaccine needed prophylactically against
bacterial diseasesPatient: **MERWIN, DANIEL DENNIS**Date: **09 Mar 2010 0824 CDT**Appt Type: **ACUT**Treatment Facility: **NBHC NTTC**Clinic: **CORRY PRIME CARE**Provider: **THOMAS, JOSHUA L****Pensacola**Patient Status: **Outpatient****Reason for Appointment:** Anthrax Vaccine**Appointment Comments:** Written by THOMAS, JOSHUA L @ 09 Mar 2010 0824 CDT

jlt

Vitals**Vitals** Written by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CST**Comments:** n/a**SO Note** Written by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CDT**History of present illness**

The Patient is a 25 year old male.

Barriers to learning were identified as: None.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Not taking medication and no contraindications to live vaccine were noted on medication reconciliation.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by WILLIAMS, TREVOR M @ 09 Mar 2010 1504 CDT**1. Vaccine needed prophylactically against bacterial diseases**

Procedure(s): -Anthrax Vaccine, For Subcutaneous Use x 1

Disposition Last Updated by WILLIAMS, TREVOR M @ 09 Mar 2010 1505 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current

prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech.

No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By THOMAS, JOSHUA L (Physician/Workstation) @ 09 Mar 2010 1512

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Dec 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-281825 Primary Dx: Parent Education: Immunizations

Patient: **MERWIN, DANIEL DENNIS**Date: **22 Dec 2009 1100 CST**Appt Type: **OPAC**Treatment Facility: **NBHC NTTC**Clinic: **CORRY PRIME CARE**Provider: **GUNTER, ROGER WILLIAM****Pensacola**Patient Status: **Outpatient****Reason for Appointment:** H1N1**Appointment Comments:** Written by LINVILLE, TREVOR S @ 22 Dec 2009 1100 CST

TSL

Vitals**Vitals** Written by SYDA, KRISTIE LYNN @ 22 Dec 2009 1114 CST**Comments:** n/a**SO Note** Written by SYDA, KRISTIE LYNN @ 22 Dec 2009 1114 CST**History of present illness**

The Patient is a 24 year old male.

Barriers to learning were identified as: None.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

See med list.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals; supplements and medications not included in AHLTA were reviewed with patient in detail.

Not taking medication and no contraindications to live vaccine were noted on medication reconciliation.

Counseling/Education

Education appropriate to the patient's needs was provided regarding the care/treatment/services provided. The patient or guardian voiced understanding and all questions were answered.

Appropriate Vaccine Information Statements were given. Patient was identified using two forms of identification (name and prefix and sponsor's social security number)

Pain control was discussed.

The patient or guardian was instructed to wait for 15 minutes in the waiting room after vaccines were administered.

A/P Last Updated by SYDA, KRISTIE LYNN @ 22 Dec 2009 1115 CST**1. Parent Education: Immunizations (MEDICATION EDUCATION)**

Procedure(s): -Immunization Administration One Vaccine x 1
 -Influenza Virus Vaccine Pandemic Formulation x 1

Disposition Last Updated by SYDA, KRISTIE LYNN @ 22 Dec 2009 1115 CST**Released w/o Limitations**

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in AHLTA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** GUNTER, ROGER WILLIAM (Physician, JACC NBHC Corry Station, Pensacola, FL) @ 22 Dec 2009 1201

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

23 Sep 2009 at NH Pensacola FL, Corry Prime Care by GUNTER, ROGER WILLIAM

Encounter ID: PENS-140818

Primary Dx:

Vaccines Prophylactic Need Against
InfluenzaPatient: **MERWIN, DANIEL DENNIS**Date: **23 Sep 2009 1438 CDT**Appt Type: **OPAC**Treatment Facility: **NBHC NTTC**Clinic: **CORRY PRIME CARE**Provider: **GUNTER, ROGER WILLIAM****Pensacola**Patient Status: **Outpatient****Reason for Appointment:** influenza**Appointment Comments:** Written by SYDA, KRISTIE LYNN @ 23 Sep 2009 1438 CDT
kls**AutoCites** Refreshed by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**Problems**

- visit for: administrative purpose
- Inquiry And Counseling: Contraceptive Practices
- exposed to venereal disease
- visit for: military services physical

Active Family History

No Active Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Sodium Fluoride, Cream, Dental	Active	BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3	3 of 3	18 Sep 2009

Vitals**Vitals** Written by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**Comments:** n/a**SO Note** Written by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**Reason for Visit**

Visit for: influenza vaccine.

Patient identified by Name and Date of Birth or other two forms of identification.

History of present illness

The Patient is a 24 year old male. Source of patient information was patient. Past medical history reviewed.

Allergies

Reviewed an allergy. No allergy to certain foods; Chicken and not to eggs. No known drug allergies.

Vaccinations

: up to date.

- Received dose of influenza live virus vaccine, for intranasal use Vaccine lot #, manufacturer, and location given recorded in Immunization module. Patient provided and reviewed current CDC Vaccine Information Sheet. Vaccine inspected for discoloration/particulates and Exp Date verified

Past medical/surgical history**Reported History:**

Recent events: No active illness.

Review of systems**Systemic symptoms:** No fever.**Counseling/Education**

- Patient education about adverse reactions to medication Patient instructed to remain in clinic for 20 minutes post vaccination. Patient educated regarding possible side effects: soreness\\, redness\\, or swelling at the site of injection, Fever\\

A/P Last Updated by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**1. Vaccines Prophylactic Need Against Influenza**

Procedure(s): -Influenza Virus Vaccine Live Intranasal x 1

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

-Immunization Administration One Vaccine x 1

2. Parent Education: Immunizations(MEDICATION EDUCATION)**Disposition** Last Updated by BELKNAP, CHARLES HOWARD @ 23 Sep 2009 1529 CDT**Released w/o Limitations**

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 20 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, NH Jacksonville, FL) @ 23 Sep 2009 1532

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM

Encounter ID: PENS-128312 Primary Dx: Visit for: military services physical

Patient: MERWIN, DANIEL DENNIS

Date: 16 Sep 2009 1430 CDT

Appt Type: WELL

Treatment Facility: NBHC NTTC

Clinic: CORRY PHYS EXAMS

Provider: GUNTER,ROGER WILLIAM

Pensacola

Patient Status: Outpatient

Reason for Appointment: re-enlistment Phy

Appointment Comments:

clw

AutoCites Refreshed by THORNTON,JAMES M @ 16 Sep 2009 1454 CDT**Problems****Chronic:**

- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

SO Note Written by GUNTER,ROGER WILLIAM @ 16 Sep 2009 1541 CDT**History of present illness**

The Patient is a 24 year old male.

He reported: Encounter Background Information: 24 y/o adm coming to medical for re-enlistment pe. Last PE greater than 2 years so will repeat his full physical to include 2808 and 2807. Labs recorded. Audiogram completed today. Eye exam was done in town but patient will bring in a copy. No changes in health history since last PE. PHA was done on ship in FEB 09 as an annual flight deck PE. Complete in scope. See DD 2808 and 2807 for details of PE. Fit for reenlistment.

Physical findings**General appearance:**

° Well-appearing. ° Patient did not appear uncomfortable.

Lab Result Cited by THORNTON,JAMES M @ 16 Sep 2009 1454 CDT**Rapid Plasma Reagin**

Reagin Ab

Site/Specimen

SERUM

20 Aug 2009 1007Units

NON-REACTIVE

Ref Rng

Lab Result Cited by THORNTON,JAMES M @ 16 Sep 2009 1454 CDT**Lipid Profile****Site/Specimen**

15 Sep 2009 0724 <o>

Units

Cholesterol

Ref Rng

PLASMA

190 <i>

mg/dL

(25-199)

HDL Cholesterol

PLASMA

56 <i>

mg/dL

(20-150)

Triglyceride

PLASMA

221 (H) <i>

mg/dL

(25-100)

LDL Cholesterol

PLASMA

90 <i>

mg/dL

(25-100)

A/P Written by GUNTER,ROGER WILLIAM @ 16 Sep 2009 1543 CDT

1. visit for: military services physical(ARMED FORCES MEDICAL EXAMINATION): Reenlistment PE. Fit for reenlistment. See DD 2808 and 2807 in health record. Unable to scan into AHLTA.

Disposition Last updated by GUNTER,ROGER WILLIAM @ 16 Sep 2009 1543 CDT**Released w/o Limitations**

Follow up: as needed with PCM and/or in the CORRY PHYS EXAMS clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By GUNTER, ROGER WILLIAM (Physician, NH Jacksonville, FL) @ 16 Sep 2009 1544

CHANGE HISTORY

The following Disposition Note Was Overwritten by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT:

The Disposition section was last updated by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1543 CDT - see above. Previous Version of Disposition section was entered/updated by THORNTON, JAMES M @ 16 Sep 2009 1457 CDT.

Released w/o Limitations

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

The following SO Note Was Overwritten by GUNTER, ROGER WILLIAM @ 16 Sep 2009 1541 CDT:

SO Note Written by THORNTON, JAMES M @ 16 Sep 2009 1455 CDT

History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: 24 y/o adm coming to medical for re-enlistment pe.

Physical findings**General appearance:**

° Well-appearing. ° Patient did not appear uncomfortable.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page 933
AR 2920

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

10 Sep 2009 at NH Pensacola FL, Corry Phys Exams by GUNTER, ROGER WILLIAM

Encounter ID: PENS-121383 Primary Dx:

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NBHC NTTC**
Pensacola
Patient Status: **Outpatient**

Date: **10 Sep 2009 1430 CDT**
Clinic: **CORRY PHYS EXAMS**

Appt Type: **WELL**
Provider: **GUNTER,ROGER WILLIAM**

Reason for Appointment: re-enlistment pe
Appointment Comments:
jmt

Appointment Cancelled by Facility

Encounter Cancelled by GUNTER,ROGER WILLIAM @ 10 Sep 2009 1529 CDT

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

20 Aug 2009 at NH Pensacola FL, Corry Prime Care by HEDARIA, ELIZABETH A

Encounter ID: PENS-94296 Primary Dx: Exposure to STD

Patient: **MERWIN, DANIEL DENNIS**
Treatment Facility: **NH Pensacola**
Patient Status: **Outpatient**Date: **20 Aug 2009 0930 CDT**
Clinic: **CORRY PRIME CARE**Appt Type: **ACUT**
Provider: **HEDARIA, ELIZABETH A****Reason for Appointment:** REQUEST FOR LABS/JACC/20/MED LIST/CTD**Appointment Comments:**

CAC-AJB

Vitals**Vitals** Written by COLE, ASHLEY @ 20 Aug 2009 0923 CDT

BP: 120/79, HR: 82, RR: 16, T: 98.2 °F, HT: 68 in, WT: 145 lbs, BMI: 22.05, BSA: 1.783 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: aac**SO Note** Written by HEDARIA, ELIZABETH A @ 20 Aug 2009 1522 CDT**Chief complaint**

The Chief Complaint is: Pt would like a male examination.

History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Denies painful urination or discharge from penis.

Subjective

Pt is a 24 yo active duty male who reports to medical for yearly male examination. Pt states that he would prefer blood work if possible.

Physical findings**Vital signs:**

° Normal.

General appearance:

° Normal.

Eyes:

General/bilateral:

° Eyes: normal.

Ears, Nose, Throat:

° ENT: normal.

Lymph Nodes:

° Normal.

Urinary system:

° Normal.

° Genital findings were normal.

Genitalia:

° Normal.

A/P Written by HEDARIA, ELIZABETH A @ 20 Aug 2009 1003 CDT**1. exposed to venereal disease**

Laboratory(ies): -CHLAMYDIA/GC NAAT PANEL (Routine); RAPID PLASMA REAGIN (Routine)

Disposition Last updated by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT**Released w/o Limitations****Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.**Signed By** HEDARIA, ELIZABETH A (NURSE PRACTITIONER, NH Pensacola FL) @ 20 Aug 2009 1532

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

CHANGE HISTORY**The following Disposition Note Was Overwritten by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT:**

The Disposition section was last updated by HEDARIA, ELIZABETH A @ 20 Aug 2009 1523 CDT - see above. Previous Version of Disposition section was entered/updated by COLE, ASHLEY @ 20 Aug 2009 0927 CDT.

Released w/o Limitations**Follow up:** as needed with PCM and/or in the CORRY PRIME CARE clinic. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.**Discussed:** Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.**The following SO Note Was Overwritten by HEDARIA, ELIZABETH A @ 20 Aug 2009 1522 CDT:****SO Note** Written by COLE, ASHLEY @ 20 Aug 2009 0922 CDT**Chief complaint**

The Chief Complaint is: Pt would like a male examination.

Subjective

Pt is a 24 yo active duty male who reports to medical for yearly male examination. Pt states that he would prefer blood work if possible.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 May 2009 at NH Pensacola FL, Corry Health Promotion And Wel by LINVILLE, TREVOR S

Encounter ID: CDR-64692598 Primary Dx: Patient Education - HIV

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NBHC NTTC**
Pensacola
 Patient Status: **Outpatient**

Date: **07 May 2009 1355 CDT**
 Clinic: **CORRY COMMUNITY HEALTH**

Appt Type: **WELL**
 Provider: **LINVILLE, TREVOR S**

Reason for Appointment: indoc

Appointment Comments:

Notes Entered by: THORNTON, JAMES M 07 May 2009 1355

jmt

AutoCites Refreshed by THORNTON, JAMES M @ 07 May 2009 1355 CDT**Problems**

- feared medical condition not demonstrated
- visit for: issue medical certificate fitness

Active Family History

No Active Family History Found.

Allergies

- OTHER: Unknown (SEE MED RECORD)

Active Medications

No Active Medications Found.

Vitals**Vitals** Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT**Comments:** n/a**SO Note** Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT**Referred here**

Referred by:

History of present illness

The Patient is a 24 year old male

Patient participated in a 60 minute group education and counseling session on medical and dental wellness and access to care. Topics include occupational and local hazards. Specifically, MRSA, STDs, sun hazards, hydration birth control. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

A/P Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT

1. Patient Education - HIV
2. Anticipatory Guidance: Unsafe Sexual Practices
3. visit for: administrative purpose
4. Inquiry And Counseling: Contraceptive Practices

Disposition Written by THORNTON, JAMES M @ 07 May 2009 1356 CDT**Released w/o Limitations**

Follow up: as needed with PCM. - Comments: Med Reconciliation completed, medication history including current prescription medications, over the counter medications, nutraceuticals, herbals, supplements and medications not included in ALTHA were reviewed with patient in detail. Patient offered medication list by pharmacy tech. No barriers to learning were identified. Education appropriate to the patient's needs was provided regarding the care, treatment, and services provided. The patient voices understanding and all questions were answered.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LINVILLE, TREVOR S (Physician/Workstation, NH Pensacola FL) @ 07 May 2009 1412

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

06 Mar 2006 at NH Pensacola FL, NATTC MHP by MAYNARD, PENELOPE A

Encounter ID: 17628314

Primary Dx:

Feared medical condition not demonstrated

Patient: **MERWIN, DANIEL DENNIS**Date: **06 Mar 2006 0815 CST**Appt Type: **ROUT**Facility: **Pensacola NH, FL**Clinic: **NATTC SICK CALL**Provider: **MAYNARD,PENELOPE A****Reason for Appointment:** abdominal pain**Appointment Comments:**

cac-ebc

AutoCites Refreshed by MAYNARD,PENELOPE A @ 06 Mar 2006 0843 CST**Allergies**

OTHER (SEE MED RECORD)

Active Medications

No Active Medications Found.

Vitals**Vitals** Written by MILLER,KATHERINE R @ 06 Mar 2006 0804 CST

BP: 120/64, HR: 60, RR: 12, T: 97.6 °F, HT: 5' 8", WT: 126 lbs, BMI: 19.16, BSA: 1.679 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free, Pain Scale Comments: none

Comments: allergies:nkda**SO Text Note** Written by MAYNARD,PENELOPE A @ 06 Mar 2006 0843 CST

SEE NOTE FOR RECORD

A/P Written by MAYNARD,PENELOPE A @ 06 Mar 2006 0844 CST**1. feared medical condition not demonstrated:** ABD PAIN RESOLVED- NO PATHOLOGY**2. visit for: issue medical certificate fitness****Disposition** Written by MAYNARD,PENELOPE A @ 06 Mar 2006 0844 CST**Released w/o Limitations****Follow up:** as needed .**Discussed:** Diagnosis with Patient who indicated understanding.**Signed By** MAYNARD,PENELOPE A (MD. GS-14, GMO, Pensacola) @ 06 Mar 2006 0844

***** End of Previous Encounters *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Clinical Notes**09 Aug 2017 1300 GMT at by HANGEMANOLE, DESPINA C**

Title:	BEHAVIORAL HEALTH	Original Date:	09 Aug 2017 1300 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	10 Aug 2017 1147 GMT
Facility:		Document ID:	9049385304
Clinician:	HANGEMANOLE, DESPINA C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: TOBAR, EDEN T
 Requesting Location: PSYCHIATRY BE
 Order ID number: 170718-20734
 MCP Referral #: 20171273185
 No. of Visits: 90
 Referral Authorized Until: 30 Sep 2017
 Reason for Consult:
 32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that. Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago. Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.
 Priority: ROUTINE
 Provisional Diagnosis:
 Alcohol use disorder
 ACV:
 Reviewed Date/Time:
 Appt Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 09 Aug 2017@08:00:00
 Requesting HCP: TOBAR, EDEN T
 Clinic: ATS ADULT BE
 Consulting HCP: HANGEMANOLE, DESPINA C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 09 Aug 2017 0800 EDT Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ATS

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

ADULT BEProvider: HANGEMANOLE,DESPINA C

Patient Status: Outpatient

Reason for Appointment:

f/u

Appointment Comments:

jbf

S/O Note Written by HANGEMANOLE,DESPINA C @ 10 Aug 2017 0742 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

Focus Of Session: Depressive Symptoms

S) SM reported that he spent the weekend watching movies and sleeping. SM stated that he did talk with his sister and his mother and examined with them some of the reasons for living. SM stated he has hopes of moving down to where they live and buying a plot of land to live on together. Sm stated that his MEB is moving forward for his IBS. SM denied having an intake date with PCS right now. SM reported that he is still depressed and often thinks about his reasons for living. SM reported he went to one AA meeting but didn't really like it because there was "drama" and he didn't feel he got anything out of it. SM reported that he was triggered to drink one time after hearing people talk about craft beer on the radio. SM stated that he turned the radio off and the feeling passed. He stated that he thought about suicide over the weekend but did not have a plan or intent to harm himself. SM denied any alcohol use or thoughts about drinking. SM denied being in pain.

O) SM reported to session on time and was dressed in uniform. His mood was euthymic in session, affect congruent. SM's thoughts and behavior were appropriate.

A) SM was cooperative and friendly. SM appears to have significant mental health issues that would be best addressed through PCS IOP. SM would benefit from continuing to engage in community recovery.

Alcohol Use D/O, Severe

P) Case will be reviewed with treatment team. SM will follow up with social worker in two weeks.

.eg

ebody

ebody

A/P Last Updated by HANGEMANOLE,DESPINA C @ 09 Aug 2017 0921 EDT

1. Alcohol dependence, uncomplicated

Procedure(s): -Psychiatric Therapy Individual Approximately 60 Minutes x 1

Disposition Last Updated by HANGEMANOLE,DESPINA C @ 09 Aug 2017 0921 EDT

Released w/o Limitations

Follow up: as needed in the ATS ADULT BE clinic. - Comments: SM will f/u with social worker in two weeks.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by HANGEMANOLE,DESPINA C @ 09 Aug 2017 0916 EDT

Consult Order

Referring Provider:TOBAR, EDEN

Date of Request:18 Jul 2017

Priority:Routine

Provisional Diagnosis:

Alcohol use disorder

Reason for Request:

32 y/o USN PO1 with generalized anxiety. Has been sober for 9 days but was drinking a liter and a half of vodka per week for the 3 months before that.

Completed inpatient alcohol rehabilitation at Ft Belvoir several years ago.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Interested in resuming ATS treatment to stay sober. Please evaluate and call home number in ahlta to reach pt. Thank you.

Signed By HANGEMANOLE, DESPINA C (LCSW-C, MAC, Addiction Treatment Services)

@ 10 Aug 2017 0742

Verified by: HANGEMANOLE, DESPINA C 10 Aug 2017 @0747

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

16 Jun 2017 1430 GMT at by NICHOLAS, LUKE C

Title:	DERMATOLOGY	Original Date:	16 Jun 2017 1430 GMT
	NCR		
Document Type:	Consultation	AHLTA Entry Date:	19 Jun 2017 1647 GMT
Facility:		Document ID:	8936043237
Clinician:	NICHOLAS, LUKE C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: RODAK, COLLEEN M
 Requesting Location: INT MED CL F MEDICAL HOME BE
 Order ID number: 170519-09885
 MCP Referral #: 20170912561
 No. of Visits: 1
 Referral Authorized Until: 18 Jun 2017
 Reason for Consult:
 32 to with penile lesions Previously treated for genital warts with topicals a
 nd cryosurgery by dermatology; on PE --> 3 less than 05mm circular flat lesion
 s consistent with warts on penis shaft; patient is very anxious about the recu
 rrence and is requesting to be evaluated by dermatology please evaluate additi
 onal question is if this patient she undergo an anal PAP thank you
 Priority: ROUTINE
 Provisional Diagnosis:
 Anogenital (venereal) warts
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 16 Jun 2017@09:30:00
 Requesting HCP: RODAK, COLLEEN M
 Clinic: DERMATOLO CL BE
 Consulting HCP: NICHOLAS, LUKE C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 16 Jun 2017 0930 EDT Appt Type: SPEC
 Treatment Facility: KIMBROUGH AMBULATORY CARE CENTER-MEADE Clinic: DERMATOLO
 CL BE Provider: NICHOLAS, LUKE C
 Patient Status: Outpatient
 Reason for Appointment:
 Anogenital (venereal) warts
 Appointment Comments:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

MJ/IRMAC

S/O Note Written by DIBLASI,DANIEL ROBERT @ 16 Jun 2017 1154 EDT

bodybodyChief complaint g1

The Chief Complaint is: Genital warts.eg

History of present illness g2

The Patient is a 32 year old male.

32 y/o male presents for evaluation/treatment of genital warts. Have been there for about 1 year. Has treated topically and with LN2 in the past and lesions have not resolved. Patient also c/o cysts on the scrotum.

In the Navy and currently on active duty.

No systemic symptoms, not feeling tired or poorly, no fever, and no chills.

No skin symptoms - No skin symptoms other than described in the HPI.eg

Allergies g24

No known drug allergies.eg

Current medication g3

Current medications reviewed, confirmed and reconciled with patient.

.eg

Past medical/surgical history g4

Diagnoses:

No basal cell carcinoma of the skin

No squamous cell carcinoma of the skin.

No malignant melanoma of the skin.eg

Personal history g5

Social history.eg

Physical findings g8

Vital Signs:

Vital Signs/MeasurementsValue

Pain level by numeric rating scale 0

General Appearance:

Well developed. Well nourished. In no acute distress. Not acutely ill.

Neurological:

Oriented to time, place, and person.

Skin:

? Skin:: On exam the following lesions were identified and examined:

Small skin colored papules in the pubic region and on the proximal penile shaft

Multiple round, subcutaneous cysts on the scrotum. ? Complexion type II.eg

ebody

ebody

A/P Last Updated by DIBLASI,DANIEL R @ 16 Jun 2017 1247 EDT

1. Anogenital (venereal) warts: 32 y/o male with genital warts. Did not improve with topical or destructive therapies in the past. Recommended repeat treatment with LN2 and then regular follow up every 4-6 weeks for repeat treatment until clear. Patient verbalized understanding.

Seen and staffed with Dr. Nicholas

Procedure(s): -Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent received, and cryo applied to lesions in standard fashion. Therapy was applied in a pulsed fashion to minimize collateral tissue injury. Patient was instructed to use Vaseline ointment to the area(s) until healed. Patient tolerated the procedure well and left in stable condition.

2. Epidermal cyst: Multiple scrotal EICs. Can schedule for excision. AHLTA and Outlook calendar unavailable at the time of encounter, so will contact patient to schedule.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Disposition Last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT

Released w/o Limitations

Follow up: in the DERMATOLO CL BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side

Effects with Patient who indicated understanding. - Comments: I saw the

patient with the resident and agree with the above assessment and plan.

Note Written by DIBLASI,DANIEL R @ 16 Jun 2017 1154 EDT

Consult Order

Referring Provider:RODAK, COLLEEN M

Date of Request:19 May 2017

Priority:Routine

Provisional Diagnosis:

Anogenital (venereal) warts

Reason for Request:

32 to with penile lesions Previously treated for genital warts with topicals

and cryosurgery by dermatology; on PE --> 3 less than 05mm circular flat

lesions consistent with warts on penis shaft; patient is very anxious about

the recurrence and is requesting to be evaluated by dermatology please

evaluate additional question is if this patient she undergo an anal PAP thank

you

Signed By NICHOLAS, LUKE C (Physician-WRNMMC, Dermatologist) @ 19 Jun 2017

1241

CHANGE HISTORY

The following Disposition Note Was Overwritten by NICHOLAS,LUKE C @ 19 Jun

2017 1241 EDT:

Disposition section was last updated by NICHOLAS,LUKE C @ 19 Jun 2017 1241 EDT

- see above.Previous Version of Disposition section was entered/updated by

DIBLASI,DANIEL R @ 16 Jun 2017 1248 EDT.

Released w/o Limitations

Follow up: in the DERMATOLO CL BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side

Effects with Patient who indicated understanding.

Verified by: LUKE C. NICHOLAS, LT,MC,USN19 Jun 2017@1246

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jun 2017 1515 GMT at by PETERSEN, MAUREEN MICHELE

Title:	ALLERGY NCR	Original Date:	07 Jun 2017 1515 GMT
Document Type:	Consultation	AHLTA Entry Date:	10 Jun 2017 1824 GMT
Facility:		Document ID:	8918397086
Clinician:	PETERSEN, MAUREEN MICHELE		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: RODAK, COLLEEN M
 Requesting Location: INT MED CL F MEDICAL HOME BE
 Order ID number: 170517-23114
 MCP Referral #: 20170899328
 No. of Visits: 1
 Referral Authorized Until: 16 Jun 2017
 Reason for Consult:
 This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander --> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you
 Priority: ROUTINE
 Provisional Diagnosis:
 Encounter for other general examination
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 07 Jun 2017@10:15:00
 Requesting HCP: RODAK, COLLEEN M
 Clinic: ALLERGY CL BE
 Consulting HCP: PETERSEN, MAUREEN MICHELE

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:
 Note:
 NOTE=Patient: MERWIN, DANIEL DENNIS Date: 07 Jun 2017 1015 EDT Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ALLERGY CL BE
 Provider: PETERSEN, MAUREEN MICHELE
 Patient Status: Outpatient
 Reason for Appointment:
 F/U skin testing
 Appointment Comments:
 yyc

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals

Vitals Written by PROVENCIO,ELISHA S. @ 07 Jun 2017 1006 EDT

BP: 129/75, HR: 75, RR: 16, HT: 69 in, WT: 168 lbs, BMI: 24.81, BSA: 1.918 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Comments: no anti-histamines in last 7 days or more

Note Written by ACKERMAN,JOI D @ 07 Jun 2017 1058 EDT

Note Written by PETERSEN,MAUREEN M @ 10 Jun 2017 1412 EDT

32 yo M who presents for skin testing.

Patient with significant PMH for anxiety and IBS was previously seen for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking zyrtec for these symptoms.

No history of food/medication/venom allergies, eczema, or history of anaphylaxis.

Medication list reviewed with patient, reconciliation completed.

Allergies

Allergies Verified and Updated

NKDA.

Current medication

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.

Past medical/surgical history

Reported:

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

.

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.

Personal history

Social history reviewed Denies etoh and tobacco abuse

Pets: none.

Family history

Family medical history

non-contributory.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Review of systems

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.

Head: No headache, no facial pain, and no sinus pain.

Eyes: No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.

Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.

Gastrointestinal: No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.

Musculoskeletal: No back pain.

Neurological: No lightheadedness.

Skin: No pruritus. No skin lesions and no rash.

Physical findings

Vital Signs:

? Temperature: Reviewed. ? RR: Reviewed. ? PR: Reviewed. ? Blood pressure: Reviewed.

General Appearance:

Normal. Well developed. Well nourished. In no acute distress.

Head:

Injuries: No evidence of a head injury.

Appearance: Head normocephalic.

Neck:

Appearance: Of the neck was normal.

Palpation: No tenderness of the neck.

Thyroid: Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: PERRL. Size of the pupil was normal. Pupil accommodation was not impaired.

External: Eyelids showed no abnormalities. Conjunctiva exhibited no abnormalities.

Sclera: Normal.

Ears:

General/bilateral:

Outer Ear: Normal.

External Auditory Canal: External auditory meatus normal.

Right Ear:

External Auditory Canal: Normal.

Tympanic Membrane: No bulging tympanic membrane. Not erythematous.

Middle Ear: No fluid in middle ear.

Left Ear:

External Auditory Canal: Normal.

Tympanic Membrane: No bulging tympanic membrane. Not erythematous.

Middle Ear: No fluid in middle ear.

Nose:

General/bilateral:

Discharge: No nasal discharge seen.

External Deformities: No external nose deformities.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Cavity: Nasal septum normal. Nasal mucosa normal. Nasal turbinate not erythematous. Nasal turbinate not swollen.

Sinus Tenderness: No sinus tenderness.

Oral Cavity:

Lips: Showed no abnormalities.

Buccal Mucosa: Examination showed no abnormalities.

Pharynx:

Oropharynx: Normal. Tonsils showed no abnormalities.

Lymph Nodes:

Cervical lymph nodes were not enlarged. Submandibular lymph nodes were not enlarged. Supraclavicular lymph nodes were not enlarged.

Lungs:

Respiration rhythm and depth was normal. Exaggerated use of accessory muscles for inspiration was not observed. Clear to auscultation. No wheezing was heard. No rhonchi were heard. No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: Normal.

Heart Sounds: Normal S1 and S2. No gallop was heard. No click was heard. No pericardial friction rub heard.

Murmurs: No murmurs were heard.

Neurological:

Oriented to time, place, and person.

Balance: Normal.

Gait And Stance: Normal.

Psychiatric:

Mood: Euthymic.

Skin:

Showed no ecchymosis. Temperature was normal. No skin lesions.

Allergic rhinitis: 32 yo M with skin testing only positive to Cat. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass (picture of back shown to me by patient today is c/w large urticaria on back). Exam today WNL.

-Cont treatment with albuterol prn symptoms

-Discussed acute urticaria and rhinitis. Plan for daily Zyrtec to prevent urticaria and prevent symptoms in the presence of cats. Discussed avoidance measures.

-Would avoid Singulair use in this patient due to behavioral health issues (Singulair has a black box warning regarding SI)

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

A/P Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT

1. Allergic rhinitis due to animal (cat) (dog) hair and dander: See above.

Procedure(s): -Allergy Percutaneous tests - allergenic extracts x 45

ADDITIONAL PROVIDER(S): ACKERMAN, JOI D -

Benefits and risks of skin testing discussed to include the risk of discomfort, bleeding/bruising, and allergic reactions. Patient agreed to proceed and consent signed. Positive and negative controls were placed along with a full aeroallergen panel. Test was read at 15 minutes and results were recorded.

Disposition Written by PETERSEN, MAUREEN M @ 10 Jun 2017 1418 EDT

Released w/o Limitations

Follow up: as needed with PCM. - Comments: f/u prn; meds reconciled.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By PETERSEN, MAUREEN M (Staff Attending, WRNMMC Allergy, Immunology, & Immunizations) @ 10 Jun 2017 1418
Verified by: MAUREEN M. PETERSEN, LTC, M10 Jun 2017@1424

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 May 2017 1430 GMT at by BANKS, TAYLOR ALLEN

Title:	ALLERGY NCR	Original Date:	25 May 2017 1430 GMT
Document Type:	Consultation	AHLTA Entry Date:	26 May 2017 0036 GMT
Facility:		Document ID:	8887468495
Clinician:	BANKS, TAYLOR ALLEN		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: RODAK, COLLEEN M
 Requesting Location: INT MED CL F MEDICAL HOME BE
 Order ID number: 170517-23114
 MCP Referral #: 20170899328
 No. of Visits: 1
 Referral Authorized Until: 16 Jun 2017
 Reason for Consult:
 This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander --> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you
 Priority: ROUTINE
 Provisional Diagnosis:
 Encounter for other general examination
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 25 May 2017@09:30:00
 Requesting HCP: RODAK, COLLEEN M
 Clinic: ALLERGY CL BE
 Consulting HCP: BANKS, TAYLOR ALLEN

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 25 May 2017 0930 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: ALLERGY CL BE
 Provider: BANKS, TAYLOR ALLEN
 Patient Status: Outpatient
 Reason for Appointment:
 Encounter for other general examination

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Appointment Comments:

MJ/IRMAC

Vitals

Vitals Written by ACKERMAN,JOI D @ 25 May 2017 1001 EDT

BP: 124/83, HR: 74, RR: 16, HT: 69 in, WT: 165 lbs, SpO2:

96%, BMI: 24.37, BSA: 1.903 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

S/O Note Written by HERNANDEZ,CAMELLIA L @ 25 May 2017 1036 EDT

bodybodyChief complaint g1

The Chief Complaint is: Concern for asthma.eg

History of present illness g2

The Patient is a 32 year old male.

<<Note accomplished in TSWF-CORE>>

32 yo M without significant PMH presents for evaluation of SOB on exposure to animals and grass. As a child pt states that he had breathing issues required treatment with inhalers until age 18-19. He even required a PICU stay at the age of 3 (no intubation) for these issues. Prior to joining the navy his symptoms had completely resolved but 5 years ago when he moved back to MD he noted symptoms of chest tightness and difficulty getting air in when around cats, dogs and doing PT in the grass. His symptoms are not exacerbated during exercise or URIs. He uses albuterol which improves his symptoms. He has not gone to the ER for these symptoms or taken oral steroids in the past year. Over the past month he has required use of albuterol 4-5 times but none at night. When around grass he also develops pruritus and sometimes small red bumps but no symptoms or rhinorrhea or congestion. He recently started taking zyrtec for these symptoms. No history of food/medication/venom allergies, eczema, or history of anaphylaxis.

Medication list reviewed with patient, reconciliation completed.eg

Allergies g24

Allergies Verified and Updated

NKDA.eg

Current medication g3

Including OTC meds, vitamins, herbals, etc.

Hyoscyamine 0.125 mg daily

Ibuprofen prn

Zyrtec 10 mg daily

Albuterol prn

Probiotic

Simethicone.eg

Past medical/surgical history g4

Reported:

Medical: Reported medical history

IBS-D

GAD / depression

HX of EtOH abuse (previous inpatient treatment)

HPV genital

.

Surgical / Procedural: Surgical / procedural history

Tonsils

PRK

Jaw surgery.eg

Personal history g5

Social history reviewed Denies etoh and tobacco abuse

Pets: none.eg

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Family history g7

Family medical history

non-contributory.eg

Review of systems g16

Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, and no recent weight loss.

Head: No headache, no facial pain, and no sinus pain.

Eyes: No itching of the eyes and no eye pain. No discharge from the eyes and no red eyes.

Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: Not feeling congested in the chest, no dyspnea, not expressed as feeling short of breath, and not during exertion. No paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.

Gastrointestinal: No nausea, no vomiting, no abdominal pain, no bright red blood per rectum, no diarrhea, and no constipation.

Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.

Musculoskeletal: No back pain.

Neurological: No lightheadedness.

Skin: No pruritus. No skin lesions and no rash.eg

Physical findings g8

Vital Signs:

? Temperature: Reviewed. ? RR: Reviewed. ? PR: Reviewed. ? Blood pressure: Reviewed.

General Appearance:

Normal. Well developed. Well nourished. In no acute distress.

Head:

Injuries: No evidence of a head injury.

Appearance: Head normocephalic.

Neck:

Appearance: Of the neck was normal.

Palpation: No tenderness of the neck.

Thyroid: Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: PERRL. Size of the pupil was normal. Pupil accommodation was not impaired.

External: Eyelids showed no abnormalities. Conjunctiva exhibited no abnormalities.

Sclera: Normal.

Ears:

General/bilateral:

Outer Ear: Normal.

External Auditory Canal: External auditory meatus normal.

Right Ear:

External Auditory Canal: Normal.

Tympanic Membrane: No bulging tympanic membrane. Not erythematous.

Middle Ear: No fluid in middle ear.

Left Ear:

External Auditory Canal: Normal.

Tympanic Membrane: No bulging tympanic membrane. Not erythematous.

Middle Ear: No fluid in middle ear.

Nose:

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

General/bilateral:

Discharge: No nasal discharge seen.

External Deformities: No external nose deformities.

Cavity: Nasal septum normal. Nasal mucosa normal. Nasal turbinate not erythematous. Nasal turbinate not swollen.

Sinus Tenderness: No sinus tenderness.

Oral Cavity:

Lips: Showed no abnormalities.

Buccal Mucosa: Examination showed no abnormalities.

Pharynx:

Oropharynx: Normal. Tonsils showed no abnormalities.

Lymph Nodes:

Cervical lymph nodes were not enlarged. Submandibular lymph nodes were not enlarged. Supraclavicular lymph nodes were not enlarged.

Lungs:

Respiration rhythm and depth was normal. Exaggerated use of accessory muscles for inspiration was not observed. Clear to auscultation. No wheezing was heard. No rhonchi were heard. No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: Normal.

Heart Sounds: Normal S1 and S2. No gallop was heard. No click was heard. No pericardial friction rub heard.

Murmurs: No murmurs were heard.

Neurological:

Oriented to time, place, and person.

Balance: Normal.

Gait And Stance: Normal.

Psychiatric:

Mood: Euthymic.

Skin:

Showed no ecchymosis. Temperature was normal. No skin lesions.eg

Test conclusions g21

[x] Written care plan and[] clinical summary of today's visit was provided to patient.eg

Practice Management g17

Preventive medicine services.eg

ebody

ebody

A/P Last Updated by HERNANDEZ,CAMELLIA L @ 25 May 2017 1055 EDT

1. Dyspnea, unspecified: 32 yo M without significant PMH presents with symptoms of chest tightness and difficulty getting air in on exposure to cats, dogs and grass. No significant symptoms of rhinorrhea but he intermittently has developed a pruritic rash on exposure to grass. Exam today WNL. Spirometry performed today also WNL. History and symptoms could be consistent with allergic asthma, however, could also be due to VCD.

-Could not perform SPT today due to recent antihistamine use, however, Pt will follow up on June 7th at 10:15 for SPT to the aeroallergens. Pt will discontinue Zyrtec 5 days prior to next apt.

-Cont treatment with albuterol prn symptoms

-If SPT negative, would consider referral to pulmonology for consideration of MCCT vs laryngoscopy to evaluate for asthma and VCD

-All questions addressed, patient/parent express understanding of the above, and have no further concerns

Procedure(s): -Spirometry Pre-bronchodilator x 1 ADDITIONAL PROVIDER(S):

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

BANKS,TAYLOR ALLEN - Interpretation: The patient has normal baseline spirometry.

Disposition Last updated by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by HERNANDEZ,CAMELLIA L @ 25 May 2017 0953 EDT

Consult Order

Referring Provider:RODAK, COLLEEN M

Date of Request:17 May 2017

Priority:Routine

Provisional Diagnosis:

Encounter for other general examination

Reason for Request:

This is a 32 yo male with a HX of developing pruritic rash when coming into contact with grass during PT in addition to severe reaction to animal dander --> wheezing /bronchospasm / cough please evaluate to determine antigens and if possible desensitization thank you

Note Written by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT

I saw and evaluated the patient. Discussed with resident/fellow and reviewed the history/PE and assessment and plan as documented in the note and agree.

Signed By BANKS, TAYLOR ALLEN (WRNMMC Allergy-Immunology Staff Physician, Physician/Workstation) @ 25 May 2017 2031

CHANGE HISTORY

The following Disposition Note Was Overwritten by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT:

Disposition section was last updated by BANKS,TAYLOR ALLEN @ 25 May 2017 2031 EDT - see above.Previous Version of Disposition section was entered/updated by HERNANDEZ,CAMELLIA L @ 25 May 2017 1056 EDT.

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

The following Allergy was Deleted: OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1038 EDT:

The following Allergy was Deleted: OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1037 EDT:

The following Allergy was Deleted: OTHER by HERNANDEZ,CAMELLIA L @ 25 May 2017 1037 EDT:

Verified by: TAYLOR A. BANKS,LT,MC,USN 25 May 2017@2036

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

13 Apr 2017 2000 GMT at by WONG, ROY KWOCK

Title:		Original Date:	13 Apr 2017 2000 GMT
	GASTROENTEROLO GY MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	14 Apr 2017 1330 GMT
Facility:		Document ID:	8790779933
Clinician:	WONG, ROY KWOCK		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160413-07484
 MCP Referral #: 20160660564
 No. of Visits: 1
 Referral Authorized Until: 13 May 2016
 Reason for Consult:
 SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 13 Apr 2017@15:00:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: GI CL BE
 Consulting HCP: WONG, ROY KWOCK HUNG

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 13 Apr 2017 1500 EDT Appt Type: FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: GI CL

BE Provider: WONG, ROY KWOCK HUNG

Patient Status: Outpatient

Limited System Patient Data at time of Encounter

Reason for Appointment:

follow up

Appointment Comments:

Ima/irmac

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals

Vitals Written by KNIGHT,ASIA L @ 13 Apr 2017 1449 EDT

BP: 129/90, HR: 72, T: 98.1 F, HT: 69 in, WT: 165.5 lbs,

SpO2: 95%, BMI: 24.44, BSA: 1.906 square meters,

Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

S/O Note Written by HALL,NOAH MONTGOMERY @ 13 Apr 2017 1739 EDT

bodybodyHistory of present illness g2

The Patient is a 32 year old male.

32 y/o AD male returns to the GI clinic for f/u regarding IBS manifested by chronic intermittent abdominal pain. He reports a long history of GI symptoms, dating back to childhood, but symptoms have been more disruptive over the past few years. Notes generalized sharp, crampy abdominal pain about every 1-2 days, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft or liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. He reports minimal improvement since starting a low-FODMAP diet and is not following this strictly currently. He denies any benefit from avoiding dairy, caffeine, and sugar-substitutes.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal wall-thickening at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal.

He was also previously noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in 2016.

.eg

Allergies g24

Allergies Verified and Updated

NKDA

.eg

Current medication g3

Including OTC meds, vitamins, herbals, etc.

Lexapro (stopped recently)

.eg

Past medical/surgical history g4

Reported:

Medical: Reported medical history

Anxiety/depression

IBS-D

Surgical / Procedural: Surgical / procedural history

Tonsillectomy

PRK

.eg

Personal history g5

Social history reviewed

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

.eg

Family history g7

Family medical history

No malignant neoplasm of the gastrointestinal tract.

.eg

Review of systems g16

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Systemic: No fever, no chills, and no recent weight loss.

Eyes: No eye pain. No red eyes.

Cardiovascular: No chest pain or discomfort.

Pulmonary: No dyspnea and no cough.

Gastrointestinal: Appetite not decreased. No dysphagia, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no hematemesis.

Abdominal pain. No jaundice and no bright red blood per rectum. Diarrhea.

No constipation.

Musculoskeletal: No back pain, no localized joint pain, and no localized joint swelling.

Neurological: No lightheadedness.

Skin: No skin lesions and no rash.eg

Physical findings g8

Vital Signs:

? Temperature: Reviewed. ? RR: Reviewed. ? PR: Reviewed. ? Blood pressure: Reviewed.

General Appearance:

Normal. Well developed. Well nourished. In no acute distress.

Head:

Injuries: No evidence of a head injury.

Appearance: Head normocephalic.

Neck:

Appearance: Of the neck was normal.

Eyes:

General/bilateral:

Pupils: PERRL. Size of the pupil was normal. Pupil accommodation was not impaired.

External: Eyelids showed no abnormalities. Conjunctiva exhibited no abnormalities.

Sclera: Normal.

Ears:

General/bilateral:

Outer Ear: Normal.

External Auditory Canal: External auditory meatus normal.

Nose:

General/bilateral:

External Deformities: No external nose deformities.

Cavity: Nasal septum normal.

Oral Cavity:

Lips: Showed no abnormalities.

Buccal Mucosa: Examination showed no abnormalities.

Pharynx:

Oropharynx: Normal. Tonsils showed no abnormalities.

Lymph Nodes:

Submandibular lymph nodes were not enlarged.

Lungs:

Respiration rhythm and depth was normal. Exaggerated use of accessory muscles for inspiration was not observed. Clear to auscultation. No wheezing was heard. No rhonchi were heard. No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: Normal.

Heart Sounds: Normal S1 and S2. No gallop was heard. No click was heard. No pericardial friction rub heard.

Murmurs: No murmurs were heard.

Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-****

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DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Abdomen:

Visual Inspection: Abdomen was not distended.

Auscultation: Bowel sounds were not diminished or absent.

Palpation: Abdomen was soft. No abdominal guarding. Abdominal non-tender. No mass was palpated in the abdomen.

Liver: Normal to palpation.

Spleen: Normal to palpation.

Hernia: No hernia was discovered.

Musculoskeletal System:**Functional Exam:**

General/bilateral: Mobility was not limited.

Other:

General/bilateral: No muscle tenderness.

Neurological:

Oriented to time, place, and person. Remote memory was not impaired.

Recent memory was not impaired.

Balance: Normal.

Gait And Stance: Normal.

Psychiatric:

Mood: Euthymic.

Affect: Normal.

Skin:

Showed no ecchymosis. Temperature was normal. No skin lesions.eg

ebody

ebody

A/P Last Updated by HALL,NOAH M. @ 13 Apr 2017 1746 EDT

1. Irritable bowel syndrome with diarrhea:

32 y/o male with IBS-D reports minimal benefit with dietary modification.

Predominant symptom is abdominal pain and episodes are closely associated with anxiety.

- Will start trial of Metamucil for stool bulking
- If bloating/flatulence becomes an issue, consider transition to a non-fermentable fiber (citrucel OTC)
- Will also provide Levsin SL for symptomatic relief
- Recommended continued f/u with Behavioral Health provider, and could discuss a trial of a low-dose TCA at bedtime as a centrally-acting pain modulator
- F/u in GI clinic in 3-4 months
- Could consider a trial of Rifaximin in the future if no benefit

Medication(s): -PSYLLIUM/SUCROSE--PO 3.4GM/SCOOP POWD - TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY #2 RF3

Ordered By: HALL,NOAH M. Ordering Provider: HALL, NOAH MONTGOMERY

-HYOSCYAMINE IR--PO 0.125MG TBSL - DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN #30 RF3 Ordered By: HALL,NOAH M.

Ordering Provider: HALL, NOAH MONTGOMERY

Disposition Last Updated by HALL,NOAH M. @ 13 Apr 2017 1747 EDT

Released w/o Limitations

Follow up: as needed in 3 to 4 month(s) in the GI CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By WONG, ROY KWOCK (Physician/Workstation, WRAMC) @ 14 Apr 2017 0925

Verified by: WONG,ROY KWOCK HUNG 14 Apr 2017@0930

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Feb 2017 1300 GMT at by BENTON, JIKESHA R

Title:	PSY DIAGNOSTIC TESTING MTF BE	Original Date:	08 Feb 2017 1300 GMT
Document Type:	Consultation	AHLTA Entry Date:	10 Feb 2017 1913 GMT
Facility:		Document ID:	8645316959
Clinician:	BENTON, JIKESHA R		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: PAUL, SHERIN
 Requesting Location: PSYCHIATRY BE
 Order ID number: 161208-20980
 MCP Referral #: 20162154263
 No. of Visits: 1
 Referral Authorized Until: 07 Jan 2017
 Reason for Consult:
 Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.
 Priority: ROUTINE
 Provisional Diagnosis:
 Generalized anxiety disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 08 Feb 2017@07:00:00
 Requesting HCP: PAUL, SHERIN
 Clinic: PSYCHOLOGY ASSESSMENT BE
 Consulting HCP: BENTON, JIKESHA R

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 08 Feb 2017 0700 EST Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

PSYCHOLOGY ASSESSMENT BE Provider: BENTON, JIKESHA R

Patient Status: Outpatient

AutoCites Refreshed by BENTON, JIKESHA R @ 10 Feb 2017 1306 EST

Problems

?Generalized anxiety disorder F41.1

?Counseling, unspecified Z71.9

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

?EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225

?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

?MAJOR DEPRESSION RECURRENT MODERATE

?ANXIETY DISORDER NOS

?Left ankle joint pain

?NEUROTIC EXCORIATION

?ANKLE SPRAIN LEFT

?ESSENTIAL HYPERTRIGLYCERIDEMIA

?ANOMALIES OF SKIN

?Abdominal pain

?ASTHMA

?POSTSURGICAL STATE OF EYE AND ADNEXA

?Difficulty breathing (dyspnea)

?SKIN NEOPLASM UNCERTAIN BEHAVIOR

?Removal Of Sutures

?ASTHMA EXTRINSIC

?ROSACEA

?PERIPHERAL RETINAL DEGENERATION - LATTICE

?REFRACTIVE ERROR - MYOPIA

?ALLERGIC RHINITIS

Family History

?no family history of malignant neoplasm of large intestine (General FHx)

?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)

?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)

?paternal grandmother's history of preliminary background HPI [use for free text] (Paternal Grandmother)

?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)

?paternal history of preliminary background HPI [use for free text] (Father)

?family medical history (General FHx)

?family history of test conclusions [Use for free text] (General FHx)

?family history of diabetes mellitus (General FHx)

?family history of heart disease (General FHx)

?family history of mental illness (not retardation) (General FHx)

?no family history of cancer (General FHx)

?family history of the options include referral (General FHx)

?family history of patient counseling (General FHx)

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)

?family history of supplemental HPI [use for free text] (General FHx)

?no family history of chronic liver disease (General FHx)

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

NALTREXONE HCL, 50 MG, TABLET, ORAL Active TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED #0 RF3 2 of 3 01 Feb 2017

ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL Active TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3 0 of 3 01 Feb 2017

ESZOPICLONE, 1 MG, TABLET, ORAL Active TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1 1 of 1 04 Jan 2017

FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE Active NR 14 Oct 2016
 PODOFILOX, 0.5 %, SOLUTION, TOPICAL Active APPLY TWICE A DAY FOR 3 DAYS THEN
 STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2 2 of 2 24 Feb 2016
 AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
 INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

Reason for Appointment:

Dx Interview

Appointment Comments:

CAC

Note Written by BENTON, JIKESHA R @ 10 Feb 2017 1406 EST

SM Merwin is as 31 year old, single, Caucasian, male, AD USN E-6
 Cryptologist. SM was seen for a 1 hour clinical interview by LT Martinez on
 02FEB17 under Dr. Benton's supervision. This writer engaged in 2 hours of
 chart review and 5 hours of psychological report preparation and writing. A
 1 hour feedback session was scheduled after the conclusion of the clinical
 interview. LT Martinez administered the MCMI-III, MMPI-2, and RISB on
 02FEB17.

Initial Impressions

Psychological testing results were consistent with the established diagnoses
 of Generalized Anxiety Disorder. SM Merwin does not meet criteria for
 Borderline Personality Disorder. SM Merwin endorsed anxious ruminative
 thoughts and stress caused by feelings of guilt. SM Merwin's pattern of
 unstable relationships appears to be more in line with Schizoid personality
 traits that may have been adaptive at a young age in the context of his
 childhood physical and emotional abuse. SM Merwin exhibits a lack of interest
 in social relationships, a tendency towards a solitary lifestyle, emotional
 coldness, and apathy. Individuals with Schizoid traits may also demonstrate a
 rich, elaborate and exclusively internal fantasy world. SM Merwin indicated
 he enjoys the fantasy world of movies and frequently finds himself
 daydreaming.

Mental Status Exam

Mental status examination revealed an alert, fully oriented, appropriately
 dressed and groomed male who appeared his stated age. SM Merwin presented
 with a pleasant mood and congruent affect. Throughout the session, SM
 Merwin's mood and affect appeared unchanged, even when discussing difficult
 or emotional topics. SM Merwin maintained appropriate eye contact throughout
 the session. SM Merwin was engaged in the interview and testing. His speech
 was normal in tone and rate. Cognition was grossly intact and abstraction was
 adequate. Recent and remote memory was intact. Thought process was clear and
 goal oriented. SM Merwin did not exhibit ideas of reference, paranoia, or
 delusions. There was no evidence of mania. Judgment and impulse control were
 good. No indication of psychomotor retardation or agitation. SM Merwin denied
 current suicidal or homicidal ideation, plans, or intent.

Risk Assessment

SM Merwin has a history of suicidal ideation occurring approximately once a
 month since adulthood. His protective factors include his job, his hobby of
 creating video games, and wanting to find purpose in his life. SM Merwin has
 low social support, but this does not seem to be a significant stressor. SM
 Merwin does not have a history of attempts and denies access to lethal means.
 He denied current ideation, plan, or intent. SM Merwin is currently assessed
 at a mild risk for suicide, and should continue to be monitored by his
 healthcare providers.

A/P Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

1. Generalized anxiety disorder

Procedure(s): -Psychiatric Diagnostic Evaluation Comprehensive Examination

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

x 1

-Psychologic Testing And Report Administered By Physician x 8

Disposition Written by BENTON, JIKESHA R @ 10 Feb 2017 1407 EST

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 10 Feb 2017 1407

Verified by: BENTON, JIKESHA R 10 Feb 2017@1412

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

02 Feb 2017 1400 GMT at by BENTON, JIKESHA R

Title:	PSY DIAGNOSTIC TESTING MTF BE	Original Date:	02 Feb 2017 1400 GMT
Document Type:	Consultation	AHLTA Entry Date:	07 Feb 2017 2047 GMT
Facility:		Document ID:	8635967203
Clinician:	BENTON, JIKESHA R		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: PAUL, SHERIN
 Requesting Location: PSYCHIATRY BE
 Order ID number: 161208-20980
 MCP Referral #: 20162154263
 No. of Visits: 1
 Referral Authorized Until: 07 Jan 2017
 Reason for Consult:
 Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.
 Priority: ROUTINE
 Provisional Diagnosis:
 Generalized anxiety disorder
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 02 Feb 2017@08:00:00
 Requesting HCP: PAUL, SHERIN
 Clinic: PSYCHOLOGY ASSESSMENT BE
 Consulting HCP: BENTON, JIKESHA R

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 02 Feb 2017 0800 EST Appt Type: PROC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

PSYCHOLOGY ASSESSMENT BE Provider: BENTON, JIKESHA R

Patient Status: Outpatient

AutoCites Refreshed by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST

Problems

?Generalized anxiety disorder F41.1

?Counseling, unspecified Z71.9

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

?EXAM/ASSESSMENT, OCCUPATIONAL, SERVICE MEMBER PERIODIC HEALTH ASSESSMENT (PHA) DOD0225

?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

?MAJOR DEPRESSION RECURRENT MODERATE

?ANXIETY DISORDER NOS

?Left ankle joint pain

?NEUROTIC EXCORIATION

?ANKLE SPRAIN LEFT

?ESSENTIAL HYPERTRIGLYCERIDEMIA

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?ASTHMA

?POSTSURGICAL STATE OF EYE AND ADNEXA

?Difficulty breathing (dyspnea)

?SKIN NEOPLASM UNCERTAIN BEHAVIOR

?Removal Of Sutures

?ASTHMA EXTRINSIC

?ROSACEA

?PERIPHERAL RETINAL DEGENERATION - LATTICE

?REFRACTIVE ERROR - MYOPIA

?ALLERGIC RHINITIS

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?paternal history of preliminary background HPI [use for free text] (Father)

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?family history of supplemental HPI [use for free text] (General FHx)

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?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

NALTREXONE HCL, 50 MG, TABLET, ORAL Active TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED #0 RF3 2 of 3 01 Feb 2017

ESCITALOPRAM OXALATE, 20 MG, TABLET, ORAL Active TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3 0 of 3 01 Feb 2017

ESZOPICLONE, 1 MG, TABLET, ORAL Active TAKE 1 TO 2 TABLETS BY MOUTH EVERY NIGHT AS NEEDED FOR SLEEP #0 RF1 1 of 1 04 Jan 2017

FLUARIX QUAD 2016-2017 (FLU VACC QS2016-17 36MOS UP/PF), 60MCG/.5ML, SYRINGE,

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

INTRAMUSC, GLAXOSMITHKLINE, 0.5 ml SYRINGE Active NR 14 Oct 2016
 PODOFILOX, 0.5 %, SOLUTION, TOPICAL Active APPLY TWICE A DAY FOR 3 DAYS THEN
 STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2 2 of 2 24 Feb 2016
 AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
 INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

Reason for Appointment:

Generalized anxiety disorder

Appointment Comments:

mta

Note Written by BENTON, JIKESHA R @ 07 Feb 2017 1531 EST

Reason for Visit

Visit for: Psychological Testing. Assessment time 5.5 hrs. PT denied any physical pain. He c/o'ed of issues w/ interpersonal relationships. PT discussed his history of physical and emotional abuse by his father. He was cooperative and no management problem. The raw data can be found in room 7131. The report will be uploaded once complete.

History of present illness

The Patient is a 31 year old male.

He reported: Feeling numb; he appeared apathetic w/ a flat affect. Not thinking about suicide. No homicidal thoughts, no hallucinations, and not hearing voices when no one is talking.

Compliant with testing: Y /

Oriented X4 Y /

Risks reported to patient treatment team NA/ none at this time

Provider follow-up scheduled Y /

If yes date is: ___ scheduled for the Dx interview w/ 2 LT Hannah Martinez; the feedback session is pending.

Subjective

The patient was seen to discuss participation in a psychological evaluation requested by his provider. The purpose, nature and limits of confidentiality were explained to the patient and all questions were answered.

Tests

He completed the RISB and the LNA.

Laboratory Studies:**Psychometric:**

Minnesota Multiphasic Personality Inventory (MMPI), Millon clinical multi-axial inventory, and projective administration of psychologic test.

A/P Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST

1. Generalized anxiety disorder

Procedure(s): -Psychologic Testing And Report Administered By Physician x 6

ADDITIONAL PROVIDER(S): MARTINEZ, HANNAH R

Disposition Written by BENTON, JIKESHA R @ 07 Feb 2017 1541 EST

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives with Patient who indicated understanding.

120 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BENTON, JIKESHA R @ 02 Feb 2017 1446 EST

Consult Order

Referring Provider: PAUL, SHERIN

Date of Request: 08 Dec 2016

Priority: Routine

Provisional Diagnosis:

Generalized anxiety disorder

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Reason for Request:

Diagnostic clarification. Patient has previous undocumented diagnoses of Borderline Personality Disorder and Reactive Attachment Disorder. Family history is significant for Bipolar disorder. Patient presents with relational apathy and anxiety.

Signed By BENTON, JIKESHA R (Physician/Workstation) @ 07 Feb 2017 1541

Verified by: BENTON, JIKESHA R 07 Feb 2017@1547

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

04 Oct 2016 2000 GMT at by COPSEY, HELEN C

Title:		Original Date:	04 Oct 2016 2000 GMT
	GASTROENTEROLO GY MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	04 Oct 2016 2028 GMT
Facility:		Document ID:	8361359185
Clinician:	COPSEY, HELEN C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160413-07484
 MCP Referral #: 20160660564
 No. of Visits: 1
 Referral Authorized Until: 13 May 2016
 Reason for Consult:
 SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 04 Oct 2016@15:00:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: GI CL BE
 Consulting HCP: COPSEY, HELEN C.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 04 Oct 2016 1500 EDT Appt Type: FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: GI CL

BE Provider: COPSEY, HELEN C.

Patient Status: Outpatient

Reason for Appointment:

F/U FOR Helicobacter pylori [H. pylori] as the cause of diseases cla

Appointment Comments:

ame.cc

Vitals

Vitals Written by THOMPSON,DEREK J @ 04 Oct 2016 1454 EDT

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

BP: 145/86, HR: 65, RR: 18, T: 98.1 F, HT: 69 in, WT: 158 lbs, BMI: 23.33, BSA: 1.869 square meters, Tobacco Use: No, Alcohol Use: Yes,

Pain Scale: 4/10 Moderate, Pain Scale Comments: abd
S/O Note Written by COPSEY, HELEN C. @ 04 Oct 2016 1617 EDT
bodybodyReason for Visit g27

Visit for: Abdominal pain.eg

History of present illness g2

The Patient is a 31 year old male.

31 yo M here for abdominal pain. Reports a long history of GI symptoms, dating back to childhood. Symptoms have been more disruptive over the past few years. Notes generalized sharp abdominal pain about every other day, that peaks prior to defecation and is relieved after bowel movements. Typically has 1-2 soft-liquid stools per day, infrequently with urgency. Symptoms may be worse with intake of insoluble fibers. Also worse during physical activity and with increased anxiety/stress. Reports he has never been formally diagnosed and has not been on treatment for these symptoms. Does consume cheese several times per week, and splenda on a daily basis.

Of note, patient underwent CT A&P in 2012 for the same abdominal pain, which showed focal colitis at the hepatic flexure with proximal stool retention. Colonoscopy (McNally) in 2012 showed mild congestion in the sigmoid, but biopsies were unremarkable. A subsequent MRE was completely normal. He saw GI earlier this year after he was noted to have a +serum AB to H.pylori. He was treated with triple therapy, and a stool test confirmed eradication in June.

.eg

Allergies g24

NKDA.eg

Past medical/surgical history g4

Reported:

Past medical history

Anxiety/depression

Surgical / Procedural: Prior surgery

Tonsillectomy

PRK

Medications: Medication history

Lexapro

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

? Pre-op ASA class 1eg

Previous therapy g19

? History of possible limitations and risks do not include complications from anesthesiaeg

Personal history g5

Tob: (-)

Etoh: (1-2 glasses of wine/ day)

.eg

Family history g7

No malignant neoplasm of large intestine

No malignant neoplasm of the gastrointestinal tract.eg

Review of systems g16

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Systemic: No fever, no chills, and no recent weight loss.
 Otolaryngeal: No mouth sores.
 Cardiovascular: No chest pain or discomfort.
 Pulmonary: No dyspnea.
 Gastrointestinal: No heartburn and no regurgitation. No early satiety, no nausea, no vomiting, no abdominal swelling, no tenesmus, no melena, no hematochezia, and no nocturnal diarrhea.
 Musculoskeletal: No arthralgias, new. No nonspecific pain, swelling, and stiffness.
 Skin: No rash, new.eg
 Physical findings g8
 Vital Signs:
 Current vital signs reviewed.
 Standard Measurements:
 Patient was not observed to be obese.
 General Appearance:
 Awake. Alert. Well developed. Well nourished. In no acute distress. Patient did not appear uncomfortable. Not acutely ill. Not chronically ill.
 Neck:
 Appearance: Of the neck was normal.
 Eyes:
 General/bilateral:
 Sclera: Showed no icterus.
 Oral Cavity:
 Normal OP clear, Mallampati score = 1.
 Chest:
 Visual inspection revealed no abnormalities.
 Lungs:
 Normal CTA B.
 Cardiovascular:
 System: normal RRR, no M or G.
 Abdomen:
 Normal soft, NT/ND, +BS.
 Neurological:
 Level of consciousness was normal. Oriented to time, place, and person.
 Speech: Normal.
 Gait And Stance: Normal.
 Psychiatric:
 Mood: Euthymic.
 Affect: Normal.
 Thought Processes: Not impaired.
 Skin:
 General appearance was normal. No jaundice. No skin lesions.eg
 Therapy g12
 ? Medical regimen review -- medication reconciliation performed.eg
 ebody
 ebody
 Lab Result Cited by COPSEY,HELEN C @ 04 Oct 2016 1454 EDT
 Comprehensive Metabolic PanelSite/Specimen16 Feb 2016 1430
 Aspartate AminotransferaseSERUM20
 Helicobacter pylori Ag EIA
 Order #160511-04658 (NNMC Bethesda)
 Filler #160606 NBL 374 (NNMC Bethesda)
 Status:Final

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Ordering Provider: SHAH, NISHA AMISH

Priority: ROUTINE

Date Ordered: 11 May 2016 0843

Date Resulted: 10 Jun 2016 0857

COLLECT_SAMPLE: STOOL

Order Comment: to be done two weeks after stopping protonix

BACTERIOLOGY RESULT: OBSERVATION: Negative

Specimen: Feces

Collected: 06 Jun 2016 1312

Results:

Final report

Tissue Exam

Date Collected: 12 Oct 2012 0001

POC Enc: E4520771

Enc Fac: WRNMMC

Clinician: COX, TIFFANY CANDACE

Status: Certify

Procedure: TISSUE EXAM

Order #: 121028-01374

Provider: COX, TIFFANY CANDACE

Ordered Date: 28 Oct 2012 1038

Priority: ROUTINE

Specimen: TISSUE

Resulted Date: 28 Oct 2012 1038.1-0500

121018 NSP 23631

Col: 12 Oct 12

TISSUE(TISSUE)

Hcp: COX, TIFFANY CANDACE

Req Loc: 5 EAST

TISSUE E

C: RB28 Oct 12 @ 1038

CoPath Report

Patient: MERWIN, DANIEL DENNIS

Specimen #: NS12-23631

Accessioned: 10/18/12

Pathologist: Ross Barner, COL MC USA

SPECIMEN:

A: ascending colon B: sigmoid colon

=====

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-==

FINAL DIAGNOSIS:

A. ASCENDING COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATE.

B. SIGMOID COLON, BIOPSY:

- BENIGN COLONIC MUCOSA WITH LYMPHOID AGGREGATES.

Comment: There is no evidence of acute cryptitis, architectural distortion, or dysplasia.

rx/10/19/12

** Report Electronically Signed Out **

Ross Barner, COL MC USA

=====

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-==

CLINICAL DIAGNOSIS AND HISTORY:

thickening of ascending colon on ct with no stranding, presented with obstructive symptoms, rule out mass vs. inflamm.

PRE-OPERATIVE DIAGNOSIS:

ascending colon thickening

POST-OPERATIVE DIAGNOSIS:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Operative Findings: sigmoid thickening

Post-operative Diagnosis: sigmoid thickening

GROSS DESCRIPTION:

A: The specimen is received in formalin, labeled with the patient's name Merwin, Daniel designated, "Ascending Colon" consists of two tan-white irregular soft tissue fragments measuring 0.4 and 0.6 cm in greatest dimension. Submitted entirely. 2/1/ng

B: The specimen is received in formalin, labeled with the patient's name Merwin, Daniel designated, "Sigmoid" consists of four tan-white irregular soft tissue fragments measuring 0.2 to 0.5 cm in greatest dimension. Submitted entirely. 4/1/ng NW/JAP/DVC

HLS/meh

Lab Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1454 EDT

Thyroid Stimulating Hormone Site/Specimen 06 Sep 2016 0923

Thyrotropin SERUM 2.500 <i>

CBC W/Diff Site/Specimen 22 Jun 2016 1240

WBC BLOOD 5.6

RBC BLOOD 4.86

Hemoglobin BLOOD 15.1

Hematocrit BLOOD 44.4

MCV BLOOD 91.4

MCH BLOOD 31.1

MCHC BLOOD 34.1

RDW CV BLOOD 12.9

Platelets BLOOD 272

MPV BLOOD 9.0

Neutrophils BLOOD 59.4

Lymphocytes BLOOD 29.8

Monocytes BLOOD 8.9

Eosinophils BLOOD 1.5

Basophils BLOOD 0.4

ABS Neutrophils BLOOD 3.3

ABS Lymphocytes BLOOD 1.7

ABS Monocytes BLOOD 0.5

ABS Eosinophils BLOOD 0.1

ABS Basophils BLOOD 0.0

Differential Review BLOOD MANUAL DIFF NOT PERFORMED

Comprehensive Metabolic Panel Site/Specimen 16 Feb 2016 1430

Albumin SERUM 4.7

Alkaline Phosphatase SERUM 53

Alanine Aminotransferase SERUM 17

Bilirubin SERUM 0.4

Urea Nitrogen SERUM 13.8

Calcium SERUM 9.7

Carbon Dioxide SERUM 29

Chloride SERUM 98

Creatinine SERUM 0.96

Glucose SERUM 89

Potassium SERUM 4.4

Protein SERUM 7.6

Sodium SERUM 141

Anion Gap SERUM 14

GFR Calculated Non-Black SERUM 105.6

GFR Calculated Black SERUM 122.1 <i>

Aspartate Aminotransferase SERUM 20

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Rad Result Cited by COPSEY, HELEN C @ 04 Oct 2016 1453 EDT
 MERWIN, DANIEL DENNIS 20/ [REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985
 M

***** MRI, ABD/PEL ENTEROCLYSIS (GI ONLY) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: MRI, ABD/PEL ENTEROCLYSIS (GI ONLY)

Event Date: 23-Oct-2012 15:54:00

Exam #: 12359730

Exam Date/Time: 02-Nov-2012 07:18:00

Transcription Date/Time: 05-Nov-2012 09:56:00

Provider: COPSEY, HELEN C

Requesting Location:

GSURG GI APU BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Supervised By: MARCIA JAVITT, MD

Approved By: JAVITT, MARCIA C

Approved Date: 05-Nov-2012 09:48:00

Supervised By: 115455 MARCIA JAVITT, MD

Supervised By Date: 05-Nov-2012 09:48:00

Amended Report Text:

ADDITIONAL HISTORY: CT examination with right-sided colonic thickening
 and

equalization of small bowel. Recent colonoscopy and without lesion the
 terminal

ileum a concern stenosis or inflammation of the distal ileum.

TECHNIQUE: Standard MR enterocleisis protocol; Three plane localizer,
 coronal

FIESTA, axial T2 SS FSE, axial and coronal T2 SS FSE, axial and coronal
 FIESTA

fat sat, axial SPGR in and out of phase, axial and coronal LAVA pre-and
 postcontrast MRI of the abdomen.

COMPARISONS: CT abdomen/pelvis 10/11/12

FINDINGS:

Bowel loops are adequately distended without focal stenosis, stricturing,
 or

luminal narrowing. There is normal bowel peristalsis and motion observed
 on the

cinematic images. Minimal mural thickening of the mid jejunum observed at
 the

left upper quadrant without corresponding abnormal mucosal enhancement,
 stricturing or stenosis.

The liver and gallbladder are normal without intra-or extrahepatic biliary
 ductal dilatation. The spleen, pancreas, adrenals, and kidneys are
 normal.

No intra-abdominal mass or fluid collection. No enlarged abdominal or
 pelvic

lymph nodes.

Osseous marrow signal is nonpathologic.

IMPRESSION:

No abnormal areas of enhancement or mural thickening within the
 gastrointestinal

system, specifically evidence of active inflammation at the site of

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

previously

observed colitis on CT examination 10/11/12. Correlate with patient's
symptomatology.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 11/05/12
Time:09:20

Electronically signed by:Dr. Marcia Javitt Date: 11/05/12 Time:09:48

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MERWIN, DANIEL DENNIS 20/[REDACTED] DoD ID: 1286180538 31yo [REDACTED] 1985
M

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)

Event Date: 11-Oct-2012 01:30:00

Exam #: 12343907

Exam Date/Time: 11-Oct-2012 00:30:00

Transcription Date/Time: 12-Oct-2012 07:00:00

Provider: HARDWARE, LESLIE

Requesting Location:

EMERGENCY RM BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Approved By: BERNARD, JACQUELINE M

Approved Date: 11-Oct-2012 08:16:00

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Supervised By Date: 11-Oct-2012 08:16:00

Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard
abdomen/pelvis CT protocol with 5 mm axial helically acquired images
obtained

from the level of the diaphragm to the level of the pubic symphysis after
the

intravenous administration of 110 mL Isovue 370 and oral contrast.

Coronal and

sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree
without

intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen,
adrenals,

and kidneys are normal. No identifiable ureteral abnormalities.

Fluid-filled

urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is
normal.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

There is fecal material and air noted within the distal ileum extending to a mildly distended stool filled cecum. The appendix is identified and is normal.

There is a focal area of vascular prominence involving the mesentery at the

level of the hepatic flexure. The colon wall at this level appears mildly thickened but otherwise decompressed. The colon distal to the hepatic flexure

is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in

configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention

and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's

disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450

hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12

Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12

Time:08:16

A/P Written by COPSEY,HELEN C @ 04 Oct 2016 1623 EDT

1. Irritable bowel syndrome with diarrhea: Clinical history is consistent with IBS-D. This diagnosis was discussed with the patient in detail and all questions were answered. Goals of management were reviewed including options such as natural interventions/ dietary change/ stress management, all the way to low dose TCA therapy. He v/u and opts to proceed as detailed below.

PLAN:

1. Celiac panel.
2. Strict dairy free trial x 2 weeks.
3. Stop Splenda.
4. Pending progress, consider 2 week course of Xifaxan.
5. F/u with me directly via phone/email/relay health with updates.

Disposition Written by COPSEY,HELEN C @ 04 Oct 2016 1623 EDT

Released w/o Limitations

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 04 Oct 2016 1623

Verified by: COPSEY,HELEN C. 04 Oct 2016@1628

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Jun 2016 1540 GMT at by KWOK, RYAN M

Title:		Original Date:	22 Jun 2016 1540 GMT
	GASTROENTEROLO GY MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	23 Jun 2016 1913 GMT
Facility:		Document ID:	8136320953
Clinician:	KWOK, RYAN M		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160413-07484
 MCP Referral #: 20160660564
 No. of Visits: 1
 Referral Authorized Until: 13 May 2016
 Reason for Consult:
 SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 22 Jun 2016@10:40:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: GI CL BE
 Consulting HCP: KWOK, RYAN MITCHELL

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 22 Jun 2016 1040 EDT Appt Type: FTR

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: GI CL

BE Provider: KWOK, RYAN MITCHELL

Patient Status: Outpatient

AutoCites Refreshed by SHAH, NISHA A @ 22 Jun 2016 1111 EDT

Allergies

?OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

f/u

Appointment Comments:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

BAR

Vitals

Vitals Written by THOMPSON,DEREK J @ 22 Jun 2016 1039 EDT

BP: 146/87, HR: 74, RR: 14, T: 98.2 F, HT: 69 in, WT:

165 lbs, SpO2: 99%, BMI: 24.37,

BSA: 1.903 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain

Scale: 4/10 Moderate,

Pain Scale Comments: Sharp Pain in Chest when taking deep breaths on inhale.

S/O Note Written by SHAH,NISHA AMISH @ 22 Jun 2016 1349 EDT

bodybodyChief complaint g1

The Chief Complaint is: F/u.eg

History of present illness g2

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male to f/u for lab results (confirmed h pylori eradication) but states he is having intense chest pain worsened with coughing and breathing right now. Denies n/v/diaphoresis. Denies pain radiating to back/jaw/arm.

He is very anxious and concerned and would like to go to ED. Appointment ended at this time.eg

ebody

ebody

A/P Last Updated by SHAH,NISHA A @ 22 Jun 2016 1335 EDT

1. Other chest pain R07.89: Due to lightheadedness/dizziness although stable vital signs and continued chest pain, will send to ED for evaluation. Can f/u in 4 weeks after trial of fodmap as discussed in past. H pylori eradication confirmed.

Disposition Written by KWOK,RYAN M @ 23 Jun 2016 1507 EDT

Immediate Referral - Referred to: ED

Follow up: 4 week(s) in the GI CL BE clinic or sooner if there are problems. -

Comments: Case discussed with GI staff, Dr. Kwok, who agrees with above plan.

Patient was wheelchaired to ED. ED staff was called and case discussed.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by KWOK,RYAN M @ 23 Jun 2016 1508 EDT

Pt not seen as triaged to ER prior to my encounter, agree with plan for urgent triage via ER prior to GI evaluation.

Signed By KWOK, RYAN M (Physician, Gastroenterology / Transplant Hepatology Staff, Walter Reed National Military Medical Center) @ 23 Jun 2016 1508

Verified by: Ryan M. Kwok, CPT, MC, USA 23 Jun 2016@1513

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Jun 2016 1800 GMT at by XYDAKIS, MICHAEL S

Title:		Original Date:	07 Jun 2016 1800 GMT
	OTOLARYNGOLOGY		
	NCR		
Document Type:	Consultation	AHLTA Entry Date:	07 Jun 2016 1803 GMT
Facility:		Document ID:	8098344099
Clinician:	XYDAKIS, MICHAEL S		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160411-10434
 MCP Referral #: 20160641249
 No. of Visits: 5
 Referral Authorized Until: 26 Jul 2016
 Reason for Consult:
 Consult from Dr Thompson to Dr Xydakis: SM with chronic bitter tastes with surgery like foods. Normal ENT exam, Ordered MRI Brain, Please evaluate and treat
 Priority: ROUTINE
 Provisional Diagnosis:
 Unspecified disturbances of smell and taste
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 07 Jun 2016@13:00:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: OTOLARYNG CL BE
 Consulting HCP: XYDAKIS, MICHAEL S

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 07 Jun 2016 1300 EDT Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

OTOLARYNG CL BE Provider: XYDAKIS, MICHAEL S

Patient Status: Outpatient

Reason for Appointment:

Unspecified disturbances of smell and taste

Appointment Comments:

emh

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

S/O Note Written by XYDAKIS,MICHAEL S @ 07 Jun 2016 1341 EDT

bodybodyChief complaint g1

The Chief Complaint is: 31 active duty navy from Ft Meade referred by colleague (dr David Thompson) for dysgusia of approximately 8 months duration. Specifically, patient indicates that on 16 Oct 2015, he was making pizza and noticed the alteration in taste. He presented to his nurse practitioner on 9 Nov 2015 and was referred to ENT. Smell is fine. NO tobacco (social smoker about 9 years ago). Patient does have a h/o alcohol dependence requiring counseling (notes in AHLTA indicate that therapy began in Aug 2014). MRI Brain (15 April 2016) = Normal olfactory eloquent structures.eg

History of present illness g2

The Patient is a 31 year old male.

He reported: Past medical history reviewed, problem list reviewed, medication list reviewed, family history reviewed, and surgical history reviewed.eg

Past medical/surgical history g4

Reported:

Recent Events: An active illness Longstanding history of irritable bowel syndrome. History of H. Pylori and GERD (followed by GI).eg

Physical findings g8

Neck:

? Neck: No palpable adenopathy.

Nose:

Right Side Of Nose:

? Examined.

Left Side Of Nose:

? Examined Moderate nasal septal deflection to the left with fracture / dislocation at the bony cartilagenous junction. No infectious, inflammatory nor obstructive pathology noted.

Oral Cavity:

General condition was good S/p tonsillectomy. + discoloration and brownish/green film noted on posterior 1/3 of the tongue. Mucosa otherwise pale pink and moist. + discoloration of the teeth.

Tongue: ? Mucositis scale.eg

ebody

ebody

A/P Written by XYDAKIS,MICHAEL S @ 07 Jun 2016 1356 EDT

1. Unspecified disturbances of smell and taste

2. Glossitis

3. Gastro-esophageal reflux disease without esophagitis: Sniffen extended battery 16 panel odorant test performed. Patient scored 16/16 with rapid, crisp reliable responses. Olfactory threshold testing performed. Patient scored 8/16 which is normal for age. Olfactory discrimination was normal. Burghart taste strips and sprays administered. Patient was able to discern tastes (sweet, salty, sour, bitter) at even the lowest concentrations. Hence, completely normal taste. A/P: Dysgusia due to mild glossitis which is due to GERD up to the level of the hypopharynx and base of tongue. Patient is scheduled to see GI in the next week or so. Likely his symptomatology will resolve once his acid reflux is under control and the tongue is no longer inflamed. Would consider Nystatin or mycelex oral troches. However, it would be preferable to address the underlying cause of the problem (i.e. Acid reflux) and see if the tongue inflammation resolves. Patient understands and agrees with this approach. He will send me an e-mail to assess interval change.

Disposition Written by XYDAKIS,MICHAEL S @ 07 Jun 2016 1357 EDT

Released w/o Limitations

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Merwin, Daniel Dennis

DOB: [REDACTED]

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SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Follow up: as needed .

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by XYDAKIS, MICHAEL S @ 07 Jun 2016 1255 EDT

Consult Order

Referring Provider: THOMPSON, DAVID HERRON

Date of Request: 11 Apr 2016

Priority: Routine

Provisional Diagnosis:

Unspecified disturbances of smell and taste

Reason for Request:

Consult from Dr Thompson to Dr Xydakis: SM with chronic bitter tastes with surgery like foods. Normal ENT exam, Ordered MRI Brain, Please evaluate and treat

Signed By XYDAKIS, MICHAEL S (Physician) @ 07 Jun 2016 1357

Verified by: XYDAKIS, MICHAEL S 07 Jun 2016 @1403

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 May 2016 1300 GMT at by LACZEK, JEFFREY T

Title:		Original Date:	11 May 2016 1300 GMT
	GASTROENTEROLO GY MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	17 May 2016 1849 GMT
Facility:		Document ID:	8054554000
Clinician:	LACZEK, JEFFREY T		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: THOMPSON, DAVID HERRON
 Requesting Location: OTOLARYNG CL BE
 Order ID number: 160413-07484
 MCP Referral #: 20160660564
 No. of Visits: 1
 Referral Authorized Until: 13 May 2016
 Reason for Consult:
 SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 11 May 2016@08:00:00
 Requesting HCP: THOMPSON, DAVID HERRON
 Clinic: GI CL BE
 Consulting HCP: LACZEK, JEFFREY T

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 11 May 2016 0800 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: GI CL
 BE Provider: LACZEK, JEFFREY T
 Patient Status: Outpatient
 AutoCites Refreshed by SHAH, NISHA A @ 11 May 2016 0808 EDT
 Allergies
 ?OTHER: Unknown (SEE MED RECORD)
 Reason for Appointment:
 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

Appointment Comments:

ek/irmac

Vitals

Vitals Written by THOMPSON,DEREK J @ 11 May 2016 0752 EDT

BP: 118/72, HR: 68, RR: 10, T: 98.4 F, HT: 69 in, WT:

167 lbs, SpO2: 98%, BMI: 24.66,

BSA: 1.913 square meters, Tobacco Use: No, Alcohol Use: No, Pain

Scale: 6/10 Moderate,

Pain Scale Comments: Cramping intermittent pain in the Intestines

S/O Note Written by SHAH,NISHA AMISH @ 11 May 2016 1523 EDT

bodybodyChief complaint g1

The Chief Complaint is: + h pylori test.eg

History of present illness g2

The Patient is a 31 year old male.

<<Note accomplished in TSWF-CORE>>

31 year old male referred from ENT when during w/u of dysgeusia was found to + serum H pylori Ab and presents for further management. Patient states he has never been treated for h pylori.

He also states that he has had 'ibs pain' since age 15. The pain is in the upper abdomen described as sharp and does not radiate. The pain can last minutes to longer and resolves once he goes to the bathroom having a soft stool; bristol type 5-6. Episodes occur weekly and are triggered by certain foods (spicy foods/fiber filled foods).

Of note, he went to the ED a few years ago for similar abdominal pain, he was then seen in the GI clinic and found to have a normal MRE after initial colonoscopy was concerning for thickened folds. He was lost to follow up.

Heartburn burning sensation - 2x per month, abdominal pain, and diarrhea.eg

Allergies g24

Allergies Verified and Updated

NKDA.eg

Current medication g3

Including OTCs, vitamins, herbals, supplements, etc.

Albuterol prn

Denies otc/herbals/supplements.eg

Past medical/surgical history g4

Reported:

Medical: Reported medical history

SAR

He denies any other medical issues.

Surgical / Procedural: Surgical / procedural history None.eg

Personal history g5

Social history reviewed Denies tob/etoh.eg

Family history g7

Family medical history

No hx of celiac/IBD

No hx of GI malignancies

Mom and grandmother with also 'stomach problems'.eg

Review of systems g16

Systemic: Not feeling tired (fatigue). No fever, no chills, and no night sweats.

Eyes: No eye pain. No red eyes.

Cardiovascular: No chest pain or discomfort.

Pulmonary: No dyspnea and no cough.

Gastrointestinal: Appetite not decreased. No dysphagia and no pain on swallowing. No nausea, no vomiting, no hematemesis, no jaundice, no bright

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

red blood per rectum, and no constipation.

Musculoskeletal: No localized joint pain.

Skin: No rash.eg

Physical findings g8

Vital Signs:

? Temperature: Reviewed. ? RR: Reviewed. ? PR: Reviewed. ? Blood pressure:

Reviewed.

General Appearance:

Normal. Well developed. Well nourished. In no acute distress.

Neck:

Appearance: Of the neck was normal.

Eyes:

General/bilateral:

External: Conjunctiva exhibited no abnormalities.

Sclera: Normal.

Ears:

General/bilateral:

Outer Ear: Normal.

Oral Cavity:

Lips: Showed no abnormalities.

Buccal Mucosa: Examination showed no abnormalities.

Pharynx:

? Pharynx: MC3.

Oropharynx: Normal. Tonsils showed no abnormalities.

Lungs:

Respiration rhythm and depth was normal. Exaggerated use of accessory muscles for inspiration was not observed. Clear to auscultation. No wheezing was heard. No rhonchi were heard. No rales/crackles were heard.

Cardiovascular:

Heart Rate And Rhythm: Normal.

Heart Sounds: Normal S1 and S2. No gallop was heard. No click was heard. No pericardial friction rub heard.

Murmurs: No murmurs were heard.

Abdomen:

Visual Inspection: Abdomen was not distended.

Auscultation: Bowel sounds were not diminished or absent.

Palpation: Abdomen was soft. No abdominal guarding. Abdominal non-tender Mild ttp in RLQ. No mass was palpated in the abdomen.

Liver: Normal to palpation.

Spleen: Normal to palpation.

Hernia: No hernia was discovered.

Musculoskeletal System:

Functional Exam:

General/bilateral: Mobility was not limited.

Neurological:

Oriented to time, place, and person.

Gait And Stance: Normal.

Psychiatric:

Mood: Euthymic.

Affect: Normal.

Skin:

Showed no ecchymosis. Temperature was normal. No skin lesions.eg

ebody

ebody

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

CBC W/o DiffSite/Specimen11 Apr 2016 1043

WBCBLOOD4.7

RBCBLOOD4.88

HemoglobinBLOOD15.4

HematocritBLOOD45.0

MCVBLOOD92.3

MCHBLOOD31.5

MCHCBLOOD34.1

PlateletsBLOOD293

RDW CVBLOOD13.3

MPVBLOOD8.6

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Basic Metabolic PanelSite/Specimen11 Apr 2016 1043

Urea NitrogenSERUM9.7

Carbon DioxideSERUM28

ChlorideSERUM97 (L)

CreatinineSERUM0.87

GlucoseSERUM92

PotassiumSERUM4.4

SodiumSERUM139

CalciumSERUM10.2

Anion GapSERUM15

GFR Calculated Non-BlackSERUM115.0

GFR Calculated BlackSERUM132.9 <i>

Lab Result Cited by SHAH,NISHA A @ 11 May 2016 0814 EDT

Helicobacter pylori Ab IgGSite/Specimen11 Apr 2016 1043

Helicobacter pylori Ab IgG SERUM7.1 (H) <i>

A/P Last Updated by SHAH,NISHA A @ 11 May 2016 1553 EDT

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere B96.81: 31 year old male with incidental finding of h pylori, unlikely related to dysguesia but would be interested at follow up to see if treatment affects symptoms. As it is a carcinogen, would recommend therapy.

No exposure to antibiotics in last 6-8 months, will do triple therapy.

Patient counseled on importance of compliance as well as confirmation of eradication two weeks after stopping PPI therapy.

Medication(s): -PANTOPRAZOLE--PO 40MG TBDR - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR TWO WEEKS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

-AMOXICILLIN--PO 500MG CAP - TAKE TWO CAPSULE BY MOUTH TWICE A DAY FOR TWO WEEKS #56 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

-CLARITHROMYCIN--PO 500MG TAB - TAKE ONE TABLET BY MOUTH TWICE A DAY FOR FOURTEEN DAYS #28 RF0 Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

Laboratory(ies): -H PYLORI AG, EIA (Routine): to be done two weeks after stopping protonix Ordered By: SHAH,NISHA A Ordering Provider: SHAH, NISHA AMISH

2. Irritable bowel syndrome with diarrhea K58.0: No red flags and triggers seem to be primarily food/stress. Will first focus on understanding triggers with food diary and assess if high fodmap (sheet given), After two week of obeservation, asked that he eliminate one food a week from his triggers. Plan to see back in 6-8 weeks and decide next step in management.

Disposition Last Updated by SHAH,NISHA A @ 11 May 2016 1612 EDT

Released w/o Limitations

Follow up: 6 to 8 week(s) in the GI CL BE clinic or sooner if there are

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

problems. - Comments: Case discussed with GI staff, Dr. Laczek, who agrees with above plan.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by MCPHERSON,CARL E @ 11 May 2016 0721 EDT

Consult Order

Referring Provider:THOMPSON, DAVID HERRON

Date of Request:13 Apr 2016

Priority:Routine

Provisional Diagnosis:

Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

Reason for Request:

SM with Reflux and Postive H. Pylori on IGG, Please evalute and treat.

Note Written by LACZEK,JEFFREY T @ 17 May 2016 1432 EDT

GI Staff

I saw PO1 Merwin with Dr. Shah. I agree with Dr. Shah's assesment that his dysguesia is unlikely related to his H. pylori infection. I also agree with the plan to treat his H. pylori infection.

Signed By LACZEK, JEFFREY T (Staff Gastroenterologist, WRNMMC Bethesda, MD) @ 17 May 2016 1434

Verified by: LACZEK,JEFFREY T 17 May 2016@1449

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

11 Apr 2016 1330 GMT at by THOMPSON, DAVID HERRON

Title:	OTOLARYNGOLOGY NCR	Original Date:	11 Apr 2016 1330 GMT
Document Type:	Consultation	AHLTA Entry Date:	11 Apr 2016 1440 GMT
Facility:		Document ID:	7968044495
Clinician:	THOMPSON, DAVID HERRON		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: AUSTIN, MARIE
 Requesting Location: QQQCHCSIITESTBETHESDA CLINIC
 Order ID number: 160301-18101
 MCP Referral #: 20160371948
 No. of Visits: 1
 Referral Authorized Until: 31 Mar 2016
 Reason for Consult:
 Pt is reporting that all sweet things taste bitter except for artifical sweet
 eners please eval and treat
 Priority: ROUTINE
 Provisional Diagnosis:
 change in taste
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 11 Apr 2016@08:30:00
 Requesting HCP: AUSTIN, MARIE
 Clinic: OTOLARYNG CL BE
 Consulting HCP: THOMPSON, DAVID HERRON

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 11 Apr 2016 0830 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:
 OTOLARYNG CL BE Provider: THOMPSON, DAVID HERRON
 Patient Status: Outpatient
 AutoCites Refreshed by THOMPSON, DAVID HERRON @ 05 Apr 2016 1011 EDT
 Problems
 ?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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DoD ID: 1286180538

Created: 16 Aug 2017

?MAJOR DEPRESSION RECURRENT MODERATE
 ?ANXIETY DISORDER NOS
 ?Left ankle joint pain
 ?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Family History

?family medical history (General FHx)
 ?family history of test conclusions [Use for free text] (General FHx)
 ?family history of diabetes mellitus (General FHx)
 ?family history of heart disease (General FHx)
 ?family history of mental illness (not retardation) (General FHx)
 ?no family history of cancer (General FHx)
 ?family history of the options include referral (General FHx)
 ?family history of patient counseling (General FHx)
 ?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
 ?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
 ?paternal history of preliminary background HPI [use for free text] (Father)
 ?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
 ?family history of supplemental HPI [use for free text] (General FHx)
 ?no family history of malignant neoplasm of the large intestine (General FHx)
 ?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
 ?no family history of chronic liver disease (General FHx)

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

PODOFILOX, 0.5 %, SOLUTION, TOPICAL Active APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2 2 of 2 24 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE, INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL Active APPLY TO SCALP EVERY DAY AS NEEDED #0 RF3 3 of 3 29 Sep 2015

Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA Active INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3 3 of 3 28 Sep 2015

Reason for Appointment:

change in taste

Appointment Comments:

pb/irmac

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Vitals

Vitals Written by KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

BP: 121/79, HR: 70, RR: 16, T: 98.5 F, Tobacco Use: No,

Alcohol Use: Yes, Pain Scale: 0 Pain Free

Comments: 4105625345

nkda

A/P Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1032 EDT

1. Unspecified disturbances of smell and taste: S: Taste abrupt onset of better taste (Oct 16, while eating pizza), now for surgery foods and chocolate, most other foods taste OK, and smell is OK. Going off zoloft did not change

All: none Rx none Ill none surgery tx , prk tooth, admits GI stuff, IBS ,

ROS: hearing ok, breath nose ok, swallow ok, no sore throats

O: tms nl , mouth, tongue is normal, phx, neck, thyroid no mass Nps: nose clear, no mass nasopharynx, tvx mobile no edema arytoids

-- b12 neg

-- HIV neg, 16 Feb 16

A: ddx olfactory nerve issue, brain pathology, h pylori, zinc, b12

P: MRI brain, labs, and referral to Dr Xydakis for taste and smell. Plant based diet

Procedure(s): -Fiberoptic Laryngoscopy Flexible (diagnostic) x 1 - After verbal informed consent, topical 4% lidocaine/ afrin mixture was sprayed into the nose bilaterally. The flexible scope was passed through bilateral nares and into hypopharynx with findings as described in above exam. The patient tolerated well without complications.

Note: Reviewed AHLTA record, and Reviewed with patient: past treatments, laboratory, and Radiological Studies, DDX symptoms, and Planned Management Laboratory(ies): -H PYLORI IGG (Routine); ZINC (Routine); BASIC METABOLIC PANEL (Routine); LYME DISEASE AB, TOTAL (Routine); CBC W/O DIFFERENTIAL (Routine); ESR (Routine); TREPONEMA PALLIDUM AB (Routine)

Radiology(ies): -MRI, BRAIN W W/O CON (Routine) Impression: SM with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad

Comment: Please use gad

Consult(s): -Referred To: OTOLARYNGOLOGY NCR (Routine) Specialty: OTORHINOLARYNGOLOGY Clinic: RM OTOLARYNGOLOGY IR Provisional Diagnosis: Unspecified disturbances of smell and taste

Disposition Written by THOMPSON,DAVID HERRON @ 11 Apr 2016 1034 EDT

Released w/o Limitations

Follow up: 2 month(s) or sooner if there are problems. - Comments: follow up with Dr Xydakis, c 410 562 5345 w 443 654 5847

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Note Written by KIPTOO,ALEX @ 11 Apr 2016 0907 EDT

Consult Order

Referring Provider:AUSTIN, MARIE R

Date of Request:01 Mar 2016

Priority:Routine

Provisional Diagnosis:

change in taste

Reason for Request:

Pt is reporting that all sweet things taste bitter except for artificial sweeteners please eval and treat

Signed By THOMPSON, DAVID HERRON (Physician/Workstation) @ 11 Apr 2016 1035

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

CHANGE HISTORY

The following Vitals Entry Was Overwritten by KIPTOO,ALEX @ 11 Apr 2016 0909

EDT:

Vitals Written by KIPTOO,ALEX @ 11 Apr 2016 0908 EDT

Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 0 Pain Free

Verified by: DAVID H. THOMPSON,CAPT,MC,U11 Apr 2016@1040

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

05 Apr 2016 1330 GMT at by BAHR, ROBERT J

Title:	PHYSICAL	Original Date:	05 Apr 2016 1330
	THERAPY MTF BE		GMT
Document Type:	Consultation	AHLTA Entry Date:	05 Apr 2016 1306
			GMT
Facility:		Document ID:	7954090961
Clinician:	BAHR, ROBERT J		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: WILSON, BRYAN JAMES
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 160216-23530
 MCP Referral #: 20160274357
 No. of Visits: 1
 Referral Authorized Until: 17 Mar 2016
 Reason for Consult:
 L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On light duty 30 days. Needs eval and likely graduated exercise.
 Priority: ROUTINE
 Provisional Diagnosis:
 Sprain of other ligament of left ankle, subsequent encounter
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 05 Apr 2016@08:30:00
 Requesting HCP: WILSON, BRYAN JAMES
 Clinic: PHYS THERAPY CL BE
 Consulting HCP: BAHR, ROBERT J.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 05 Apr 2016 0830 EDT Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS
 THERAPY CL BE Provider: BAHR, ROBERT J.
 Patient Status: Outpatient
 AutoCites Refreshed by BAHR, ROBERT J @ 05 Apr 2016 0835 EDT
 Problems
 ?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
 ?MAJOR DEPRESSION RECURRENT MODERATE
 ?ANXIETY DISORDER NOS

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

?Left ankle joint pain
 ?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

PODOFILOX, 0.5 %, SOLUTION, TOPICAL Active APPLY TWICE A DAY FOR 3 DAYS THEN
 STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2 2 of 2 24 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
 INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL Active APPLY TO SCALP
 EVERY DAY AS NEEDED #0 RF3 3 of 3 29 Sep 2015

Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA Active INHALE

2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3 3 of 3 28
 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAH,ROBERT J. @ 05 Apr 2016 0858 EDT

bodybodyHistory of present illness g2

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo
 WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed
 a thickening of his ligament. He was treated in PT here. His pain has been
 off and on until two months ago when his foot was plantarflexed. He has had
 no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with
 activity. Mild swelling noted laterally. Pain increases with walking and
 the pushing off of his foot and going up and down stairs. Pain decreases
 with foot into the neutral position. He states he uses no meds--see AHLTA
 for medication reconciliation. He works with computers, exercises
 moderately running/walking 3-11 miles. He had new xrays three days ago which
 appear WNL. He learns without preference. His goal is to have a pain free
 ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle
 dorsiflexors, plantarflexors, everters, inverters 5/5. negative drawer.
 Mild tenderness along lateral malleolus on left. Mild swelling noted. No
 heat or warmth or discoloration noted. Gait WNL, heel and toe walk within
 normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will
 benefit from skilled physical therapy program. ~PLAN: Home program of
 eccentric heel lowering and calf stretches for three weeks and then followup.
 ~GOAL: Decrease pain 75% in three weeks STG. Increase running without
 pain to four miles in 2 months. Pt educated on exercises and given handouts.
 ~PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain is

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

now gone. He is training for a marathon and is up to running 25 miles per week. Pt does not want his foot examined today. Plan: discharge PT.

F/U prn.eg

ebody

ebody

A/P Written by BAHR,ROBERT J @ 05 Apr 2016 0900 EDT

1. Pain in left ankle and joints of left foot

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAHR,ROBERT J @ 05 Apr 2016 0900 EDT

Released w/o Limitations

Signed By BAHR, ROBERT J (Physical Therapist, wrnmmc) @ 05 Apr 2016 0900

Verified by: BAHR,ROBERT J. 05 Apr 2016@0905

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

07 Mar 2016 1430 GMT at by BAHR, ROBERT J

Title:	PHYSICAL	Original Date:	07 Mar 2016 1430
	THERAPY MTF BE		GMT
Document Type:	Consultation	AHLTA Entry Date:	07 Mar 2016 1418
			GMT
Facility:		Document ID:	7884138692
Clinician:	BAHR, ROBERT J		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: WILSON, BRYAN JAMES
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 160216-23530
 MCP Referral #: 20160274357
 No. of Visits: 1
 Referral Authorized Until: 17 Mar 2016
 Reason for Consult:
 L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On light duty 30 days. Needs eval and likely graduated exercise.
 Priority: ROUTINE
 Provisional Diagnosis:
 Sprain of other ligament of left ankle, subsequent encounter
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 07 Mar 2016@08:30:00
 Requesting HCP: WILSON, BRYAN JAMES
 Clinic: PHYS THERAPY CL BE
 Consulting HCP: BAHR, ROBERT J.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 07 Mar 2016 0830 EDT Appt Type: FTR
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS
 THERAPY CL BE Provider: BAHR, ROBERT J.
 Patient Status: Outpatient
 AutoCites Refreshed by BAHR, ROBERT J @ 07 Mar 2016 0823 EDT
 Problems
 ?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR
 ?MAJOR DEPRESSION RECURRENT MODERATE
 ?ANXIETY DISORDER NOS

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

?Left ankle joint pain
 ?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

PODOFILOX, 0.5 %, SOLUTION, TOPICAL Active APPLY TWICE A DAY FOR 3 DAYS THEN
 STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #0 RF2 2 of 2 24 Feb 2016

IBUPROFEN, 800 MG, TABLET, ORAL Active TAKE ONE TABLET BY MOUTH THREE TIMES
 A DAY AS NEEDED FOR PAIN #0 RF0 NR 24 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
 INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL Active APPLY TO SCALP
 EVERY DAY AS NEEDED #0 RF3 3 of 3 29 Sep 2015

Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA Active INHALE
 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3 3 of 3 28
 Sep 2015

Appointment Comments:

dhj

S/O Note Written by BAH,ROBERT J. @ 07 Mar 2016 0909 EDT

bodybodyHistory of present illness g2

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo
 WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed
 a thickening of his ligament. He was treated in PT here. His pain has been
 off and on until two months ago when his foot was plantarflexed. He has had
 no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with
 activity. Mild swelling noted laterally. Pain increases with walking and
 the pushing off of his foot and going up and down stairs. Pain decreases
 with foot into the neutral position. He states he uses no meds--see AHLTA
 for medication reconciliation. He works with computers, exercises
 moderately running/walking 3-11 miles. He had new xrays three days ago which
 appear WNL. He learns without preference. His goal is to have a pain free
 ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle
 dorsiflexors, plantarflexors, everters, interverters 5/5. negative drawer.
 Mild tenderness along lateral malleolus on left. Mild swelling noted. No
 heat or warmth or discoloration noted. Gait WNL, heel and toe walk within
 normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will
 benefit from skilled physical therapy program. ~PLAN: Home program of
 eccentric heel lowering and calf stretches for three weeks and then followup.
 ~GOAL: Decrease pain 75% in three weeks STG. Increase running without

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

pain to four miles in 2 months. Pt educated on exercises and given handouts.

`PROGNOSIS: good. TODAY'S INTERVENTION: Pt reports that his pain has decreased and his strength is good. Exercise causes pain laterally while doing the exercises but he feels better afterwards. He rates his pain at 1/10 at rest and 3/10 with activity. Pt to do saphenous and peroneal nerve glides throughout the day and to return in two to three weeks for followup.

eg

body

A/P Written by BAHR,ROBERT J @ 07 Mar 2016 0912 EDT

1. Pain in left ankle and joints of left foot

Procedure(s): -Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

-Physical Therapy Service Re-Evaluation x 1

Disposition Written by BAHR,ROBERT J @ 07 Mar 2016 0912 EDT

Released w/o Limitations

Signed By BAHR, ROBERT J (Physician) @ 07 Mar 2016 0913

Verified by: BAHR,ROBERT J. 07 Mar 2016@0918

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

24 Feb 2016 1900 GMT at by MARQUART, JASON DANIEL

Title:	DERMATOLOGY	Original Date:	24 Feb 2016 1900 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	24 Feb 2016 2012 GMT
Facility:		Document ID:	7858019868
Clinician:	MARQUART, JASON DANIEL		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: WILSON, BRYAN JAMES
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 160216-23515
 MCP Referral #: 20160274355
 No. of Visits: 1
 Referral Authorized Until: 17 Mar 2016
 Reason for Consult:
 1mm x 1mm papules at base of penis previously treated empirically for genital warts, did not respond to Imiquimod. Skin changes are very limited, may be physiologic. Please evaluate and treat.
 Priority: ROUTINE
 Provisional Diagnosis:
 Sprain of other ligament of left ankle, subsequent encounter
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 24 Feb 2016@13:00:00
 Requesting HCP: WILSON, BRYAN JAMES
 Clinic: DERMATOLO CL BE
 Consulting HCP: MARQUART, JASON DANIEL

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 24 Feb 2016 1300 EST Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

DERMATOLO CL BE Provider: MARQUART, JASON DANIEL

Patient Status: Outpatient

Reason for Appointment:

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Note Written by LAM,THOMAS KIN @ 24 Feb 2016 1329 EST

CC: Genital warts

HPI: 31 yo man who was referred here by PCM for further evaluation and/or management of warts on penis not responsive to topical Aldara.

Hx of skin cancer: None ? BCC ? SCC ? MM ?

Family Hx of melanoma: None

Drug Allergies: None

Medication list reviewed ?

Pain (10-pt scale): 0

Tobacco Use: Y ? N?

Alcohol Use: Y ? N ?

OBJECTIVE:

Fitzpatrick Type: I ? II ? III ? IV ? V ? VI ?

Standby: N/A

A focused skin exam was notable for the following:

1.Scattered (~10) skin-colored, verrucous papules on the dorsal penis.

A/P Last Updated by LAM,THOMAS KIN @ 24 Feb 2016 1330 EST

1. Anogenital (venereal) warts: Lesions on exam c/w warts. Treated today with LN2. Will give Condylox for continued Tx at home. Also counseled Pt on wart clinic on Thursday mornings. Pt voiced understanding and agreement.

Procedure(s): -Destruction Of Benign Lesion By Cryosurgery x 1 - After discussion of risks, benefits, and alternatives, verbal consent was received and cryo applied to lesions in standard fashion. Tx was applied in a pulsed fashion to minimize collateral tissue injury. Pt was instructed to use Vaseline ointment to the area(s) until healed. Pt tolerated the procedure well and left in stable condition.

Locations: DORSAL PENIS x8

Medication(s): -PODOFILOX--TOP 0.5% SOLN - APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED #1 RF2

Disposition Last Updated by LAM,THOMAS KIN @ 24 Feb 2016 1330 EST

Released w/o Limitations

Note Written by LAM,THOMAS KIN @ 24 Feb 2016 1324 EST

Consult Order

Referring Provider:WILSON, BRYAN J

Date of Request:16 Feb 2016

Priority:Routine

Provisional Diagnosis:

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

1mm x 1mm papules at base of penis previously treated empirically for genital warts, did not respond to Imiquimod. Skin changes are very limited, may be physiologic. Please evaluate and treat.

Note Written by MARQUART,JASON DANIEL @ 24 Feb 2016 1404 EST

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service) @ 24 Feb 2016 1404

Verified by: JASON D. MARQUART, MAJ,MC 24 Feb 2016@1512

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

19 Feb 2016 1245 GMT at by BAHR, ROBERT J

Title:	PHYSICAL THERAPY MTF BE	Original Date:	19 Feb 2016 1245 GMT
Document Type:	Consultation	AHLTA Entry Date:	19 Feb 2016 1436 GMT
Facility:		Document ID:	7845695746
Clinician:	BAHR, ROBERT J		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: WILSON, BRYAN JAMES
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 160216-23530
 MCP Referral #: 20160274357
 No. of Visits: 1
 Referral Authorized Until: 17 Mar 2016
 Reason for Consult:
 L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On light duty 30 days. Needs eval and likely graduated exercise.
 Priority: ROUTINE
 Provisional Diagnosis:
 Sprain of other ligament of left ankle, subsequent encounter
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 19 Feb 2016@06:45:00
 Requesting HCP: WILSON, BRYAN JAMES
 Clinic: PHYS THERAPY CL BE
 Consulting HCP: BAHR, ROBERT J.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 19 Feb 2016 0645 EST Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS

THERAPY CL BE Provider: BAHR, ROBERT J.

Patient Status: Outpatient

AutoCites Refreshed by BAHR, ROBERT J @ 19 Feb 2016 0928 EST

Problems

?ALCOHOL DEPENDENCE WITH CONTINUOUS DRINKING BEHAVIOR

?MAJOR DEPRESSION RECURRENT MODERATE

?ANXIETY DISORDER NOS

?Left ankle joint pain

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

IBUPROFEN, 800 MG, TABLET, ORAL Active TAKE ONE TABLET BY MOUTH THREE TIMES
 A DAY AS NEEDED FOR PAIN #0 RF0 NR 17 Feb 2016

AFLURIA 2015-2016 (FLU VACCINE TS2015-16(5YR+)/PF), 45MCG/.5ML, SYRINGE,
 INTRAMUSC, CSL BIOTHERAPIE, 0.5 ml SYRINGE Active NR 05 Oct 2015

FLUOCINOLONE ACETONIDE, 0.01 %, SOLUTION, TOPICAL Active APPLY TO SCALP
 EVERY DAY AS NEEDED #0 RF3 3 of 3 29 Sep 2015

Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA Active INHALE
 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3 3 of 3 28
 Sep 2015

Reason for Appointment:

Sprain of other ligament of left ankle, subsequent encounter

Appointment Comments:

lat/irmac

S/O Note Written by BAH,ROBERT J. @ 19 Feb 2016 0912 EST

bodybodyHistory of present illness g2

The Patient is a 31 year old male.

He reported: Encounter Background Information: SUBJECTIVE: Pt is a 31 yo
 WM who injured his left ankle 1.5 years ago while sprinting. The MRI showed
 a thickening of his ligament. He was treated in PT here. His pain has been
 off and on until two months ago when his foot was plantarflexed. He has had
 no recent injury. He reports that his pain is 2-3/10 at rest, 4-5/10 with
 activity. Mild swelling noted laterally. Pain increases with walking and
 the pushing off of his foot and going up and down stairs. Pain decreases
 with foot into the neutral position. He states he uses no meds--see AHLTA
 for medication reconciliation. He works with computers, exercises
 moderately running/walking 3-11 miles. He had new xrays three days ago which
 appear WNL. He learns without preference. His goal is to have a pain free
 ankle. No BTL. ~OBJECTIVE: FROM ankle left, strength in ankle
 dorsiflexors, plantarflexors, everters, inverters 5/5. negative drawer.
 Mild tenderness along lateral malleolus on left. Mild swelling noted. No
 heat or warmth or discoloration noted. Gait WNL, heel and toe walk within
 normal limits. ~ASSESSMENT: Pt has chronic left ankle pain which will
 benefit from skilled physical therapy program. ~PLAN: Home program of
 eccentric heel lowering and calf stretches for three weeks and then followup.
 ~GOAL: Decrease pain 75% in three weeks STG. Increase running without
 pain to four miles in 2 months. Pt educated on exercises and given handouts.

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

`PROGNOSIS: good.eg

ebody

ebody

A/P Written by BAHR,ROBERT J @ 19 Feb 2016 0930 EST

1. Acquired absence of right leg below knee

Procedure(s): -Physical Therapy Service Evaluation x 1

-Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

Disposition Written by BAHR,ROBERT J @ 19 Feb 2016 0930 EST

Released w/o Limitations

Note Written by HARMON,DAVID JR @ 19 Feb 2016 0703 EST

Consult Order

Referring Provider:WILSON, BRYAN J

Date of Request:16 Feb 2016

Priority:Routine

Provisional Diagnosis:

Sprain of other ligament of left ankle, subsequent encounter

Reason for Request:

L anterior talofibular ligament sprain 2 yr ago, now recurrence of pain. On

light duty 30 days. Needs eval and likely graduated exercise.

Signed By BAHR, ROBERT J (Physical Therapist, wrnmmc) @ 19 Feb 2016 0931

Verified by: ROBERT J. BAHR, LTC, SP 19 Feb 2016@0936

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Sep 2015 1814 GMT at WRNMMC by MITZMAN, NEIL

Title: 16SEP15 Original Date: 29 Sep 2015 1814 GMT
 Document Type: Encounter Note AHLTA Entry Date: 29 Sep 2015 1815 GMT
 Facility: WRNMMC Document ID: 7530276084
 Clinician: MITZMAN, NEIL

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
<p>PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.</p>			
DATE	SYMPTOMS DIAGNOSIS TREATMENT TREATING ORGANIZATION (Sign each entry)		
9/16/15	<p>TIME 0738 AGE 30 DOB [REDACTED] S LMP N/A</p> <p>TEMP 98.0 BP 132/82 HR 72 RR 18 Pulse OXIMETRY 96%</p> <p>Weight 165 Measured Stated Refused Height 69" Measured Stated</p> <p>SMOKER (N) Y Smoking cessation education N Y (N/A)</p> <p>ALLERGIES Cats / Feathers / Cats ^{ever} N/A</p> <p>CURRENT MEDICATION Zoloft</p> <p>OTC MEDICATIONS/SUPPLEMENTS Milt, Advantasson Pw, Joles Pw</p> <p>CHIEF COMPLAINT: Pt. No productive cough starting 9/5/15 persisting in intermittent SOB. Pt. denies any known sick contacts / fever. Pt. states cough at HS. Lungs auscultated scattered rhonchi. Pt. to be seen by Provider <i>J. Lee</i></p> <p>OVER THE PAST TWO WEEKS, HAVE YOU FELT DOWN, DEPRESSED OR HOPELESS? Y (N)</p> <p>SUMMARY OF CARE REVIEWED/UPDATED N/A TRIAGE SIGNATURE <i>J. Lee</i></p> <p>As above. Symptoms / cough gotten worse. Has noticed some wheezing. No fever. SI 9 in Nasal d/c. No signif. impt this a.m. in OTC's. Pe / N/A, AAO x 3 (Over)</p>		
HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/D NUMBER	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give Name - last, first, middle, IO NUMBER or Social Security Number, Gender, Date of Birth, Rank/Grade.)		REGISTER NUMBER	WARD NUMBER
<p>Merwin, Daniel</p> <p>[REDACTED]</p> <p>USN</p> <p>[REDACTED]</p>		<p>CHRONOLOGICAL RECORD OF MEDICAL CARE</p> <p>Medical Record</p> <p>STANDARD FORM 600 (REV. 1-2012)</p> <p>Prescribed by SSA/CAR</p> <p>FORM (41 CFR) 201-5-202-1</p> <p>AUTHORIZED FOR LOCAL REPRODUCTION</p>	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

DATE	SYMPTOMS	DIAGNOSIS	TREATMENT	TREATING ORGANIZATION (Sign each entry)
16 Sep 13	(cont)	TM's sh; pharynx sh; mmm Nuch Supple & adenop Heart Reg lungs CTA b/l Mild Sinus HP of maxillary A/P Sinusitis - R, 2 pack Rt Alveolar of MOI & fluids Tol / Met prn Rt maxillary B If No imp, F/u & PCP explained / understood TB Brittle		
		Discussed above		
	PATIENT PROVIDED		DISCHARGE INSTRUCTIONS/PATIENT EDUCATION	

Merwin, Daniel

STANDARD FORM 600 (REV. 11-2010) BACK

Merwin, Daniel Dennis

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1985 SSN: ***-**-****

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Page

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

29 Sep 2015 1500 GMT at by MARQUART, JASON DANIEL

Title:	DERMATOLOGY	Original Date:	29 Sep 2015 1500 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	29 Sep 2015 1615 GMT
Facility:		Document ID:	7529705480
Clinician:	MARQUART, JASON DANIEL		

CONSULT REPORT**Order Request for MERWIN, DANIEL**

Requesting HCP: AUSTIN, MARIE
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 150928-15177
 MCP Referral #: 20151695924
 No. of Visits: 10
 Referral Authorized Until: 27 Nov 2015
 Reason for Consult:
 Pt was worked up for herpes and it was negative suspect active molluscum contagiosum please evla and treat confirm DX I am going to start aldara
 Priority: ROUTINE
 Provisional Diagnosis:
 MOLLUSCUM CONTAGIOSUM
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 29 Sep 2015@10:00:00
 Requesting HCP: AUSTIN, MARIE
 Clinic: DERMATOLO CL BE
 Consulting HCP: MARQUART, JASON DANIEL

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 29 Sep 2015 1000 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:
 DERMATOLO CL BE Provider: MARQUART, JASON DANIEL
 Patient Status: Outpatient
 AutoCites Refreshed by CUNNINGHAM, RACHEL E @ 29 Sep 2015 1031 EDT
 Allergies
 ?OTHER: Unknown (SEE MED RECORD)
 Active Medications
 Active Medications Status Sig Refills Left Last Filled

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

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Created: 16 Aug 2017

GUAIFENESIN, 600 MG, TABLET ER, ORAL Active TAKE ONE TABLET BY MOUTH TWICE A DAY #0 RF0 NR 28 Sep 2015

Fluticasone Propionate 220mcg, Aerosol powder, Inhalation, HFA Active INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER #0 RF3 3 of 3 28 Sep 2015

BENZONATATE, 100 MG, CAPSULE, ORAL Active TAKE ONE CAPSULE BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR COUGH #0 RF0 NR 28 Sep 2015

Imiquimod 5%, Cream, Topical Active APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS #0 RF3 3 of 3 28 Sep 2015

SERTRALINE HCL, 100 MG, TABLET, ORAL Active TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2 0 of 2 08 Sep 2015

SERTRALINE HCL, 100 MG, TABLET, ORAL Ordered TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF2 2 of 2 11 Aug 2015

Imiquimod 5%, Cream, Topical Ordered APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK #0 RF1 1 of 1 11 Aug 2015

Reason for Appointment:

MOLLUSCUM CONTAGIOSUM

Appointment Comments:

LCR

S/O Note Written by CUNNINGHAM,RACHEL ELIZABETH @ 29 Sep 2015 1037 EDT

bodybodyChief complaint g1

The Chief Complaint is: Rash.eg

Reason for Visit g27

Visit for: STAFFED WITH DR. [] HANDFIELD [] GRATRIX [] GREEN [] LACKEY [] KENTOSH [x] MARQUART [] MEYERLE [] STEARNS [] SPERLING [] DARLING

30 yo M with 1 month hx of painful eroded papules in the groin and on the penis, STD workup negative per PCM and previous course of valtrex did not improve. Has hx of multiple sexual partners. Here for further evaluation, notes he does have hx of genital warts and uses aldara on them but has not been using it on the areas in question. Partner currently does not have any STD or similar rash. Uses condoms. Has recently had bronchitis with subjective fevers which began before the papules appeared. HIV testing recently negative.eg

History of present illness g2

The Patient is a 30 year old male.

He reported: Past medical history reviewed and updated dermatology problem list.

No previous history of skin symptoms. Rash:

Visit is not deployment-related.eg

Past medical/surgical history g4

Reported:

Surgical / Procedural: Surgical / procedural history reviewed and updated in patient's Problem List.

Medications: Medication history was reviewed and updated in patient medication list as needed.

Diagnoses:

No eczema

No psoriasis.

No malignant skin neoplasm

No basal cell carcinoma of the skin

No squamous cell carcinoma of the skin.

No malignant melanoma of the skin

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Page

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Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Personal history g5

Behavioral: No tobacco use.

Alcohol: No consumption of alcohol.eg

Family history g7

Family medical history: Reviewed in Problem List.eg

Review of systems g16

Systemic: No systemic symptoms and no night sweats.

Skin: Skin scaling.eg

Physical findings g8

General Appearance:

? General appearance: Alert.

Neurological:

Oriented to time, place, and person.

Speech: Normal.

Skin:

? Multiple skin lesions. ? Lesions located. ? Lesions on the scalp Vertex scalp with short vellus hairs, mild boggy scalp and mild erythema with generalized mild scale. Pustule on R parietal scalp. ? Perineal lesions. ? Lesions in the inguinal region Punched out erythematous eroded papules on L and R groin without papules on the penis or scrotum on exam. ? Lesions on the right side of the groin. ? Lesions on the left side of the groin.

General appearance was normal. Mobile. Texture was normal. Turgor was normal. Color and pigmentation were normal. Moisture was normal. Temperature was normal. No lesions on the ear. No lesions on the face.

No lesions on the neck. No lesions on the upper extremities. No lesions on the scrotum. No lesions on the penile shaft. No lesions on the buttocks. No lesions on the lower extremities.

Hair:

? Quantity and distribution were abnormal.

Nails:

Normal.eg

ebody

ebody

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

HIV RapidSite/Specimen08 Sep 2015 0817

HIV-1 Ab RapidBLOODNEGATIVE-ONBOARD QC ACCEPTED <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Rapid Plasma ReaginSite/Specimen08 Sep 2015 0817

Reagin AbSERUMNONREACTIVE <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Chlamydia+Gonococcus DNA Panel NAATSite/Specimen08 Sep 2015 0817

Neisseria gonorrhoeae DNAURINENEGATIVE FOR N.GONORRHOEAE <i>

Chlamydia trachomatis DNAURINENEGATIVE FOR C.TRACHOMATIS <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Herpes Simplex Virus 1+2 Ab IgGSite/Specimen08 Sep 2015 0817

Herpes Simplex Virus 1 Ab IgGSERUM<0.91 <i>

Herpes Simplex Virus 2 Ab IgGSERUM<0.91 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT

HSV 1 & 2 Abs Indirect PanelSite/Specimen08 Sep 2015 0817

Herpes Simplex Virus 1 Ab IgMSERUM<1:10

Herpes Simplex Virus 2 Ab IgMSERUM<1:10 <i>

Lab Result Cited by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1042 EDT

Herpes Virus Culture

Order #150909-02160 (NNMC Bethesda)

Filler #150909 NVI 2193 (NNMC Bethesda)

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Status:Final

Ordering Provider:FIACCO, NICHOLAS RYAN

Priority:ROUTINE

Date Ordered:09 Sep 2015 0748

Date Resulted:14 Sep 2015 1210

COLLECT_SAMPLE:OTHER SOURCE

Order Comment:for specimen already in lab

VIROLOGY RESULT:NO HERPES SIMPLEX VIRUS ISOLATED.

Specimen:Groin, Left

Collected:08 Sep 2015 0819

Results:

Final report

A/P Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT

1. SKIN NEOPLASM GROIN: Given punched out erosions on groin hx of multiple sexual partners, will get DFA today to rule out HSV infection. Previous tests showed non acute phase of HSV (IgG positive, IgM negative). Has had course of valtrex 500 twice daily for 10 days 1 month ago but did not resolve, may not have been correct treatment or may represent atypical presentation of another herpetic infection. Rest of STD workup negative.

Laboratory(ies): -HERPES DFA ~ (Routine) Ordered By: CUNNINGHAM,RACHEL E

Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH; VARICELLA DFA (Routine)

Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

2. FOLLICULITIS DECALVANS: Tufted folliculitis in the past on biopsy with scarring alopecia from inflammation and manipulation. Continued reports of itching, flaking and occasional pustules. Will use topical steroid solution daily as needed with antifungal shampoo.

Medication(s): -FLUOCINOLONE--TOP 0.01% SOLN - APPLY TO SCALP EVERY DAY AS NEEDED #1 RF3 Ordered By: CUNNINGHAM,RACHEL E Ordering Provider: CUNNINGHAM, RACHEL ELIZABETH

Disposition Last Updated by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1043 EDT

Released w/o Limitations

Follow up: as needed in the DERMATOLO CL BE clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by RANDOLPH,CANDICE M @ 29 Sep 2015 0955 EDT

Consult Order

Referring Provider:AUSTIN, MARIE R

Date of Request:28 Sep 2015

Priority:Routine

Provisional Diagnosis:

MOLLUSCUM CONTAGIOSUM

Reason for Request:

Pt was worked up for herpes and it was negative suspect active molluscum contagiosum please evla and treat confirm DX I am going to start aldera

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT

Additional A/P Information:

Discontinued IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME THREE TIMES A WEEK

Note Written by CUNNINGHAM,RACHEL E @ 29 Sep 2015 1037 EDT

Additional A/P Information:

Discontinued IMIQUIMOD--TOP 5% PACK - APPLY TO WARTS AT BEDTIME, THREE TIMES EVERY DAY FOR 5 CONSECUTIVE DAYS PER WEEK . FOR 4 WEEKS

Note Written by MARQUART,JASON DANIEL @ 29 Sep 2015 1132 EDT

I saw and evaluated the patient. Discussed with resident and agree with

Merwin, Daniel Dennis

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Page

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Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

resident's findings and plan as documented in the resident's note. Chart QA performed.

Signed By MARQUART, JASON DANIEL (Physician, WRNMMC Dermatology/Mohs Service)

@ 29 Sep 2015 1132

Verified by: JASON D. MARQUART, MAJ,MC 29 Sep 2015@1215

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

22 Jun 2015 1930 GMT at by STEARNS, LAUREL R

Title:	DERMATOLOGY	Original Date:	22 Jun 2015 1930 GMT
	MTF BE		
Document Type:	Consultation	AHLTA Entry Date:	23 Jun 2015 1945 GMT
Facility:		Document ID:	7318652769
Clinician:	STEARNS, LAUREL R		

CONSULT REPORT**Order Request for MERWIN, DANIEL**

Requesting HCP: ARGUINZONI, JUAN B.
 Requesting Location: INT MED MEDICAL HOME CL C BE
 Order ID number: 150507-19278
 MCP Referral #: 20150820065
 No. of Visits: 20
 Referral Authorized Until: 06 Jul 2015
 Reason for Consult:
 30 y/o male with alopecia areata. Please evaluate and treat as needed;
 thanks.
 Priority: ROUTINE
 Provisional Diagnosis:
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 22 Jun 2015@14:30:00
 Requesting HCP: ARGUINZONI, JUAN B.
 Clinic: DERMATOLO CL BE
 Consulting HCP: STEARNS, LAUREL REINHART

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 22 Jun 2015 1430 EDT Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:

DERMATOLO CL BE Provider: STEARNS, LAUREL REINHART

Patient Status: Outpatient

AutoCites Refreshed by TAYLOR, BRADLEY M @ 23 Jun 2015 0722 EDT

Allergies

?OTHER: Unknown (SEE MED RECORD)

Reason for Appointment:

alopecia areata

Appointment Comments:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

anb

S/O Note Written by TAYLOR,BRADLEY MICHAEL @ 23 Jun 2015 0724 EDT

bodybodyChief complaint g1

The Chief Complaint is: Scalp.eg

History of present illness g2

The Patient is a 30 year old male.

30 y/o male. Per patient, has history of MRSA infection on scalp about 5 to 6 years ago. Hair has never completely grown back. More recently has started to develop scale in same area as well as other areas of scalp. Unsure if area has remained the same size. He feels it has been getting larger.

Medication list reviewed with patient, reconciliation completed, and list given to patient.eg

Allergies g24

Current Allergies Reviewed.eg

Past medical/surgical history g4

Reported:

Medical: Reported medical history reviewed

.eg

Review of systems g16

Systemic: No fever and no chills.

Skin: Pruritus and skin lesion: rash:eg

Physical findings g8

General Appearance:

Well developed. Well nourished. In no acute distress.

Neurological:

Oriented to time, place, and person.

Psychiatric:

Mood: Euthymic.

Affect: Normal.

Skin:

? Skin: Scalp: Approx 1.5 to 2 cm annular patch of noticeably decreased hair density on posterior apex scalp. Smaller but also annular area next to it.

Slightly raised scar like plaque. Follicle drop and tufting of hair noted.

Mild erythema and scale.eg

ebody

ebody

Note Written by TAYLOR,BRADLEY M @ 23 Jun 2015 0722 EDT

A/P Last Updated by TAYLOR,BRADLEY M @ 23 Jun 2015 1135 EDT

1. Alopecia: Tufted, scarring alopecia on scalp after reported infection about 6 years ago. Patient feels it is slowly progressing. Mild erythema and some scale which feel most likely represents overlying mild seb derm but cannot completely rule out active scarring process. Discussed options with patient to include treating for seb derm and monitoring response vs biopsy for further evaluation. Patient elected to proceed with biopsy. Two punch biopsies completed today. Perilesional and normal posterior scalp. Tolerated well. Wound care discussed. Follow up in 10 to 14 days for suture removal and biopsy results. Sooner for concerns. Ddx includes mature scar w/overlying seb derm v folliculitis decalvans v LPP v other scarring etiologies.

Seen and d/w Dr. Stearns.

Procedure(s): -Biopsy Skin x 1 - Universal protocol requirements were met per WRNMMC Policy. Patient's identification was checked (name & birthdate). procedure and site, side matches the consent form. the lesion was prepped with alcohol. local anesthesia was provided by local injection with a 30g

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needle of 1ml of 1%lidocaine with epinephrine. a 4 mm punch biopsy was then performed. estimated blood loss was negligible. the wound was closed with 4 -0 suture, and a sterile dressing applied. wound care discussed, f/u 10 days for suture removal and discussion of path results.

-Biopsy Skin Each Additional Lesion x 1

Laboratory(ies): -TISSUE EXAM (Routine) Start Date: 06/23/2015 Order Date: 06/23/2015 11:35 Ordered By: TAYLOR,BRADLEY M Ordering Provider: TAYLOR, BRADLEY MICHAEL

Disposition Last Updated by TAYLOR,BRADLEY M @ 23 Jun 2015 1136 EDT
Released w/o Limitations

Follow up: in the DERMATOLO CL BE clinic. - Comments: 10 to 14 days
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by TAYLOR,BRADLEY M @ 23 Jun 2015 0722 EDT
Consult Order

Referring Provider:ARGUINZONI, JUAN B.

Date of Request:07 May 2015

Priority:Routine

Provisional Diagnosis:

Reason for Request:

30 y/o male with alopecia areata. Please evaluate and treat as needed;thanks.

Note Written by STEARNS,LAUREL R @ 23 Jun 2015 1537 EDT

I have seen and evaluated the patient and agree with the findings as documented in the note.

Signed By STEARNS, LAUREL R (Cpt, USA, MC, NPI 1356491393, Staff Dermatologist, Dermatology, WHMC/BAMC) @ 23 Jun 2015 1537

Verified by: STEARNS,LAUREL REINHART 23 Jun 2015@1545

Merwin, Daniel Dennis

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Page

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

23 Apr 2015 1400 GMT at by ZEMBRZUSKA, HANNA DOMINIKA

Title:	BEHAVIORAL HEALTH MTF BE	Original Date:	23 Apr 2015 1400 GMT
Document Type:	Consultation	AHLTA Entry Date:	23 Apr 2015 1539 GMT
Facility:		Document ID:	7185654377
Clinician:	ZEMBRZUSKA, HANNA DOMINIKA		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: EDWARDS, OLUSOLA
 Requesting Location: FB4SSA
 Order ID number: 150415-24728
 MCP Referral #: 20150673545
 No. of Visits: 1
 Referral Authorized Until: 13 May 2015
 Reason for Consult:
 Patient will need follow-up appointment for inpatient discharge. Patient was diagnosed with generalized anxiety disorder. Patient reported history of physical and emotional abuse from his father.
 Priority: ROUTINE
 Provisional Diagnosis:
 Generalized Anxiety Disorder & Alcohol Use Disorder, Severe
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 23 Apr 2015@09:00:00
 Requesting HCP: EDWARDS, OLUSOLA
 Clinic: PSYCHIATRY BE
 Consulting HCP: ZEMBRZUSKA, HANNA DOMINIKA

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 23 Apr 2015 0900 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic:
 PSYCHIATRY BE Provider: ZEMBRZUSKA, HANNA DOMINIKA
 Patient Status: Outpatient
 AutoCites Refreshed by ZEMBRZUSKA, HANNA DOMINIKA @ 23 Apr 2015 0853 EDT
 Allergies
 ?OTHER: Unknown (SEE MED RECORD)

Merwin, Daniel Dennis

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Labs

20 Apr 2015 0012

ETG/ETS, UA (500 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative <o> ng/mL Cutoff=500

20 Apr 2015 0012 <o>

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE not detected <i> (Not-detected)

Barbiturates URINE not detected <i> (Not-detected)

Benzodiazepines URINE not detected <i> (Not-detected)

Cocaine URINE not detected <i> (Not-detected)

Opiates URINE not detected <i> (Not-detected)

Phencyclidine, UA URINE not detected <i> (Not-detected)

Cannabinoids URINE not detected <i> (Not-detected)

Methadone URINE not detected <i> (Not-detected)

Oxycodone URINE not detected <i> (Not-detected)

13 Apr 2015 0548

ETG/ETS, UA (500 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative ng/mL Cutoff=500

13 Apr 2015 0548

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE not detected <i> (Not-detected)

Barbiturates URINE not detected <i> (Not-detected)

Benzodiazepines URINE not detected <i> (Not-detected)

Cocaine URINE not detected <i> (Not-detected)

Opiates URINE not detected <i> (Not-detected)

Phencyclidine, UA URINE not detected <i> (Not-detected)

Cannabinoids URINE not detected <i> (Not-detected)

Methadone URINE not detected <i> (Not-detected)

Oxycodone URINE not detected <i> (Not-detected)

06 Apr 2015 0722

ETG/ETS, UA (500 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative ng/mL Cutoff=500

06 Apr 2015 0722

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE not detected <i> (Not-detected)

Barbiturates URINE not detected <i> (Not-detected)

Benzodiazepines URINE not detected <i> (Not-detected)

Cocaine URINE not detected <i> (Not-detected)

Opiates URINE not detected <i> (Not-detected)

Phencyclidine, UA URINE not detected <i> (Not-detected)

Cannabinoids URINE not detected <i> (Not-detected)

Methadone URINE not detected <i> (Not-detected)

Oxycodone URINE not detected <i> (Not-detected)

30 Mar 2015 2236

Chlamydia+Gonococcus DNA Panel NAATSite SpecimenResultUnitsRef Range

Neisseria gonorrhoeae DNA URINE negative for n.gonorrhoeae <i>

Chlamydia trachomatis DNA URINE negative for c.trachomatis <i> (Negative)

30 Mar 2015 0805

ETG/ETS, UA (500 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative ng/mL Cutoff=500

30 Mar 2015 0805

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE not detected <i> (Not-detected)

Barbiturates URINE not detected <i> (Not-detected)

Benzodiazepines URINE not detected <i> (Not-detected)

Merwin, Daniel Dennis

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SSN: ***-**-****

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Created: 16 Aug 2017

Cocaine URINE not detected <i> (Not-detected)
 Opiates URINE not detected <i> (Not-detected)
 Phencyclidine, UA URINE not detected <i> (Not-detected)
 Cannabinoids URINE not detected <i> (Not-detected)
 Methadone URINE not detected <i> (Not-detected)
 Oxycodone URINE not detected <i> (Not-detected)

27 Mar 2015 2159

Urinalysis PanelSite SpecimenResultUnitsRef Range

Color URINE straw (Yellow)

Ketones URINE neg mg/dL (neg)

Hemoglobin URINE neg (neg)

Nitrite URINE neg (neg)

pH URINE 7.0 (5.0-9.0)

Protein URINE neg mg/dL (neg)

Appearance URINE clear (Clear)

Leukocyte Esterase URINE neg (neg)

Specific Gravity URINE 1.006 (1.000-1.035)

Urobilinogen URINE normal mg/dL (norm 0.2-1)

Glucose URINE neg mg/dL (neg)

Bilirubin URINE neg (neg)

27 Mar 2015 1630

Mephedrone, MDPV, MethyloneSite SpecimenResultUnitsRef Range

Mephedrone URINE negative NEGATIVE

Methylenedioxypyrovalerone URINE negative NEGATIVE

Methylone URINE negative <r> NEGATIVE

27 Mar 2015 1630

Cannabinoids (THC), SyntheticSite SpecimenResultUnitsRef Range

Cannabinoids, Synthetic URINE negative <r>

27 Mar 2015 1630

Chlamydia+Gonococcus DNA Panel NAATSite SpecimenResultUnitsRef Range

Neisseria gonorrhoeae DNA URINE negative for n.gonorrhoeae <i>

Chlamydia trachomatis DNA URINE negative for c.trachomatis <i> (Negative)

27 Mar 2015 1630

ETG/ETS, UA (250 Cut-Off)Site SpecimenResultUnitsRef Range

Ethyl Glucuronide URINE negative ng/mL Cutoff=250

27 Mar 2015 1630

Drug Abuse ScreenSite SpecimenResultUnitsRef Range

Amphetamines URINE not detected <i> (Not-detected)

Barbiturates URINE not detected <i> (Not-detected)

Benzodiazepines URINE not detected <i> (Not-detected)

Cocaine URINE not detected <i> (Not-detected)

Opiates URINE not detected <i> (Not-detected)

Phencyclidine, UA URINE not detected <i> (Not-detected)

Cannabinoids URINE not detected <i> (Not-detected)

Methadone URINE not detected <i> (Not-detected)

Oxycodone URINE not detected <i> (Not-detected)

27 Mar 2015 1630

Urinalysis PanelSite SpecimenResultUnitsRef Range

Color URINE straw (Yellow)

Ketones URINE neg mg/dL (neg)

Hemoglobin URINE neg (neg)

Nitrite URINE neg (neg)

pH URINE 7.0 (5.0-9.0)

RBC URINE < 1 /HPF (0-3)

Protein URINE neg mg/dL (neg)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Page

Medical Record

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Appearance URINE clear (Clear)
 Leukocyte Esterase URINE mod (H)(neg)
 Specific Gravity URINE 1.008 (1.000-1.035)
 Urobilinogen URINE normal mg/dL (norm 0.2-1)
 WBC URINE 3 (H)/HPF (0-2)
 Glucose URINE neg mg/dL (neg)
 Bilirubin URINE neg (neg)
 27 Mar 2015 1600
 Vitamin D, 1,25-Dihydroxy (Calcitriol) PanelSite SpecimenResultUnitsRef Range
 Vitamin D, 1,25-Dihydroxy SERUM 78 <r> pg/mL
 Vitamin D2, 1,25-Dihydroxy SERUM <10 pg/mL
 Vitamin D3, 1,25-Dihydroxy SERUM 76 pg/mL
 27 Mar 2015 1600
 Vitamin B1 (Thiamine)Site SpecimenResultUnitsRef Range
 Vitamin B1 (Thiamine) BLOOD 193.4 nmol/L 66.5-200.0
 27 Mar 2015 1600
 HIV-1/O/2 AbSite SpecimenResultUnitsRef Range
 HIV-1/O/2 Ab SERUM *****
 27 Mar 2015 1600
 Rapid Plasma ReaginSite SpecimenResultUnitsRef Range
 Reagin Ab SERUM nonreactive <i> (Non-Reactive)
 27 Mar 2015 1600
 HomocysteineSite SpecimenResultUnitsRef Range
 Homocysteine SERUM 9.1 <r> <i> mcmol/L (4.0-15.4)
 27 Mar 2015 1600
 Vitamin B12 (Cyanocobalamin)+Folate PanelSite SpecimenResultUnitsRef Range
 Vitamin B12 (Cobalamins) SERUM 329 <i> pg/mL (211-946)
 Folate SERUM >20.00 <i> ng/mL (4.6-34.8)
 27 Mar 2015 1600
 MagnesiumSite SpecimenResultUnitsRef Range
 Magnesium SERUM 2.2 mg/dL (1.7-2.6)
 27 Mar 2015 1600
 Thyroid Stimulating HormoneSite SpecimenResultUnitsRef Range
 Thyrotropin SERUM 0.757 <i> mIU/mL (0.27-4.20)
 27 Mar 2015 1600
 Gamma Glutamyl TransferaseSite SpecimenResultUnitsRef Range
 Gamma-Glutamyl Transferase SERUM 40 U/L (10-71)
 27 Mar 2015 1600
 Comprehensive Metabolic PanelSite SpecimenResultUnitsRef Range
 Albumin SERUM 4.9 g/dL (3.5-5.2)
 Alkaline Phosphatase SERUM 71 U/L (40-130)
 Alanine Aminotransferase SERUM 29 <i> U/L (0-41)
 Bilirubin SERUM 0.3 mg/dL (0-1.0)
 Urea Nitrogen SERUM 14 mg/dL (6-20)
 Calcium SERUM 10.0 mg/dL (8.6-10.2)
 Carbon Dioxide SERUM 29 mmol/L (22-31)
 Chloride SERUM 98 mmol/L (98-107)
 Creatinine SERUM 0.9 mg/dL (0.7-1.4)
 Glucose SERUM 82 mg/dL (74-106)
 Potassium SERUM 4.7 mmol/L (3.5-5.1)
 Protein SERUM 7.9 g/dL (6.4-8.3)
 Sodium SERUM 139 mmol/L (135-145)
 Anion Gap SERUM 13 mmol/L (8-18)
 GFR Calculated Non-Black SERUM 114.7 mL/min (>=90)

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Page

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GFR Calculated Black SERUM 132.6 <i> mL/min (>=90)

Aspartate Aminotransferase SERUM <5 U/L (0-40)

27 Mar 2015 1600

CBC W/DiffSite SpecimenResultUnitsRef Range

WBC BLOOD 6.8 x10(3)/mcL (3.6-10.6)

RBC BLOOD 4.65 x10(6)/mcL (4.21-5.92)

Hemoglobin BLOOD 14.5 g/dL (12.8-17.7)

Hematocrit BLOOD 43.1 % (37.5-50.9)

MCV BLOOD 92.6 fL (79.5-96.8)

MCH BLOOD 31.1 pg (26.2-33.1)

MCHC BLOOD 33.6 g/dL (32.6-35.0)

RDW CV BLOOD 12.0 % (12.0-16.2)

Platelets BLOOD 296 x10(3)/mcL (162-427)

MPV BLOOD 8.5 fL (7.0-10.9)

Neutrophils BLOOD 67.0 % (40.7-76.4)

Lymphocytes BLOOD 25.1 % (15.9-47.8)

Monocytes BLOOD 6.7 % (4.5-11.8)

Eosinophils BLOOD 0.9 % (0.3-7.1)

Basophils BLOOD 0.3 % (0.2-1.2)

ABS Neutrophils BLOOD 4.5 x10(3)/mcL (1.8-7.5)

ABS Lymphocytes BLOOD 1.7 x10(3)/mcL (1.0-3.1)

ABS Monocytes BLOOD 0.5 x10(3)/mcL (0.2-0.8)

ABS Eosinophils BLOOD 0.1 x10(3)/mcL (0.0-0.5)

ABS Basophils BLOOD 0.0 x10(3)/mcL (0.0-0.4)

Differential Review BLOOD manual diff not performed

27 Mar 2015 16

Coagulation Panel 1 (PT+APTT)Site SpecimenResultUnitsRef Range

Protime PLASMA 12.5 Sec (12.4-14.4)

INR PLASMA 1.0 <i>

APTT PLASMA 32.9 <i> Sec (23.4-36.2)

Microbiology Results

Urine Culture

Order # 150327-24502 (NNMC Bethesda)

Filler # 150327 DWB 64394 (NNMC Bethesda)

Status: Final

Ordering Provider: CEREMUGA, GEORGE J

Priority: ROUTINE

Date Ordered: 27 Mar 2015 1557

Date Resulted: 29 Mar 2015 0651

COLLECT_SAMPLE: URINE/CLEAN CATCH

BACTERIOLOGY RESULT: 03/28/15: LESS THAN 24 HOURS, FURTHER INCUBATION
REQUIRED

BACTERIOLOGY RESULT: 03/29/15 URINE CULTURE NEGATIVE

Specimen: Urine

Collected: 27 Mar 2015 1630

Results:

Final report

Rads

No Rads Found.

Reason for Appointment:

Generalized Anxiety Disorder & Alcohol Use Disorder, Severe

Appointment Comments:

ddr

Vitals

Vitals Written by ERICKSON,NANCY A @ 23 Apr 2015 0855 EDT

Merwin, Daniel Dennis

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Page

Medical Record

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Created: 16 Aug 2017

BP: 122/68, HR: 70, RR: 16, T: 96.0 F, HT: 5' 9", WT:

160 lbs, BMI: 23.63, BSA: 1.879 square meters

Comments: PT weighed in uniform and boots.

S/O Note Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1113 EDT

bodybodyHistory of present illness g2

The Patient is a 30 year old male.

<<Note accomplished in Tri-Service Behavioral Health AIM>>

30 y/o single Caucasian man E-6/AD/USN, with approximately 9 ? years continuous active duty service, currently assigned to Navy Information Operations Command (NIOC) at Fort Meade, Maryland with a past psychiatric history of GAD and Alcohol Use Disorder. Pt initially presented to Integrative Care on 16JUN2014 and was diagnosed with GAD and neurotic excoriation (scalp picking when anxious). He was then referred to a LCSW at WRNMMC for therapy and attended therapy sessions until 30OCT2014. He was then command referred to SARP on 17MAR2015 and diagnosed with Alcohol Use Disorder, moderate to severe. SARP referred pt to a 28 day inpatient alcohol rehab at Ft. Belvoir from which the pt was discharged yesterday. SARP would like psychiatrist to evaluate pt for psychotropic medication for his depressed mood, anxiety, and sleep symptoms. Pt reports that every day he experiences either a depressed mood or apathy. He does have moments of happiness when he works on his computer game or cooks, but these moments don't last long. He often wonders what the point of life is and what his purpose in life is. He often worries about the future and tasks he has to complete. He feels that he is always planning and runs through scenarios (good version, bad version) of things in his head. He is frequently irritable, impatient, and judgmental of others. His anxious ruminations lead to initial insomnia. He did sleep well last night, but in rehab he was using Melatonin at bedtime. He has been started on Zoloft, but has not noticed a benefit yet. Denies side effects.

From SARP note: The SM self-referred for SARP evaluation due to his growing concern about his drinking and inability to stop. According to the SM, his alcohol of choice is vodka. He prefers to drink alone at home. His drinking frequency is daily. He reported an increase in his drinking, over the past 8 months, to daily drinking. He described drinking 2 ? 3 self-poured drinks, which has an estimated 4 ounces of alcohol per drink. He described the appeal in terms of the calming effect on his mind, specifically to dampen his anxious ruminations and ?obsessing.? He further reported that drinking helps prepare him for sleep onset (he has had problems with initial insomnia). Clinical interview further revealed evidence for marked tolerance, significant spending on alcohol (\$400 - \$500 per month), hangovers (every other week), being told that he drinks too much (past girlfriends), drinking despite the consistent worsening of his negative mood state, and unsuccessful efforts to reduce/quit drinking. In his personal reflection, he indicated that he does not like himself relative to his drinking and desires to stop. He recognizes that there are multiple triggers to his drinking and usually these involve longstanding feelings of disappointment, frustration, and loneliness. It should be noted that the SM indicated that he has been engaging in painful introspection, particularly regarding his childhood and family life.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Visit is not deployment-related.

Pain Severity 0 / 10.eg

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Page

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Created: 16 Aug 2017

Allergies g24

Current Allergies Reviewed. NKDA.eg

Current medication g3

Zoloft 50mg daily started on 26MAR2015

Melatonin for insomnia.eg

Past medical/surgical history g4

Reported:

Recent Events: Medication compliance.

Medical: Reported medical history Neurotic excoriation (scalp picking when anxious)

Asthma during childhood

Allergic response to pets

Recurrent intestinal pain (possibly lactose intolerance)

PRK (2011)

and psychiatric history

* THERAPY: multiple visits with clinical social worker, Linda Nilsen, at WRNMMC, between August 2014 and October 2014. She documented Anxiety Disorder, NOS. The SM indicated that he discontinued his participation in treatment due to the limited impact of these visits.

* MEDS: Denies other medication trials

* INPATIENT/RESIDENTIAL CARE: Denies psychiatric hospitalizations. Completed 28 day inpatient alcohol rehab at Ft. Belvoir.

* SELF HARM OR MUTILATION/SUICIDE ATTEMPTS: Attempted suicide at 16 y/o by overdosing on Aspirin and Alcohol in context of conflict with father. Did not seek care. Attempted suicide (?) at 17 y/o by consuming a large quantity of alcohol and blacking out. Did not seek care. Denies self-injurious behavior.

Family history:

F: Alcohol use disorder

M: depression

Sister#1: depression, hx of suicide attempts

Sister#2: bipolar disorder, hx of suicide attempts, unknown drug abuse which led to loss of custody of 2 children

Maternal grandmother: bipolar

.eg

Personal history g5

Social history Pt is the oldest of 3 children from a Sacramento, California home, broken by divorce when the SM was a toddler (3-6 y/o). He and his two sisters were raised by their father, whose employment challenges qualified them for welfare. There was also a tumultuous home environment. Father was not involved with his children and was emotionally/physically abusive. Pt felt that he was an inconvenience to his father. Growing up pt had few friends because he would isolate himself. He left his family abruptly, upon graduation from high school, in 2003. Moved out of state and enrolled in college. He found himself 'bored' with college. He enlisted in the Navy in October, 2005, after dropping out of college, working two jobs, and being on the verge of 'living on the street.' There were mounting debts (rent, college tuition, basic apartment furniture) also at the time. He started as an Aviation Boatswain's Mate, then cross-rated in 2009 to Cryptologic Technician - Network. His duty stations have included USS ESSEX, Pensacola, and NIOC Maryland. He has been very successful in his enlisted service thus far, but has been disenchanted at his current Command because everyone is physically separated and it is not a tight knit command.

Pt was engaged to a Filipino girl he met while stationed overseas, but he ended the engagement in 2010 because she was 'crazy.' No kids.

.

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Page

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Behavioral: Caffeine use 16 oz tea/day and never a smoker / Never Used Tobacco Products.

Alcohol: Not using alcohol Not currently. Discharged yesterday from Ft.

Belvoir 28 day Residential Alcohol Treatment.eg

Subjective g6

Additional Screening Questions:

Are you having any thoughts about harming another person? Denies

Do you feel like you are at risk for workplace violence? Denies

PTSD CHECKLIST (PCL-C)

[2] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

[0] Repeated, disturbing dreams of a stressful experience from the past?

[0] Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

[2] Feeling very upset when something reminded you of a stressful experience from the past?

[2] Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?

[1] Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?

[1] Avoid activities or situations because they remind you of a stressful experience from the past?

[0] Trouble remembering important parts of a stressful experience from the past?

[0] Loss of interest in things that you used to enjoy?

[0] Feeling distant or cut off from other people?

[2] Feeling emotionally numb or being unable to have loving feelings for those close to you?

[0] Feeling as if your future will somehow be cut short?

[0] Trouble falling or staying asleep?

[1] Feeling irritable or having angry outbursts?

[1] Having difficulty concentrating?

[1] Being 'super alert' or watchful on guard?

[0] Feeling jumpy or easily startled?

Add point values from each response. Total Score = 13 DATE:

IF you had a positive score on any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? [] Not difficult [X] Somewhat difficult

[] Very difficult [] Extremely difficult

During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? [] Yes [X] No

If 'Yes', how often? [] Several days [] More than half the days []

Almost everyday.

Depression Screening:

[1] 1. Little Interest or pleasure in doing things

[1] 2. Feeling down depressed or hopeless

[0] 3. Trouble sleeping or sleeping too much

[1] 4. Feeling tired or little energy

[0] 5. Poor appetite or overeating

[0] 6. Feeling bad about self

[0] 7. Trouble concentrating on things

[1] 8. Moving or speaking slowly or being restless

[0] 9. Thoughts that you would be better off dead

Merwin, Daniel Dennis

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Add point values from each response. Total (PHQ-9) Score = 4

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

Generalized Anxiety Disorder Screening:

☐ 1. Feeling nervous, anxious, or on edge

☐ 2. Not being able to stop or control worrying

☐ 3. Worrying too much about different things

☐ 4. Trouble relaxing

☐ 5. Being so restless that it's hard to sit still

☐ 6. Becoming easily annoyed or irritable

☐ 7. Feeling afraid as if something awful might happen

Add point values from each response. Total (GAD-7) Score = 5

Difficulty doing work, taking care of things at home, or getting along with other people? ☐ Not at all ☒ Somewhat ☐ Very ☐ Extremely.

NO Learning Disability, Language or Learning Barriers.eg

Review of systems g16

No current substance use symptoms

No current cognitive symptoms

No current psychotic symptoms

.eg

Physical findings g8

Psychiatric:

Neurovegetative Assessment: ? Dangerousness assessment: suicide risk Suicide

Risk and Protective Factors Review:

Non-Modifiable:

Gender (risk factor if male): Y

H/O Suicide Attempts:Y

Organized Plan:N

Chronic Psychiatric Disorder:Y

Recent Psychiatric Hospitalization: RECENT REHAB

H/O Abuse or Trauma:Y

Chronic Physical Illness:N

Family H/O Suicide/Attempts:Y

Other Recent Loss:N

Chronic Pain:N

Age (risk factor if <25 or >60):N

Modifiable:

Suicidal ideation/plans/intent:N

Access to Lethal Means:N

Poor Treatment Compliance:N

Hopelessness:?

Psychic Pain/Anxiety:Y

Acute Event:N

Insomnia:N

Low Self-Worth:Y

Impulsivity:N

Substance Abuse:Y

Financial Stress:Y, PAYING OFF DEBT

Legal Stress:N

Protective:

Strong Therapeutic Alliance:Y

Positive Coping Skills:Y

Responsible to/for Family:Y

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Responsible to/for Pet:N
 Frustration Tolerance:Y
 Resilience:Y
 Good Reality Testing:Y
 Amenable to Treatment:Y
 Social Support:Y

Risk of Harm to Others: DENIES

Action Taken Based on Risk Assessment:

[X] Released without limitations. Advised of emergency procedures.

[] SM released to Chain of Command with the following limitations:

[] SM sent to ER for evaluation for admission to inpatient psychiatry

[] Other:eg

Therapy g12

? Duration of the encounter 60 min.eg

Practice Management g17

Continue assessment and intervention

Multi-Disciplinary Treatment Plan:

Treatment Team Members -

Individual Therapist: SARP

Medication Prescriber: ZEMBRZUSKA

Group Therapist: MELTON FOR CBT-I

Additional Provider and treatment: SARP at Washington Navy Yard

Date last updated: 23APR2015

Reviewed with patient on: 23APR2015

Does patient agree with plan? Yes

If not, what part?

Projected date of next treatment plan update: f/u in 3 weeks

Discussion of assessment and intervention

Tx Plan cont'd:

Diagnosis

Generalized Anxiety Disorder

Alcohol Use Disorder, moderate to severe

Active Problem List:

1. Anxiety, worry, irritability
2. Depressed/apathetic mood
3. Insomnia

Long-Term Goals:

1. Improve relationship/increase social support from mother and sister
2. Improve financial knowledge/pay off debts

Discussion of risk of assessment and intervention

Interventions Provided at this session:

Objective 1 (Corresponds to Goal #): Anxiety, worry, irritability

-

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next session.
4. R/o OCD.

Objective 2 (Corresponds to Goal #): Depressed/apathetic mood

-

Interventions:

1. Increase Zoloft from 50mg to 75mg daily. Discussed r/b/se.
2. Continue SARP.
3. Will discuss pt being referred for individual therapy for CBT at next

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Page

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Created: 16 Aug 2017

session.

Objective 3 (Corresponds to Goal #): Insomnia

-

Interventions:

1. Pt to obtain Melatonin OTC to help with insomnia
 2. Pt to download free CBT-I app and use progressive muscle relaxation and imagery at bedtime to promote relaxation and decrease ruminative thoughts
 3. Pt referred to CBT-I group with Ms. Melton at WRNMMC. First group starts Monday, 27 April 13-14:00 for 4 weeks
- Patient agrees to contact the clinic, call 911, or go to the nearest Emergency Department if symptoms worsen or if suicidal or homicidal thoughts develop.

ebody

ebody

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0856 EDT

Lipid PanelSite/Specimen10 Apr 2014 0951

CholesterolSERUM208 (H) <i>

TriglycerideSERUM158 (H) <i>

HDL CholesterolSERUM64.0 (H)

LDL CholesterolSERUM112 <i>

VLDL CholesterolSERUM32

Cholesterol/HDL CholesterolSERUM3.25

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0856 EDT

Hemoglobin A1cSite/Specimen04 Jun 2013 0925

Hemoglobin A1cBLOOD5.4 <i>

Lab Result Cited by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0855 EDT

Lipid PanelSite/Specimen19 Mar 2013 1107

CholesterolSERUM209 (H) <i>

TriglycerideSERUM265 (H) <i>

HDL CholesterolSERUM63.0 (H)

LDL CholesterolSERUM93 <i>

VLDL CholesterolSERUM53 (H)

Cholesterol/HDL CholesterolSERUM3.32

A/P Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1026 EDT

1. GENERALIZED ANXIETY DISORDER 300.02

Procedure(s): -(90792) Psychiatric Diagnostic Evaluation With Medical Evaluation And Management x 1

2. ALCOHOL DEPENDENCE (ALCOHOLISM) 303.90

Disposition Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 1134 EDT

Released w/o Limitations

Follow up: 3 week(s) in the PSYCHIATRY BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by ZEMBRZUSKA,HANNA DOMINIKA @ 23 Apr 2015 0852 EDT

Consult Order

Referring Provider:EDWARDS, OLUSOLA O

Date of Request:15 Apr 2015

Priority:Routine

Provisional Diagnosis:

Generalized Anxiety Disorder ~T~ Alcohol Use Disorder,Severe

Reason for Request:

Patient will need follow-up appointment for inpatient discharge. Patient was diagnosed with generalized anxiety disorder. Patient reported history of physical and emotional abuse from his father.

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Page

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Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Signed By ZEMBRZUSKA, HANNA DOMINIKA (MAJ, Psychiatrist/Internist, Walter
Reed National Military Medical Center, Bethesda, MD) @ 23 Apr 2015 1134
Verified by: ZEMBRZUSKA,HANNA DOMINIKA 23 Apr 2015@1139

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

24 Sep 2014 1600 GMT at by LAI, PHILOMENA C

Title:	PHYSICAL THERAPY MTF BE	Original Date:	24 Sep 2014 1600 GMT
Document Type:	Consultation	AHLTA Entry Date:	24 Sep 2014 1952 GMT
Facility:		Document ID:	6734360621
Clinician:	LAI, PHILOMENA C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: DOUGHERTY, DIANA LYNN

Requesting Location: HEMATOLOG CL BE

Order ID number: 140604-07457

MCP Referral #: 20140984342

No. of Visits: 1

Referral Authorized Until: 04 Jul 2014

Reason for Consult:

29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM. Please
 e eval and provide exercises to improve strength, ROM. Please consider soft br
 ace for stability while recovering.

Priority: ROUTINE

Provisional Diagnosis:

ANKLE SPRAIN LEFT

ACV:

Reviewed Date/Time:

Appoint Status:

Appointment Review Comment:

Reviewer: ,

CONSULT RESULT

Appointment Date: 24 Sep 2014@11:00:00

Requesting HCP: DOUGHERTY, DIANA LYNN

Clinic: PHYS THERAPY CL BE

Consulting HCP: LAI, PHILOMENA C.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 24 Sep 2014 1100 EDT Appt Type: EST

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS

THERAPY CL BE Provider: LAI, PHILOMENA C.

Patient Status: Outpatient

AutoCites Refreshed by LAI, PHILOMENA C @ 24 Sep 2014 1506 EDT

Problems

?MAJOR DEPRESSION RECURRENT MODERATE

?ANXIETY DISORDER NOS

?Left ankle joint pain

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Family History

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
 ?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
 ?paternal history of preliminary background HPI [use for free text] (Father)
 ?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
 ?family medical history (General FHx)
 ?family history of supplemental HPI [use for free text] (General FHx)
 ?no family history of malignant neoplasm of the large intestine (General FHx)
 ?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
 ?no family history of chronic liver disease (General FHx)

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled
 OXYCODONE HCL/ACETAMINOPHEN, 5MG-325MG, TABLET, ORAL Active TAKE ONE TABLET EVERY 4-6 HOURS AS NEEDED FOR PAIN #0 RF0 NR 18 Sep 2014
 Chlorhexidine Gluconate 0.12%, Solution, Oral Active SWISH AND SPIT 15 ML TWICE A DAY FOR 2 WEEKS STARTING TOMORROW #0 RF0 NR 18 Sep 2014
 IBUPROFEN, 800 MG, TABLET, ORAL Active TAKE ONE TABLET THREE TIMES A DAY AS NEEDED FOR PAIN #0 RF0 NR 18 Sep 2014
 DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL Ordered TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1 1 of 1 16 Jun 2014

Appointment Comments:

tan

Note Written by LAI, PHILOMENA C @ 24 Sep 2014 1547 EDT

Chief complaint

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation

(9/24/2014)

Subjective: Patient presents to clinic reporting continue L ankle pain since his return doing PT as he has been walking, running, jumping a lot, L ankle swelling resurface, now pain on L ankle even walking for long distance. Patient states he will be doing his PFT in 2 weeks but will not be able to do the running portion of PT.

(8/8/2014)

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: [REDACTED] DoD ID: 1286180538

Created: 16 Aug 2017

some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout.

Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: Improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole.

Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).

Past medical/surgical history

Reported:

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.

Objective

Observation: genu and tibial varus, normal calcaneus alignment, mild swelling L lateral malleolus area

palpation: TTP lateral L ankle anterior to lateral malleolus

flexibility: mod tightness hamstrings, calf

Joint Mobility: normal L ankle joint mobility

Sensation/Reflex: intact

ROM: ankle: DF L15 deg R 13 deg, PF L 44 deg R 50 deg, IV L 35 deg R 35 deg, EV L12 deg R 15 deg, 1st ray ext L 50 deg R 70 deg, flex L 12 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 5/5 R 5/5, EV L 5/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle stability bil, SLHR L 25/25 R 25/25, no instability noted but fatigue quickly L with pain

Tests

Re-evaluation (9/24/2014): Patient with recurrent ankle pain, most likely repeated strain from excessive impact activities. Recommend patient hold off from jumping, squatting and running activities at this time to allow sufficient time for healing. Patient will need to continue strengthening and stretching program. Provided prescription for ankle brace to provide support.

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP- met

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg - met

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5 - met

Improve function to: tolerate long distance walking without increased in symptoms

running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (8/8/2014): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Continue HEP for stretching and strengthening. Follow up in 5-6 weeks for re-evaluation.

A/P Written by LAI, PHILOMENA C @ 24 Sep 2014 1509 EDT

1. Left ankle joint pain

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI, PHILOMENA C @ 24 Sep 2014 1547 EDT

Released w/o Limitations

Follow up: 5 to 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 24 Sep 2014 1548

Verified by: PHILOMENA C. LAI 24 Sep 2014@1552

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

08 Aug 2014 1200 GMT at by LAI, PHILOMENA C

Title:	PHYSICAL	Original Date:	08 Aug 2014 1200
	THERAPY MTF BE		GMT
Document Type:	Consultation	AHLTA Entry Date:	08 Aug 2014 1155
			GMT
Facility:		Document ID:	6641060874
Clinician:	LAI, PHILOMENA C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: DOUGHERTY, DIANA L
 Requesting Location: HEMATOLOG CL BE
 Order ID number: 140604-07457
 MCP Referral #: 20140984342
 No. of Visits: 1
 Referral Authorized Until: 04 Jul 2014
 Reason for Consult:
 29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM. Please
 e eval and provide exercises to improve strength, ROM. Please consider soft br
 ace for stability while recovering.
 Priority: ROUTINE
 Provisional Diagnosis:
 ANKLE SPRAIN LEFT
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 08 Aug 2014@07:00:00
 Requesting HCP: DOUGHERTY, DIANA L
 Clinic: PHYS THERAPY CL BE
 Consulting HCP: LAI, PHILOMENA C.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 08 Aug 2014 0700 EDT Appt Type: EST
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS
 THERAPY CL BE Provider: LAI, PHILOMENA C.
 Patient Status: Outpatient
 AutoCites Refreshed by LAI, PHILOMENA C @ 08 Aug 2014 0649 EDT
 Problems
 ?ANXIETY DISORDER NOS
 ?Left ankle joint pain

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Created: 16 Aug 2017

?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA
 ?ANOMALIES OF SKIN
 ?Abdominal pain
 ?ASTHMA
 ?POSTSURGICAL STATE OF EYE AND ADNEXA
 ?Difficulty breathing (dyspnea)
 ?SKIN NEOPLASM UNCERTAIN BEHAVIOR
 ?Removal Of Sutures
 ?ASTHMA EXTRINSIC
 ?ROSACEA
 ?PERIPHERAL RETINAL DEGENERATION - LATTICE
 ?REFRACTIVE ERROR - MYOPIA
 ?ALLERGIC RHINITIS

Family History

?fraternal history of SUBJECTIVE [Use for s.o.a.p. note free text] (Brother)
 ?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)
 ?paternal history of preliminary background HPI [use for free text] (Father)
 ?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)
 ?family medical history (General FHx)
 ?family history of supplemental HPI [use for free text] (General FHx)
 ?no family history of malignant neoplasm of the large intestine (General FHx)
 ?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)
 ?no family history of chronic liver disease (General FHx)

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled
 DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL Ordered TAKE ONE TABLET BY MOUTH
 TWICE A DAY FOR 30 DAYS #0 RF1 1 of 1 16 Jun 2014

Reason for Appointment:

est

Appointment Comments:

tan

S/O Note Written by LAI, PHILOMENA C. @ 08 Aug 2014 0735 EDT

bodybodyChief complaint g1

The Chief Complaint is: L ankle sprain

Visit for: Re- Evaluation

Subjective: Patient reports he has no ankle pain with walking, he has done 2-mile walking, doing stairs with no pain, noticed bruising on L ankle and some swelling, L ankle looks slightly different from R, L ankle popping/cracking with movement and there is pain when that happens. Patient reports he has not tried running yet and he will be doing his PFT (1.5 m run) in Oct.

Objective: Observation: very mild swelling L ankle ROM: L ankle DF 10 deg, PF 45 deg, EV 15 deg, IV 35 deg Strength: L ankle 5/5 throughout.

Flexibility: mod tightness hamstrings, mild/mod tightness calf

Assessment/Plan: Improved L ankle ROM with full strength, bilateral hamstrings and calf tightness continue. Patient was instructed on continue with ankle ROM, emphasized importance of daily stretching, proper running gait. Patient will gradual progress to jog/run on his own Follow up in 4 weeks to

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

re-assess.

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole.

Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10 best 0/10 worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 times per week).eg

Past medical/surgical history g4

Reported:

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.eg

Objective g9

Observation: genu and tibial varus, normal calcaneus alignment

palpation: no TTP

flexibility: mod tightness hamstrings, calf

Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob

Sensation/Reflex: intact

ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg,

EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle

stability bil, SLHR L 25/25 R 25/25, no instability noted.eg

Tests g10

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5

Improve function to: tolerate long distance walking without increased in symptoms

running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (15 min): stretch - hamstrings, calf, joint

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..eg

ebony

ebony

A/P Written by LAI, PHILOMENA C @ 08 Aug 2014 0653 EDT

1. Left ankle joint pain

Procedure(s): -Physical Therapy Service Re-Evaluation x 1

Disposition Written by LAI, PHILOMENA C @ 08 Aug 2014 0750 EDT

Released w/o Limitations

Follow up: 4 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 08 Aug 2014 0751

Verified by: PHILOMENA C. LAI 08 Aug 2014@0755

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

27 Jun 2014 1200 GMT at by LAI, PHILOMENA C

Title:	PHYSICAL THERAPY MTF BE	Original Date:	27 Jun 2014 1200 GMT
Document Type:	Consultation	AHLTA Entry Date:	27 Jun 2014 1448 GMT
Facility:		Document ID:	6561280185
Clinician:	LAI, PHILOMENA C		

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: DOUGHERTY, DIANA L
 Requesting Location: HEMATOLOG CL BE
 Order ID number: 140604-07457
 MCP Referral #: 20140984342
 No. of Visits: 1
 Referral Authorized Until: 04 Jul 2014
 Reason for Consult:
 29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM. Please
 e eval and provide exercises to improve strength, ROM. Please consider soft br
 ace for stability while recovering.
 Priority: ROUTINE
 Provisional Diagnosis:
 ANKLE SPRAIN LEFT
 ACV:
 Reviewed Date/Time:
 Appoint Status:
 Appointment Review Comment:
 Reviewer: ,

CONSULT RESULT

Appointment Date: 27 Jun 2014@07:00:00
 Requesting HCP: DOUGHERTY, DIANA L
 Clinic: PHYS THERAPY CL BE
 Consulting HCP: LAI, PHILOMENA C.

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS
 Problem List:

Note:

NOTE=Patient: MERWIN, DANIEL DENNIS Date: 27 Jun 2014 0700 EDT Appt Type: SPEC
 Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR Clinic: PHYS
 THERAPY CL BE Provider: LAI, PHILOMENA C.
 Patient Status: Outpatient
 AutoCites Refreshed by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT
 Problems
 ?NEUROTIC EXCORIATION
 ?ANKLE SPRAIN LEFT
 ?ESSENTIAL HYPERTRIGLYCERIDEMIA

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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?ANOMALIES OF SKIN

?Abdominal pain

?ASTHMA

?POSTSURGICAL STATE OF EYE AND ADNEXA

?Difficulty breathing (dyspnea)

?SKIN NEOPLASM UNCERTAIN BEHAVIOR

?Removal Of Sutures

?ASTHMA EXTRINSIC

?ROSACEA

?PERIPHERAL RETINAL DEGENERATION - LATTICE

?REFRACTIVE ERROR - MYOPIA

?ALLERGIC RHINITIS

Family History

?paternal grandfather's history of preliminary background HPI [use for free text] (Paternal Grandfather)

?paternal history of preliminary background HPI [use for free text] (Father)

?paternal grandmother's history of HPI [use for free text] (Paternal Grandmother)

?family medical history (General FHx)

?family history of supplemental HPI [use for free text] (General FHx)

?no family history of malignant neoplasm of the large intestine (General FHx)

?no family history of malignant neoplasm of the gastrointestinal tract (General FHx)

?no family history of chronic liver disease (General FHx)

Allergies

?OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications Status Sig Refills Left Last Filled

DOXYCYCLINE HYCLATE, 100 MG, TABLET, ORAL Ordered TAKE ONE TABLET BY MOUTH TWICE A DAY FOR 30 DAYS #0 RF1 1 of 1 16 Jun 2014

Reason for Appointment:

ANKLE SPRAIN LEFT

Appointment Comments:

snf

Vitals

Vitals Written by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT

Comments: Patient has falls in the past 6 months, minor injury to L ankle.

Patient is not a fall risk.

S/O Note Written by LAI, PHILOMENA C. @ 27 Jun 2014 1034 EDT

bodybodyChief complaint g1

The Chief Complaint is: L ankle sprain

Visit for: Initial Evaluation

History of present illness: INITIAL EVALUATION (6/27/2014): Patient is a 29 y/o M referred to physical therapy for evaluation and treatment of L ankle sprain. Patient initially injured L ankle in April 2014 while he was sprinting during softball game when his L foot went into the hole.

Since onset, symptoms have unchanged

Meds: reviewed in AHLTA.

Pain scale 72 hrs: current 0/10best 0/10worst 3/10

Description of pain: comes and goes

Aggravating factors: motion

Mitigating factors: rest, elevation, ice

Day pattern: episodic

Recent/previous treatment: none

Functional limitations: no running at this time, increased throbbing sensation

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

after prolonged walking

Patient goals: to run again (patient used to run 5 miles per day 4-5 time per week).eg

Past medical/surgical history g4

Reported:

Past medical history reviewed and discussed. Co-morbidities: none

Diagnostics: x-ray L ankle in AHLTA

Medical precautions: none

Job duties: desk primarily.eg

Objective g9

Observation: genu and tibial varus, normal calcaneus alignment

palpation: no TTP

flexibility: mod tightness hamstrings, calf

Joint Mobility: decreased L TC ant/post mob, STJ med/lat mob

Sensation/Reflex: intact

ROM: ankle: DF L 3 deg R 13 deg, PF L 28 deg R 50 deg, IV L 24 deg R 35 deg,

EV L 6 deg R 15 deg, 1st ray ext L 56 deg R 70 deg, flex L 25 deg R 30 deg

Strength: DF - 5/5 bil, PF 5/5 bil, IV L 4+/5 R 5-/5, EV L 4+/5 R 5/5

Special Tests: thompson - neg, talar tilt - neg, ant/post drawer - neg

function: gait - no significant deviations, SLS EO - L/R = 30 sec, good ankle

stability bil, SLHR L 25/25 R 25/25, no instability noted.eg

Tests g10

Assessment (6/27/2014): Patient presented with decreased L ankle ROM s/p ankle sprain, mild weakness of ankle IV and EV with no instability. Patient would benefit from physical therapy home based ex program to improve ROM and strength.

Rehab prognosis: good

Physical Therapy goals:

STG to be achieved in 3 weeks

Patient to be independent with HEP

Patient to increase ROM to: L ankle DF 10 deg, PF 40 deg, IV 35 deg EV 10 deg

LTG to be achieved in 6-8 weeks

Decrease pain to: 0/10

Increase MMT to: 5/5

Improve function to: tolerate long distance walking without increased in symptoms

running 1 mile 50% pace with no increased in symptoms

Patient education: Patient educated on his/her condition in reference to pertinent anatomy and biomechanics using anatomical models and illustrations, self care, physical therapy and POC.

HEP instructions and performance (15 min): stretch - hamstrings, calf, joint mobilization for DF/PF, ROM, alphabets

Plan of Care: Patient has consented to physical therapy treatment. Patient to perform HEP indep. Follow up in 6 weeks..eg

ebody

ebody

A/P Written by LAI, PHILOMENA C @ 27 Jun 2014 1043 EDT

1. Left ankle joint pain

Procedure(s): -Physical Therapy Service Evaluation x 1

-Physical Therapy: ____ Session Segments, 15 Minutes Each x 1

Disposition Written by LAI, PHILOMENA C @ 27 Jun 2014 1043 EDT

Released w/o Limitations

Follow up: 6 week(s) in the PHYS THERAPY CL BE clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Effects with Patient who indicated understanding.

60 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by LAI, PHILOMENA C @ 27 Jun 2014 0753 EDT

Consult Order

Referring Provider: DOUGHERTY, DIANA L

Date of Request: 04 Jun 2014

Priority: Routine

Provisional Diagnosis:

ANKLE SPRAIN LEFT

Reason for Request:

29 yo 6 weeks s/p L ankle sprain. Residual pain/swelling, decreased ROM.

Please eval and provide exercises to improve strength, ROM. Please consider soft brace for stability while recovering.

Signed By LAI, PHILOMENA C (Physical Therapist, Walter Reed National Military Medical Center) @ 27 Jun 2014 1043

Verified by: PHILOMENA C. LAI 27 Jun 2014@1048

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

24 Oct 2012 1425 GMT at by

Title:		Original Date:	24 Oct 2012 1425 GMT
Document Type:	Consultation	AHLTA Entry Date:	24 Oct 2012 1425 GMT
Facility:		Document ID:	5263466095
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: SALTER, CAROLYN A
 Requesting Location: 5 EAST
 Order ID number: 121012-04930
 MCP Referral #: 20121814182
 No. of Visits: 10
 Referral Authorized Until: 11 Dec 2012
 Reason for Consult:
 27 y/o male w/ ascending colon inflammation s/p colonoscopy 12 OCT. Pt needs
 GI f/u to discuss results.
 Priority: ASAP
 Provisional Diagnosis:
 IBD vs mass
 ACV:
 Reviewed Date/Time: 12 Oct 2012@08:52:00
 Appoint Status: APPOINT TO MTF
 Appointment Review Comment:
 Reviewer: BROWN, CANDICE C

CONSULT RESULT

Appointment Date: 23 Oct 2012@08:00:00
 Requesting HCP: SALTER, CAROLYN A
 Clinic: GI INFLAM BOWEL DIS BE
 Consulting HCP: COPSEY, HELEN C

HCDP: 106-TRICARE PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

Patient: MERWIN, DANIEL DENNIS

Date: 23 Oct 2012 0800 EDT

Appt Type: SPEC

Treatment Facility: WALTER REED NATIONAL MILITARY MEDICAL CNTR

Clinic: GI INFLAM BOWEL DIS BE

Provider: COPSEY, HELEN C

Patient Status: Outpatient

AutoCites Refreshed by COPSEY, HELEN C @ 23 Oct 2012 0756 EDT

Problems

Chronic:

Conditions influencing health status

Merwin, Daniel Dennis

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Asthma
 Postsurgical state of eye and adnexa
 Dyspnea
 Skin neoplasm of uncertain behavior
 Removal of sutures
 Extrinsic asthma
 Rosacea
 Lattice peripheral retinal degeneration
 Myopia
 Allergic rhinitis
 Visit for: occupational health/fitness exam
 Parent education about immunizations
 Visit for: military services physical
 Exposure to venereal disease
 Visit for: administrative purposes
 Inquiry and counseling about contraceptive practices
 Family History
 Family medical history (General FHx)
 Allergies
 OTHER: Unknown (SEE MED RECORD)
 Reason for Appointment:
 IBD vs mass
 Appointment Comments:
 ccb

Vitals

Vitals Written by FARRINGTON,SHAUN C @ 23 Oct 2012 0739 EDT

BP: 114/66, HR: 79, T: 95.4 F, HT: 5' 9", WT: 147 lbs,
 SpO2: 97%, BMI: 21.71, BSA: 1.812 square meters,
 Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut
 down on your drinking? No,
 Have people Annoyed you by criticizing or complaining about your drinking?
 No,

Have you ever felt bad or Guilty about your drinking? No,
 Have you ever had a drink or drug in the morning (Eye opener) to steady your
 nerves or to get rid of a hangover? No,
 Alcohol Comments: COUPLE DRINKS/WEEK, Pain Scale: 0 Pain Free
 SO Note Written by COPSEY,HELEN C @ 24 Oct 2012 0936 EDT

Reason for Visit

Visit for: R/O of IBD.

History of present illness

The Patient is a 27 year old male.

This is a WM, AD PO2, who presents for R/O of IBD. He reports a long history
 of presumed IBS presenting with intermittent lower abdominal cramping that
 occurs several times per week, and is triggered by dairy intake, anxiety, and
 physical activity. This can be associated with looser stool and mild urgency,
 although in general he reports a soft stool each day. An evaluation for these
 symptoms along with isolated BRBPR in 2005 (IL) includes a CT scan showing
 moderate stool retention in the colon, and a flex sig that was reportedly
 limited d/t patient discomfort. He denies any rectal bleeding since that
 time. He does endorse occasional oral aphthi but otherwise denies any
 additional complaints. His weight has been stable.

Earlier this month he experienced worsening of his baseline abdominal pain,
 possibly precipitated by consuming a milk-shake. A CT in the ER showed focal
 colitis at the right colon (hepatic flexure) with fecalization of the small
 bowel, concerning for IBD. CRP was 1.2, labs otherwise nl. A follow-up

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

colonoscopy with Dr. McNally showed clogged appearing mucosa in the left colon. Images of the right colon/ cecum are limited due to liquid stool, and the TI was not intubated per report. Biopsies are pending. The patient reports self-resolution of the pain, and has since been feeling back to baseline.

Allergies

ASA- (nausea).

Past medical/surgical history

Reported:

Past medical history

- Allergic asthma (cats); Headache, NOS

Surgical / Procedural: Prior surgery

- PRK, Tonsillectomy

Medications: Medication history

- Albuterol, Aleve prn (less than once per week)

(I personally reviewed the medication history, allergy history and compliance with medications with this patient)

Surgical:

Pre-op ASA class 1

Previous therapy

History of possible limitations and risks do not include complications from anesthesia

Personal history

Tob: (-)

Etoh: (2 drinks every other day)

Drug use: (-)

Family history

No chronic liver disease

No malignant neoplasm of the large intestine

No malignant neoplasm of the gastrointestinal tract

No known FH of IBD, autoimmune diseases.

Review of systems

Systemic: Not feeling tired (fatigue). No fever, no chills, no night sweats, and no recent weight loss.

Head: No headache.

Eyes: No vision problems.

Otolaryngeal: No hoarseness, no lump in the throat, and no mouth sores.

Cardiovascular: No chest pain or discomfort and no palpitations.

Pulmonary: No dyspnea and no cough.

Gastrointestinal: No dysphagia, no pain on swallowing, no heartburn, no regurgitation, no early satiety, no nausea, no vomiting, no hematemesis, no hematemesis ('coffee grounds'), no abdominal swelling, no jaundice, no recent increase in bowel frequency, and not decrease. No tenesmus, no melena, no hematochezia, no acholic stools, no steatorrhea, and stool diameter is not smaller. No change in consistency of stool and no nocturnal diarrhea. No rectal pain.

Genitourinary: No urinary symptoms.

Endocrine: No endocrine symptoms.

Hematologic: No tendency for easy bruising.

Musculoskeletal: No arthralgias, new. No nonspecific pain, swelling, and stiffness.

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Page

Medical Record

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Neurological: No confusion and no memory lapses or loss.

Psychological: Mood was euthymic and no sleep complaints.

Skin: No pruritus, no change in skin texture, new, and no rash, new.

Physical findings

Vital Signs:

Current vital signs reviewed.

Standard Measurements:

Patient was not observed to be obese.

General Appearance:

Awake. Alert. Oriented to time, place, and person. Well developed.

Well nourished. In no acute distress. Patient did not appear uncomfortable. Not acutely ill. Not chronically ill.

Neck:

Appearance: Of the neck was normal.

Eyes:

General/bilateral:

Sclera: Showed no icterus.

Oral Cavity:

Normal OP clear, Mallampati score = 1.

Chest:

Visual inspection revealed no abnormalities.

Lungs:

Normal CTA B.

Cardiovascular:

System: normal RRR, no M or G.

Abdomen:

Normal soft, NT/ND, +BS.

Neurological:

Level of consciousness was normal.

Speech: Normal.

Gait And Stance: Normal.

Psychiatric:

Mood: Euthymic.

Affect: Normal.

Thought Processes: Not impaired.

Skin:

General appearance was normal. No jaundice. No skin lesions.

Therapy

Medical regimen review -- medication reconciliation performed.

Lab Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EDT

ESR Site/Specimen 12 Oct 2012 1209

ESR BLOOD 10

C-Reactive Protein Site/Specimen 12 Oct 2012 1209

C-Reactive Protein SERUM 1.206 (H)

Magnesium Site/Specimen 12 Oct 2012 0434

Magnesium SERUM 2.1

Phosphorus Site/Specimen 12 Oct 2012 0434

Phosphate SERUM 3.5

Basic Metabolic Panel Site/Specimen 12 Oct 2012 0434

Urea Nitrogen SERUM 5 (L)

Carbon Dioxide SERUM 27

Chloride SERUM 107

Creatinine SERUM 0.80

Glucose SERUM 113 (H)

Potassium SERUM 4.0

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Page

Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

Sodium SERUM 141
 Calcium SERUM 9.2
 Anion Gap SERUM 8
 GFR SERUM >60 <i>
 CBC W/o Diff Site/Specimen 12 Oct 2012 0434
 WBC BLOOD 5.5
 RBC BLOOD 4.02 (L)
 Hemoglobin BLOOD 13.1
 Hematocrit BLOOD 38.1
 MCV BLOOD 94.9
 MCH BLOOD 32.6
 MCHC BLOOD 34.3
 Platelets BLOOD 264
 RDW CV BLOOD 13.1
 MPV BLOOD 7.8
 Neutrophil Cytoplasmic Ab (ANCA) Site/Specimen 11 Oct 2012 1147
 Myeloperoxidase Ab SERUM <0.2 <i>
 Proteinase 3 Ab SERUM <0.2 <i>
 Neutrophil Cytoplasmic Ab (ANCA) Screen W/Reflex Titer Site/Specimen 11 Oct 2012 1147
 Neutrophil Cytoplasmic Ab Cytoplasmic SERUM Titer not indicated-ANCA screen Negative
 Neutrophil Cytoplasmic Ab Perinuclear SERUM Titer not indicated-ANCA screen Negative
 Neutrophil Cytoplasmic Ab SERUM Negative
 Neutrophil Cytoplasmic Ab Perinuclear Atypical SERUM Titer not indicated-ANCA screen Negative <r> <i>
 Carcinoembryonic Ag Site/Specimen 11 Oct 2012 1147
 Carcinoembryonic Ag SERUM 0.9 <i>
 Magnesium Site/Specimen 11 Oct 2012 1147
 Magnesium SERUM 2.3
 Amylase Site/Specimen 11 Oct 2012 1147
 Amylase SERUM 49
 Comprehensive Metabolic Panel Site/Specimen 11 Oct 2012 1147
 Albumin SERUM 4.7
 Alkaline Phosphatase SERUM 56
 Alanine Aminotransferase SERUM 33
 Aspartate Aminotransferase SERUM 29
 Bilirubin SERUM 0.5
 Urea Nitrogen SERUM 9
 Calcium SERUM 9.5
 Carbon Dioxide SERUM 29
 Chloride SERUM 101
 Creatinine SERUM 0.85
 Glucose SERUM 82
 Potassium SERUM 4.0
 Protein SERUM 7.3
 Sodium SERUM 139
 Anion Gap SERUM 9
 GFR SERUM >60 <i>
 Lipase Site/Specimen 11 Oct 2012 1147
 Triacylglycerol Lipase SERUM 19
 Phosphorus Site/Specimen 11 Oct 2012 1147
 Phosphate SERUM 3.5
 CBC W/Diff Site/Specimen 11 Oct 2012 1147

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Page

Medical Record

Merwin, Daniel Dennis

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Created: 16 Aug 2017

WBC BLOOD 6.4
 RBC BLOOD 4.30
 Hemoglobin BLOOD 14.1
 Hematocrit BLOOD 41.0
 MCV BLOOD 95.4
 MCH BLOOD 32.6
 MCHC BLOOD 34.2
 RDW CV BLOOD 13.1
 Platelets BLOOD 268
 MPV BLOOD 8.3
 Neutrophils BLOOD 72.7
 Lymphocytes BLOOD 18.1
 Monocytes BLOOD 7.1
 Eosinophils BLOOD 1.8
 Basophils BLOOD 0.3
 Neutrophils BLOOD 4.6
 Lymphocytes BLOOD 1.2
 Monocytes BLOOD 0.5
 Eosinophils BLOOD 0.1
 Basophils BLOOD 0.0
 Differential Review BLOOD MANUAL DIFF NOT PERFORMED
 Rad Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0957 EDT
 MERWIN, DANIEL DENNIS 20/ [REDACTED] 27yo [REDACTED] 1985 M

***** CT, ABD/PELVIS W/ CONTRAST *****

POC Enc: #E923164 POC Fac: NH Great Lakes IL

Status: Complete

Procedure: CT, ABD/PELVIS W/ CONTRAST

Event Date: 22-Nov-2005 10:48:00

Order Comment: NO BRIEF COMMENT

Reason for Order:

20y/o male dot 2-5 with intermittent abdominal pain x 4-5 years with
 rectal

bleeding on 19th of NOV. Had normal sigmoidoscopy to proximal transverse colon
 and mild int hemorrhoids done on Nov 21.

Exam #: 05050343

Exam Date/Time: 23-Nov-2005 09:26:00

Transcription Date/Time: 29-Nov-2005 10:02:00

Provider: ARTATES, NEMESIA F

Requesting Location:

COURAGE (WHITE) 1007 NBHC 1007/1017

Status: COMPLETE

Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MARINBERG, BORIS V

Approved By: MARINBERG, BORIS V

Approved Date: 29-Nov-2005 12:25:00

Report Text:

ba/DICTATION DATE: 23 November 2005

CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST:

Technique: 7.5 mm cross-sectional images of the abdomen and pelvis were
 obtained following oral and intravenous introduction of contrast.

Findings: There is a normal appearance of the liver, spleen, and
 pancreas.

There is no gallstones. No dilatation of biliary ducts or pancreatic
 duct

identified. There is no enlargement of the adrenal glands. There is no

Merwin, Daniel Dennis

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Page

Medical Record

Merwin, Daniel Dennis

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1985

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Created: 16 Aug 2017

hydronephrosis. No renal stones are seen. There is no lymphadenopathy.

No

abnormal collection of fluid in the abdomen or pelvis identified.

Moderate

amount of fecal material noted throughout the colon. There is no changes of

appendicitis. No aneurysmal dilatation of the abdominal aorta noted.

There is

no signs of bowel obstruction.

IMPRESSION: NORMAL COMPUTED TOMOGRAPHY OF THE ABDOMEN AND PELVIS.

MODERATE AMOUNT OF FECAL MATERIAL THROUGHOUT THE COLON.

Rad Result Cited by COPSEY, HELEN C @ 24 Oct 2012 0956 EDT

MERWIN, DANIEL DENNIS 20/ [REDACTED] 27yo [REDACTED] 1985 M

***** CT, ABDOMEN / PELVIS WITH (PG) *****

POC Enc: #E4520771 POC Fac: WRNMMC

Status: Complete (Amended)

Procedure: CT, ABDOMEN / PELVIS WITH (PG)

Event Date: 11-Oct-2012 01:30:00

Exam #: 12343907

Exam Date/Time: 11-Oct-2012 00:30:00

Transcription Date/Time: 12-Oct-2012 07:00:00

Provider: HARDWARE, LESLIE

Requesting Location:

EMERGENCY RM BE WRNMMC BETHESDA, MD

Status: COMPLETE (Amended)

Amended Result Code: SEE RADIOLOGIST'S REPORT

Interpreted By: MOLLURA, JOSEPH G

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Approved By: BERNARD, JACQUELINE M

Approved Date: 11-Oct-2012 08:16:00

Supervised By: BERNARD, JACQUELINE, MD, CDR, USN

Supervised By Date: 11-Oct-2012 08:16:00

Amended Report Text:

ADDITIONAL HISTORY: Abdominal pain.

TECHNIQUE: CT of the abdomen and pelvis was performed under standard abdomen/pelvis CT protocol with 5 mm axial helically acquired images obtained

from the level of the diaphragm to the level of the pubic symphysis after the

intravenous administration of 110 mL Isovue 370 and oral contrast.

Coronal and

sagittal reformatted images were also obtained.

COMPARISONS: Acute abdominal series 10/10/12.

FINDINGS:

Lung bases are clear.

Liver parenchyma and vasculature is unremarkable. Normal biliary tree without

intra-or extrahepatic biliary ductal dilatation. Pancreas, spleen, adrenals,

and kidneys are normal. No identifiable ureteral abnormalities.

Fluid-filled

urinary bladder is unremarkable.

Enteric contrast visualized to the level of the mid ileum. Stomach is normal.

There is fecal material and air noted within the distal ileum extending

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

to a

mildly distended stool filled cecum. The appendix is identified and is normal.

There is a focal area of vascular prominence involving the mesentery at the

level of the hepatic flexure. The colon wall at this level appears mildly

thickened but otherwise decompressed. The colon distal to the hepatic flexure

is decompressed and normal in appearance.

Shotty subcentimeter mesenteric lymph nodes about the upper abdomen. No intra-abdominal mass or fluid collection. Vascular structures are normal in

configuration.

Pelvic organs are unremarkable. No free pelvic fluid. No pelvic or inguinal

lymphadenopathy.

Soft tissues, muscles, and osseous structures are unremarkable.

IMPRESSION:

Focal colitis at the level of the hepatic flexure with proximal stool retention

and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's

disease. Clinical correlation is recommended.

Note: Findings above were discussed with Dr. Hardware, via telephone at 0450

hours on 10/11/12.

Electronically signed by resident: Dr. JOSEPH G MOLLURA Date: 10/11/12

Time:07:22

Electronically signed by:Dr. Jacqueline M Bernard Date: 10/11/12

Time:08:16

A/P Last Updated by COPSEY,HELEN C @ 24 Oct 2012 1002 EDT

1. Imaging Studies Nonspecific Abnormal Findings: CT concerning for colitis and fecalization of SB ? radiographic artifact, constipation, acute vs. chronic inflammation, stenosis. Colonoscopy with limited evaluation of right colon, ICV, distal ileum. Recommend MRE for further evaluation of small bowel as d/w Dr. Kikendall. He may ultimately require repeat colonoscopy, however will await biopsy results prior to determining next steps. Patient voices understanding/ agreement.

2. abdominal pain: Patient with long history of intermittent abdominal pain ? due to IBS vs. dietary intolerance vs. inflammatory. Will proceed with evaluation to r/o IBD, however if negative encouraged patient to continue f/u with GI for management of chronic symptoms.

Disposition Last Updated by COPSEY,HELEN C @ 24 Oct 2012 1003 EDT Released w/o Limitations

Follow up: in the GI INFLAM BOWEL DIS BE clinic. - Comments: Will call pt 850-602-8501 after obtaining pathology and discussing need for repeat colonoscopy with IBD staff.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: 45 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Note Written by BROWN,CANDICE C @ 23 Oct 2012 0738 EDT

Merwin, Daniel Dennis

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Consult Order

Referring Provider: SALTER, CAROLYN A

Date of Request: 12 Oct 2012

Priority: ASAP

Provisional Diagnosis:

IBD vs mass

Reason for Request:

27 y/o male w/ ascending colon inflammation s/p colonoscopy 12 OCT. Pt needs GI f/u to discuss results.

Signed By COPSEY, HELEN C (PA-C, MSHS, WRAMC- GI Clinic) @ 24 Oct 2012 1003

Note Written by COPSEY, HELEN C @ 24 Oct 2012 1004 EDT

(Added after encounter was signed.)

PATH

PATH

Spoke with Dr. Barner re: patient's pathology results- not yet placed into CHCS. Biopsies of left-colon show benign colonic mucosa, without active inflammation, chronicity or architectural distortion.

Verified by: COPSEY, HELEN C 24 Oct 2012 @ 1025

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

15 Oct 2012 1543 GMT at WRNMMC by JORDAN, MARIA T.

Title:	Colonoscopy	Original Date:	15 Oct 2012 1543 GMT
Document Type:	Study Report	AHLTA Entry Date:	15 Oct 2012 1543 GMT
Facility:	WRNMMC	Document ID:	5240682287
Clinician:	JORDAN, MARIA T.		

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Walter Reed National Military Medical Center**Endoscopy Dept.**

Patient Name:	Daniel Merwin	Procedure Date:	10/12/2012 8:23 AM
MRN:	20 [REDACTED]	SSN:	[REDACTED]
Date of Birth:	[REDACTED] 1985	Admit Type:	Inpatient
Age:	27	Note Status:	Finalized
Attending MD:	Michael McNally, MD		

Procedure: Colonoscopy**Indications:** Generalized abdominal pain**Providers:** Michael McNally, MD (Doctor), Tiffany Cox, MD (Fellow), Stephanie R. Raskulnec, RN, Nickole R. Hooks, Technician**Patient Profile:** This is a 27 year old patient.**Referring MD:****Medicines:** Fentanyl 150 mcgs, Versed 4 mgs**Complications:** No immediate complications.**Requesting Provider:****Procedure:**

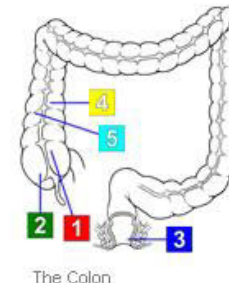
Pre-Anesthesia Assessment:

- Prior to the procedure, a History and Physical was performed, and patient medications and allergies were reviewed. The patient is competent. The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered and informed consent was obtained. Patient identification and proposed procedure were verified by the physician in the pre-procedure area. Mental Status Examination: alert and oriented. Airway Examination: normal oropharyngeal airway and neck mobility. Respiratory Examination: clear to auscultation. CV Examination: normal. Prophylactic Antibiotics: The patient does not require prophylactic antibiotics. Prior

Anticoagulants: The patient has taken no previous anticoagulant or antiplatelet agents. ASA Grade Assessment: II - A patient with mild systemic disease. After reviewing the risks and benefits, the patient was deemed in satisfactory condition to undergo the procedure. The anesthesia plan was to use moderate sedation / analgesia (conscious sedation). Immediately prior to administration of medications, the patient was re-assessed for adequacy to receive sedatives. The heart rate, respiratory rate, oxygen saturations, blood pressure, adequacy of pulmonary ventilation, and response to care were monitored throughout the procedure. The physical status of the patient was re-assessed after the procedure.

After the risks of infection, bleeding, and perforation were explained to the patient, informed consent was obtained. A procedure team TIME OUT consisting of correct patient name, FMP and complete social security number, date of birth and procedure was conducted prior to the scope being passed under direct visualization. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. Medication reconciliation was performed. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.

Post Anesthesia Evaluation: No apparent anesthetic complications. The Colonoscope was introduced through the anus and advanced to.

**Findings:**

The perianal and digital rectal examinations were normal.

An area of congested mucosa was found in the descending colon. This was biopsied with a cold forceps for histology.

Powered by Provation MD

Page 1 of 2

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Walter Reed National Military Medical Center**Endoscopy Dept.**

Patient Name:	Daniel Merwin	Procedure Date:	10/12/2012 8:23 AM
MRN:	20 [REDACTED]	SSN:	[REDACTED]
Date of Birth:	[REDACTED] 985	Admit Type:	Inpatient
Age:	27	Note Status:	Finalized
Attending MD:	Michael McNally, MD		

An area of congested mucosa was found in the sigmoid colon.

Add'l Images:

1 Cecum



2 Cecum



3 Rectum



4 Ascending Colon



5 Ascending Colon

Impression:

- Congested mucosa in the descending colon. This was biopsied.
- Congested mucosa in the sigmoid colon.

Michael McNally, MD
10/12/2012 9:34:02 AM

Tiffany Cox, MD

Number of Addenda: 0**Note Initiated On:** 10/12/2012 8:23:15 AM**Procedure Date:** 10/12/2012 8:23:15 AM**Scope Withdrawal Time:**

11 Minutes 40 Seconds

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

29 Mar 2011 2052 GMT at by

Title:		Original Date:	29 Mar 2011 2052 GMT
Document Type:	Consultation	AHLTA Entry Date:	29 Mar 2011 1952 GMT
Facility:		Document ID:	4042153933
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: ZENT, JOHN W
 Requesting Location: NASP OPTOMETRY CLINIC
 Order ID number: 110316-03593
 MCP Referral #: 20110080617
 No. of Visits: 5
 Referral Authorized Until: 16 May 2011
 Reason for Consult:
 CRS, please eval peripheral retinal lesion OD for correct diagnosis and possible laser retinopexy.
 Priority: ROUTINE
 Provisional Diagnosis:
 Lattice peripheral retinal degeneration
 ACV:
 Reviewed Date/Time: 17 Mar 2011@15:20:00
 Appoint Status: APPOINT TO MTF
 Appointment Review Comment:
 Clinic will make appointment.
 Reviewer: CORDOVA, CARLOS

CONSULT RESULT

Appointment Date: 29 Mar 2011@13:30:00
 Requesting HCP: ZENT, JOHN W
 Clinic: OPHTHALMOLOGY CLINIC
 Consulting HCP: ROPP, CORBY D

Problem List:**Note:**

Patient: MERWIN, DANIEL DENNIS
 Date: 29 Mar 2011 1330 CDT
 Appt Type: SPEC
 Treatment Facility: NH Pensacola
 Clinic: OPHTHALMOLOGY CLINIC
 Provider: ROPP,CORBY D
 Patient Status: Outpatient
 Reason for Appointment: PRK Screen
 Appointment Comments:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

CJC

AutoCites Refreshed by ROPP,CORBY D @ 29 Mar 2011 1335 CDT

Problems

Chronic:

Dyspnea

Skin neoplasm of uncertain behavior

Removal of sutures

Extrinsic asthma

Folliculitis

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Visit for: occupational health/fitness exam

Parent education about immunizations

Visit for: military services physical

Exposure to venereal disease

Inquiry and counseling about contraceptive practices

Visit for: administrative purposes

Family History

No Family History Found.

Allergies

OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications

Status

Sig

Refills Left

Last Filled

CETIRIZINE HCL, 10 MG, TABLET, ORAL

Active

T1 TAB PO HS #30 RF5

5 of 5

24 Jan 2011

Fluticasone Propionate 0.05%, Spray, Nasal

Active

INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3

3 of 3

24 Jan 2011

Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device,

Inhalation

Active

INHALE 1 PUFF ORALLY BID #1 RF1

0 of 1

24 Jan 2011

KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL

Active

USE ON TRUNK AND SCALP BID AS DIRECTED

4 of 4

13 Oct 2010

Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous

Active

KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2

RF4

4 of 4

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

13 Oct 2010

Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA

Active

INH 2 PF PO Q4H FOR WHEEZING #1 RF1

1 of 1

01 Sep 2010

FEXOFENADINE HCL, 180 MG, TABLET, ORAL

Active

T1 TAB PO QD F ALLERGIES UD #30 RF2

2 of 2

25 Aug 2010

Cetaphil/Aquanil Cleanser Lotion Topical

Active

INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6

6 of 6

20 Jul 2010

A/P Written by ROPP,CORBY D @ 29 Mar 2011 1446 CDT

1. visit for: preoperative exam: The risks and benefits and CRS alternatives eligible for this patient were discussed including PRK/LASIK options.

PRK was discussed as use of a brush to create a large abrasion like defect which will take several days to heal with aid of a CL. Potential of pain/discomfort was mentioned. Risks of haze which may cause loss of best vision was discussed. Significantly slower visual recovery than LASIK (up to 6 months) worsening of dry eye or causing dry eye, and infection were discussed. Glare and halos, new dry eye that may persist for 6 months or longer was mentioned. The use of MMC as surgeon preference in order to minimize risk of corneal haze development was discussed as well as it's unknown long -term affects on the cornea and that it is not FDA approved for CRS. It was mentioned that the Navy has a long history of successful application of MMC with much less haze formation and minimal side effects. The LASIK option was discussed as creation of a corneal flap which establishes a thinner corneal structure than PRK, but faster and less painful visual recovery. The lesser risk of haze was mentioned. The potential for re-lifting the flap if necessary for debri, folds, or re-treatment and risk for epithelial down-growth was discussed. The risk of flap dislocation although small was discussed. The risk for flap infection although small was discussed. The risk of worsening or creation of dry eye symptoms due to the corneal incision, as well as glare and halos at night during the healing process were discussed. The risk of worsened dry eye with age was also discussed, and that its long-term affects not known. The risk for multiple suction loss events, even during flap creation w/ potential for resultant aberrations was discussed.

It was mentioned that people who have either PRK or LASIK are generally happy and most would recommend to a friend w/ a few exceptions

After a discussion of the risks and benefits the patient elected to have PRK with MMC application.

Procedure(s):

-Ophthalmological New Patient Start Comprehensive Care x 1

-Determination Of Refractive State x 1

-Corneal Pachymetry Both Eyes x 1

-Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment, Unilateral x 2 (50-BILATERAL PROCEDURE) - Wavescan, low RMS, okay for Allegretto

PentaCam - nl A/P floats and Belin-Ambrosio scans ou - Hard copy on file on system - no printer ink

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

-Computerized Corneal Topography x 1

2. REFRACTIVE ERROR - MYOPIA

Disposition Written by ROPP,CORBY D @ 29 Mar 2011 1446 CDT

Released w/o Limitations

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential

Side Effects with Patient who indicated understanding.

Note Written by CORDOVA,CARLOS @ 29 Mar 2011 1219 CDT

Consult Order

Referring Provider: ZENT, JOHN W

Date of Request: 16 Mar 2011

Priority: Routine

Provisional Diagnosis:

Lattice peripheral retinal degeneration

Reason for Request:

Clinic will make appointment.CRS, please eval peripheral retinal lesion OD
for correct diagnosis and possible laser retinopexy.

Signed By ROPP, CORBY D (Corby D. Ropp, USN, LCDR, 81st Medical Group,
Refractive Surgery) @ 29 Mar 2011 1447

Verified by: ROPP,CORBY D 29 Mar 2011@1452

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

25 Mar 2011 1831 GMT at by

Title:		Original Date:	25 Mar 2011 1831 GMT
Document Type:	Consultation	AHLTA Entry Date:	25 Mar 2011 1731 GMT
Facility:		Document ID:	4035106101
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: LEWIS, CHRISTOPHER T
 Requesting Location: PULMONARY DISEASE CLINIC
 Order ID number: 110216-01478
 MCP Referral #: 20110050565
 No. of Visits: 1
 Referral Authorized Until: 18 Mar 2011
 Reason for Consult:
 Pt is a 26 yo male with chest tightness and dyspnea. Please evaluate with baseline PFTs and a methacholine challenge study if necessary to rule out asthma.
 Priority: ROUTINE
 Provisional Diagnosis:
 difficulty breathing (dyspnea)
 ACV:
 Reviewed Date/Time: 17 Feb 2011@08:32:00
 Appoint Status: APPOINT TO MTF
 Appointment Review Comment:
 clinic will schedule. Per Ms Mcgee.
 Reviewer: ALLEN, SARAH H

CONSULT RESULT

Appointment Date: 17 Mar 2011@13:00:00
 Requesting HCP: LEWIS, CHRISTOPHER T
 Clinic: PULMONARY FUNCTION LAB
 Consulting HCP: LEWIS, CHRISTOPHER T

Problem List:**Note:**

Patient: MERWIN, DANIEL DENNIS
 Date: 17 Mar 2011 1300 CDT
 Appt Type: PROC\$
 Treatment Facility: NH Pensacola
 Clinic: PULMONARY FUNCTION LAB
 Provider: LEWIS, CHRISTOPHER T
 Patient Status: Outpatient
 Reason for Appointment: difficulty breathing (dyspnea)
 Appointment Comments:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

LHM

A/P Last Updated by MCGEE,LINDA H @ 24 Mar 2011 1225 CDT

1. difficulty breathing (dyspnea)

Procedure(s):

-Special Dr. Services Analysis Of Computerized Data x 1

-Pulse Oximetry x 1

-Pulmonary Function MVV x 1

-Pulmonary Function FRC (% Predicted Normal) x 1

-Pulmonary Function Carbon Monoxide Diffusion % (DLCO) x 1

-Bronchial Challenge With Methacholine x 1

-Spirometry Pre-bronchodilator x 1

-Spirometry Post-bronchodilator x 1

Disposition Last Updated by MCGEE,LINDA H @ 24 Mar 2011 1225 CDT

Released w/o Limitations

Note Written by DAW,PAMELA J @ 17 Mar 2011 1300 CDT

Consult Order

Referring Provider: LEWIS, CHRISTOPHER T

Date of Request: 16 Feb 2011

Priority: Routine

Provisional Diagnosis:

difficulty breathing (dyspnea)

Reason for Request:

clinic will schedule. Per Ms Mcgee.Pt is a 26 yo male with chest tightness and dyspnea. Please evaluate with baseline PFTs and a methacholine challenge study if necessary to rule out asthma.

Note Written by MCGEE,LINDA H @ 24 Mar 2011 1224 CDT

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 25 Mar 2011 1117

Verified by: Christopher T. Lewis 25 Mar 2011@1231

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

16 Feb 2011 1552 GMT at by

Title:		Original Date:	16 Feb 2011 1552 GMT
Document Type:	Consultation	AHLTA Entry Date:	16 Feb 2011 1552 GMT
Facility:		Document ID:	3954332842
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: BROWN, TRAVIS SCOTT
 Requesting Location: DEPLOYMENT HEALTH CLINIC
 Order ID number: 110208-01279
 MCP Referral #: 20110041136
 No. of Visits: 1

Referral Authorized Until: 10 Mar 2011

Reason for Consult:

25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment. thank you. contact phone # 850 292 7149

Priority: ROUTINE

Provisional Diagnosis:

ASTHMA EXTRINSIC

ACV:

Reviewed Date/Time: 09 Feb 2011@11:03:00

Appoint Status: APPOINT TO MTF

Appointment Review Comment:

LVM ON CELL PHONE

Reviewer: MARVIN, MELISSA A

CONSULT RESULT

Appointment Date: 16 Feb 2011@08:30:00
 Requesting HCP: BROWN, TRAVIS SCOTT
 Clinic: PULMONARY DISEASE CLINIC
 Consulting HCP: LEWIS, CHRISTOPHER T

Problem List:

Note:

Patient: MERWIN, DANIEL DENNIS

Date: 16 Feb 2011 0830 CST

Appt Type: SPEC

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Treatment Facility: NH Pensacola

Clinic: PULMONARY DISEASE CLINIC

Provider: LEWIS,CHRISTOPHER T

Patient Status: Outpatient

Reason for Appointment: ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN

Appointment Comments:

CAC-CN

Screening Written by LEE,BRANDON G @ 16 Feb 2011 0803 CST

Reason For Appointment: ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN

Allergen information verified by LEE, BRANDON G @ 16 Feb 2011 0803 CST

Vitals

Vitals Written by LEE,BRANDON G @ 16 Feb 2011 0803 CST

BP: 123/74, HR: 85, RR: 15, HT: 69 in, WT: 157 lbs, SpO2: 98%, BMI: 23.18, BSA: 1.864 square meters,

Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by LEWIS,CHRISTOPHER T @ 16 Feb 2011 0905 CST

Chief complaint

The Chief Complaint is: Chest tightness.

History of present illness

The Patient is a 26 year old male.

He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression Screen: Negative PHQ-2 (Score < 3).

Pt is a 26 yo male with a history of allergies and childhood asthma. He notes a history of asthma in childhood which was associated with allergic symptoms. He remarks on 1 hospitalization for his asthma as a child but none since. Since the age of 8 he has been doing well and was not maintained on any inhalers. He is very active and is an active marathoner. Recently he has noted increased symptoms of chest tightness associated with exposure to cats and dogs. He was briefly treated with Advair, but is currently being maintained on Zyrtec and Flonase as well as allergen avoidance with excellent control of his symptoms. He will have one weekly chest tightness and albuterol use, but is otherwise doing well, and recently completed a marathon. He presents for routine follow up.

Pain Severity 0 / 10.

Past medical/surgical history

Reported History:

Past Medical History:

1) childhood asthma

2) allergies.

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history 1) T&A.

Reported medications: Medication history Zyrtec t1 tab po qd

Flonase.

Personal history

-Tob: none

-EtOH: none

Originally from California. Lived in PA and NJ. USN for 5 years. Works as a cryptologist. Deployed to Japan recently, but no other travel or occupational exposure. .

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

1053

AR 3040

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Family history

Family medical history N/A.

Review of systems

Military service: Visit is not deployment-related Location:

Date:

Systemic symptoms: Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.

Pulmonary symptoms: No dyspnea, not coughing up sputum, no hemoptysis, and no wheezing.

Gastrointestinal symptoms: No heartburn, no nausea, and no vomiting.

Physical findings

Vital signs:

Current vital signs reviewed.

General appearance:

Well-appearing. Awake. Alert. In no acute distress.

Neck:

Palpation: Of the neck revealed no abnormalities.

Nose:

General/bilateral:

Nasal Discharge: No nasal discharge seen.

Sinus Tenderness: No sinus tenderness.

Pharynx:

Oropharynx: Uvula was not enlarged. Tonsils were not enlarged.

Lymph Nodes:

Cervical lymph nodes were not enlarged. Supraclavicular lymph nodes were not enlarged.

Lungs:

No wheezing was heard. No rhonchi were heard. No prolonged expiratory time. No rales/crackles were heard.

Cardiovascular system:

Jugular Venous Pressure: JVP was normal.

Jugular Venous Distention: JVD not increased.

Heart Rate And Rhythm: Normal.

Heart Sounds: S1 normal. S2 normal. No S3 heard. No S4 heard.

No pericardial friction rub heard.

Murmurs: No murmurs were heard.

Abdomen:

Palpation: Abdomen was not soft. No abdominal tenderness.

Skin:

No generalized cyanosis.

A/P Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0930 CST

1. difficulty breathing (dyspnea): Pt is a 26 yo male with a history of childhood asthma and allergy type symptoms. His clinical history is suggestive of mild intermittent asthma, and his symptoms are under excellent control with control of his allergies with zyrtec and flonase. He will continue on these medications and prn albuterol for now, and will be referred for baseline PFTs and methacholine challenge study to definitive rule in/out asthma. Even with a positive study, his symptoms are under excellent control on his current therapy, and if needed he can be successful controlled with an inhaled steroid. He is highly functional, and even if a diagnosis of asthma is established this in no way should impact upon his fitness for duty. He is currently fit for duty and fit for world wide deployment. He will follow up in 3-4 weeks to review the results of his PFTs.

Consult(s):

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

-Referred To: PULMONARY FUNCTION STUDIES (Routine) Specialty: PULMONARY DISEASE Clinic: PULMONARY FUNCTION LAB Primary Diagnosis: difficulty breathing (dyspnea)

Disposition Written by LEWIS,CHRISTOPHER T @ 16 Feb 2011 0931 CST

Released w/o Limitations

Administrative Options: Consultation requested

Note Written by AEPPLI,CAROL @ 16 Feb 2011 0755 CST

Consult Order

Referring Provider: BROWN, TRAVIS S

Date of Request: 08 Feb 2011

Priority: Routine

Provisional Diagnosis:

ASTHMA EXTRINSIC

Reason for Request:

LVM ON CELL PHONE25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment.

thank you. contact phone # 850 292 7149

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 16 Feb 2011 0931

CHANGE HISTORY

The following SO Note Was Overwritten by LEWIS,CHRISTOPHER T @ 16 Feb 2011 0905 CST:

SO Note Written by LEE,BRANDON G @ 16 Feb 2011 0806 CST

Chief complaint

The Chief Complaint is: ASTHMA.

History of present illness

The Patient is a 26 year old male.

He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression

Screen: Negative PHQ-2 (Score < 3).

Pain Severity 0 / 10.

Past medical/surgical history

Reported History:

Medical: Reported medical history N/A.

Surgical / procedural: Surgical / procedural history N/A.

Reported medications: Medication history Zyrtec t1 tab po qd

Flonase.

Personal history

Behavioral history: Never a smoker / Never Used Tobacco Products.

Alcohol: No consumption of alcohol.

Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

Review of systems

Military service: Visit is not deployment-related Location:

Date:

Verified by: Christopher T. Lewis 16 Feb 2011@0952

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

20 Jul 2010 2204 GMT at by

Title:		Original Date:	20 Jul 2010 2204 GMT
Document Type:	Consultation	AHLTA Entry Date:	20 Jul 2010 2204 GMT
Facility:		Document ID:	3506040982
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: GUNTER, ROGER WILLIAM

Requesting Location: CORRY PRIME CARE

Order ID number: 100614-01665

MCP Referral #: 20100165780

No. of Visits: 1

Referral Authorized Until: 13 Jul 2010

Reason for Consult:

25 yo male active duty member with 9 months of facial break outs - pustules, papules on forehead, nose and cheeks with any sun exposure. Patient has tried every sun screen he knows but every time he goes out to the beach or has any outdoor time for 4 or more hours he'll break out. Clears after about 2-4 days but comes back every time he gets sun exposure. It has some features of Rosacea but a very unusual onset and resolution. Please evaluate and treat definitively.

Priority: ROUTINE

Provisional Diagnosis:

ROSACEA

ACV:

Reviewed Date/Time: 15 Jun 2010@10:12:00

Appoint Status: APPOINT TO MTF

Appointment Review Comment:

1ST L/M ON VM

Reviewer: HOLLINS, ERICA

CONSULT RESULT

Appointment Date: 20 Jul 2010@09:20:00

Requesting HCP: GUNTER, ROGER WILLIAM

Clinic: DERMATOLOGY CLINIC

Consulting HCP: SMITH, ERIC P

HCDP: 152-TRICARE OVERSEAS PRIME INDIVIDUAL COVERAGE FOR ACTIVE DUTY SPONSORS

Problem List:

Note:

Patient: MERWIN, DANIEL DENNIS

Date: 20 Jul 2010 0920 CDT

Appt Type: SPEC

Treatment Facility: NH Pensacola

Clinic: DERMATOLOGY CLINIC

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Provider: SMITH,ERIC P

Patient Status: Outpatient

Reason for Appointment: ROSACEA/DERM-NHP/MED LIST/CTD/20/RECORDS/UNIFORM

Appointment Comments:

CAC-EH

AutoCites Refreshed by SMITH,ERIC P @ 20 Jul 2010 0948 CDT

Problems

Chronic:

Rosacea

Lattice peripheral retinal degeneration

Myopia

Allergic rhinitis

Visit for: occupational health/fitness exam

Parent education about immunizations

Visit for: military services physical

Exposure to venereal disease

Visit for: administrative purposes

Inquiry and counseling about contraceptive practices

Allergies

OTHER: Unknown (SEE MED RECORD)

Active Medications

Active Medications

Status

Sig

Refills Left

Last Filled

Sodium Fluoride, Cream, Dental

Active

BRUSH FOR 5 MINUTES BEFORE BEDTIME. DO NOT RINSE. #2 RF3

3 of 3

18 Sep 2009

SO Note Written by SMITH,ERIC P @ 20 Jul 2010 1115 CDT

Chief complaint

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related /deployment-related. Paygrade E5.

Presents for evaluation of her recurrent rash that has been occurring over the past two summers. He states that when he spends time in the sun and especially in the water he will develop crops of pustules across his forehead, cheeks, and somewhat on his back and chest. These are typically painful and he tends to puncture these or pick them. He did that this morning and does not have any significant acute lesions. He denies breakouts on other sun exposed areas of his skin.

He has tried many different types of sunscreens, but most recently used a baby sunscreen that one time helped prevent a breakout and the other time did not.

He does not take medications regularly, though occasionally takes Aleve.

He does relate that he had MRSA 3 times, and has been using an antibacterial

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

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DoD ID: 1286180538

Created: 16 Aug 2017

soap on all of his skin since April of 2009.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Past medical/surgical history**Reported History:**

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals;

supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

Pain level (0-10): Reviewed.

Current vital signs reviewed.

General appearance:

Well-appearing. Alert. Oriented to time, place, and person. Well nourished. Well hydrated.

Skin:

Lesions: See add note for details.

Also noted to have very fair skin and fairly moderate photo damage with hundreds of ephelids. General appearance was normal.

Therapy

No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

A/P Last Updated by SMITH,ERIC P @ 20 Jul 2010 1643 CDT

1. FOLLICULITIS: Appears to developing pustules of unclear etiology. The sudden onset following sun exposure may point towards a photosensitive reaction which could be photo drug or photo toxic or photoallergic. He only takes Aleve occasionally, and this could be a potential cause of pseudo-porphyrria though he has no lesions on the back of his hands and no milia. It would be atypical for acne, even though he complains of blackheads, as the sun tends to be more immunosuppressive rather than causing acne breakouts.

He may have a reaction to sunscreen products, though states that he is broken out even when not wearing sunscreen. There does not appear to be a likely interaction between water in his skin. These lesions are not urticarial.

There may be a relationship to him starting his antibacterial soap and the onset of this rash. Discussed the importance of good skin care without damaging the surface.

Pityrosporum folliculitis is also in the differential diagnosis.

Recommended:

Stop antibacterial soap.

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Start Dove or Cetaphil for washing his body.

They tried different sunscreens on his skin to see if there is a relationship between outbreaks.

Return 3 to 6 weeks for reevaluation

Medication(s):

-CETAPHIL (AQUANIL)CLNSR 240ML --TOP SOAP - INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6 Qt: 2 Rf: 6

Disposition Written by SMITH,ERIC P @ 20 Jul 2010 1645 CDT

Released w/o Limitations

Follow up: 2 to 6 week(s) in the DERMATOLOGY CLINIC clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential

Side Effects with Patient who indicated understanding.

Note Written by NEWTON,TYLER JEROME @ 20 Jul 2010 0916 CDT

Consult Order

Referring Provider: GUNTER, ROGER WILLIAM

Date of Request: 14 Jun 2010

Priority: Routine

Provisional Diagnosis:

ROSACEA

Reason for Request:

1ST L/M ON VM25 yo male active duty member with 9 months of facial break outs

- pustules, papules on forehead, nose and cheeks with any sun exposure.

Patient has tried every sun screen he knows but every time he goes out to the beach or has any outdoor time for 4 or more hours he'll break out. Clears after about 2-4 days but comes back every time he gets sun exposure. It has some features of Rosacea but a very unusual onset and resolution. Please evaluate and treat definitively.

Note Written by NEWTON,TYLER JEROME @ 20 Jul 2010 1154 CDT

Signed By SMITH, ERIC P (Physician, NH Pensacola FL) @ 20 Jul 2010 1646

CHANGE HISTORY

The following SO Note Was Overwritten by SMITH,ERIC P @ 20 Jul 2010 1115 CDT:

SO Note Written by MATTHEWS,KARLA M @ 20 Jul 2010 0923 CDT

Chief complaint

The Chief Complaint is: Rosacea.

Referred here

Referred by:

History of present illness

The Patient is a 25 year old male Source of patient information was patient.

Barriers to learning were identified as: None. Barriers considered were social; cultural; emotional; motivational; physical; religious; cognitive and language.

In the Navy and currently on active duty. Visit is not deployment-related /deployment-related. Paygrade E5.

Allergies

Allergy information in Autocite area was reviewed and verified with patient.

Current medication

Pt is not taking meds at this time.

Past medical/surgical history

Reported History:

Reported medications: Medication history including current prescription medications; over-the-counter medications; nutraceuticals; herbals;

Merwin, Daniel Dennis

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Page

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DoD ID: 1286180538

Created: 16 Aug 2017

supplements and medications not included in AHLTA were reviewed with patient in detail.

Personal history

: Reviewed.

Behavioral history: Caffeine use. No tobacco use.

Alcohol: Alcohol use.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings

Vital signs:

Pain level (0-10): Reviewed.

Current vital signs reviewed.

General appearance:

Well-appearing. Alert. Oriented to time, place, and person. Well nourished. Well hydrated.

Therapy

No herbal medicines.

Counseling/Education

Education appropriate to the patients needs was provided regarding the care/treatment/services provided. The patient voices understanding and all questions were answered.

Verified by: ERIC P. SMITH, CDR, MC, USN20 Jul 2010@1704

Merwin, Daniel Dennis

DOB: [REDACTED]

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

24 Dec 2005 0302 GMT at by

Title:		Original Date:	24 Dec 2005 0302 GMT
Document Type:	Consultation	AHLTA Entry Date:	24 Dec 2005 0302 GMT
Facility:		Document ID:	740509843
Clinician:			

CONSULT REPORT

Order Request for MERWIN, DANIEL

Requesting HCP: ARTATES, NEMESIA F
 Requesting Location: COURAGE (WHITE) 1007
 Order ID number: 051122-02775
 MCP Referral #: 20050168555
 No. of Visits: 1
 Referral Authorized Until: 20 Dec 2005
 Reason for Consult:
 20y/o male SR dot 2-5 with hx of intermittent abdominal pain 4-5 yrs
 EPTe, sometimes triggered by food intake. Then had rectal bleeding Nov
 19th., seen by surgery, had normal sigmoidoscopy to proximal transverse colon
 and mild internal hemorrhoids. Also pt has hx of easy bruising with low
 platelet. PT, PTT, Bleeding Time _ Pending. For further eval and FFD status. Thank
 you
 Priority: ROUTINE
 Provisional Diagnosis:
 Internal Hemorrhoids/Thrombocytopenia with easy bruising
 ACV:
 Reviewed Date/Time: 23 Dec 2005@21:02:00
 Appoint Status: ADMIN CLOSURE - 30 DAY AUTO
 Appointment Review Comment:
 This referral/consult order has been administratively closed. It has been
 30 days or greater since it was ordered, and has no related appointment.
 Reviewer: POSTMASTER,

CONSULT RESULT

Appointment Date:
 Requesting HCP: ARTATES, NEMESIA F
 Clinic: INTERNAL MEDICINE 200H
 Consulting HCP: ,

Problem List:**Note:**

This referral/consult order has been administratively closed. It has been
 30 days or greater since it was ordered, and has no related appointment.
 Administratively Closed on 23 Dec 2005

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

Medical Record

Merwin, Daniel Dennis DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538 Created: 16 Aug 2017

***** End of Clinical Notes *****

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

DoD ID: 1286180538

Created: 16 Aug 2017

Vitals

Date: 08 Aug 2017 Facility: WRNMMC Clinician: JONES, ANDRUW

Type	Value	Units
SBP	127	mmHg
DBP	86	mmHg
HR	78	beats/min
WT	160	Pounds
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 07 Aug 2017 Facility: WRNMMC Clinician: JASLIN, ALFREDO E

Type	Value	Units
SBP	123	mmHg
DBP	80	mmHg
HR	81	beats/min
RR	12	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	160	Pounds
BMI	23.63	kg/mm
BSA	1.88	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Stomach	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 27 Jul 2017 Facility: WRNMMC Clinician: WESLEY, LATASHA

Type	Value	Units
SBP	118	mmHg
DBP	78	mmHg
HR	86	beats/min
RR	18	breaths/min
T	98	Fahrenheit
HT	69	Inches
WT	171	Pounds
BMI	25.25	kg/mm
BSA	1.93	square meters
Oxygen Saturation	100	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments: Weight with shoes.		

Date: 27 Jul 2017 Facility: WRNMMC Clinician: WONG, CHARMIN A

Type	Value	Units
SBP	128	mmHg

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

DBP	79	mmHg
HR	76	beats/min
HT	69	Inches
WT	162	Pounds
BMI	23.92	kg/mm
BSA	1.89	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 18 Jul 2017 Facility: WRNMMC Clinician: FOX, THOMAS J

Type	Value	Units
SBP	112	mmHg
DBP	66	mmHg
HR	74	beats/min
RR	18	breaths/min
T	97.1	Fahrenheit
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 13 Jul 2017 Facility: WRNMMC Clinician: BANGURA, JOHN A

Type	Value	Units
SBP	124	mmHg
DBP	82	mmHg
HR	78	beats/min
RR	18	breaths/min
T	98.3	Fahrenheit
HT	69	Inches
WT	78.6	kg
BMI	25.59	kg/mm
BSA	1.94	square meters
Oxygen Saturation	95	Percent Saturation
Pain Scale	2/10	Adult
Pain Scale Comments	STOMACH	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 12 Jul 2017 Facility: WRNMMC Clinician: THOMAS, LAUREN A

Type	Value	Units
HT	69	Inches
WT	178	Pounds
BMI	26.29	kg/mm
BSA	1.97	square meters
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 10 Jul 2017 Facility: WRNMMC Clinician: TOBAR, EDEN

Type	Value	Units
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Merwin, Daniel Dennis

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1985

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Page

Medical Record

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DoD ID: 1286180538

Created: 16 Aug 2017

SBP	130	mmHg
DBP	86	mmHg
HR	81	beats/min
T	98.8	Fahrenheit
Comments: vitals taken by clinic enlisted staff		

Date: 19 Jun 2017 Facility: WRNMMC Clinician: GRIFFIN, GERALDINE

Type	Value	Units
SBP	132	mmHg
DBP	87	mmHg
HR	81	beats/min
RR	20	breaths/min
T	98.5	Fahrenheit
HT	69	Inches
WT	178.5	Pounds
BMI	26.36	kg/mm
BSA	1.97	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Abdomen.	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	4-5 per week.	None
Comments:		

Date: 12 Jun 2017 Facility: WRNMMC Clinician: GRIFFIN, GERALDINE

Type	Value	Units
SBP	127	mmHg
DBP	82	mmHg
HR	86	beats/min
RR	20	breaths/min
T	98.3	Fahrenheit
HT	69	Inches
WT	180.7	Pounds
BMI	26.68	kg/mm
BSA	1.98	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Abdomen.	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	2-3 days a week.	None
Comments:		

Date: 12 Jun 2017 Facility: WRNMMC Clinician: GRIFFIN, GERALDINE

Type	Value	Units
SBP	127	mmHg
DBP	82	mmHg
HR	86	beats/min
RR	20	breaths/min
T	98.3	Fahrenheit
HT	69	Inches
WT	180.7	Pounds
BMI	26.68	kg/mm

Merwin, Daniel Dennis

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BSA	1.98	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Abdomen.	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	2-3 days a week.	None
Comments:		

Date: 07 Jun 2017 Facility: WRNMMC Clinician: PROVENCIO, ELISHA S.

Type	Value	Units
SBP	129	mmHg
DBP	75	mmHg
HR	75	beats/min
RR	16	breaths/min
HT	69	Inches
WT	168	Pounds
BMI	24.81	kg/mm
BSA	1.92	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	no anti-histamines in last 7 days or more	

Date: 25 May 2017 Facility: WRNMMC Clinician: ACKERMAN, JOI D

Type	Value	Units
SBP	124	mmHg
DBP	83	mmHg
HR	74	beats/min
RR	16	breaths/min
HT	69	Inches
WT	165	Pounds
BMI	24.37	kg/mm
BSA	1.9	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 17 May 2017 Facility: WRNMMC Clinician: KAMARA, KADIDJA B

Type	Value	Units
SBP	116	mmHg
DBP	78	mmHg
HR	85	beats/min
RR	18	breaths/min
T	98.4	Fahrenheit
HT	69	Inches
WT	82.2	kg
BMI	26.76	kg/mm
BSA	1.98	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	6/10	Adult
Pain Scale Comments	Tooth and facial pain	Adult

Merwin, Daniel Dennis

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DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	2 TO 3 PER WEEK	None
Comments:		

Date: 16 May 2017 Facility: WRNMMC Clinician: DAVIS, ANNETTE R

Type	Value	Units
SBP	116	mmHg
DBP	68	mmHg
HR	88	beats/min
RR	18	breaths/min
HT	69	Inches
WT	170	Pounds
BMI	25.1	kg/mm
BSA	1.93	square meters
Pain Scale	5/10	Adult
Pain Scale Comments	Acute Fluctuating Jaw pain	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	Social Drinker	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None

Comments: Denies fever and or chills in the past 72 hours.

Date: 13 Apr 2017 Facility: WRNMMC Clinician: KNIGHT, ASIA L

Type	Value	Units
SBP	129	mmHg
DBP	90	mmHg
HR	72	beats/min
T	98.1	Fahrenheit
HT	69	Inches
WT	165.5	Pounds
BMI	24.44	kg/mm
BSA	1.91	square meters
Oxygen Saturation	95	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 05 Apr 2017 Facility: WRNMMC Clinician: VASQUEZ, BLANCA T

Type	Value	Units
SBP	123	mmHg
DBP	77	mmHg
HR	72	beats/min
RR	20	breaths/min
T	98.4	Fahrenheit
HT	69	Inches
WT	165	Pounds
BMI	24.37	kg/mm
BSA	1.9	square meters
Oxygen Saturation	96	Percent Saturation

Merwin, Daniel Dennis

DOB: [REDACTED]

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Pain Scale	0/10	Adult
Vision Uncorrected Right Eye	40	None
Vision Uncorrected Left Eye	40	None
Vision Uncorrected Both Eyes	40	None
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	4 Drink per week.	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None
Comments:	SM:Presents to Medical Readiness for PHA. Arrives in civilian attire . States feeling good at this time but in several days he feeling down . Reports no H/O of Positive PPD. Referred to speak with Ms. Herbert (Health Educator for Anxiety & Depression screening and Epworth sleepiness scale.)	

Date: 01 Mar 2017 Facility: WRNMMC Clinician: DAVIS, ANNETTE R

Type	Value	Units
SBP	120	mmHg
DBP	80	mmHg
HR	64	beats/min
RR	18	breaths/min
T	98.4	Fahrenheit
HT	69	Inches
WT	162	Pounds
BMI	23.92	kg/mm
BSA	1.89	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None
Comments:		

Date: 01 Feb 2017 Facility: WRNMMC Clinician: NATHAN, YOGESWARI S

Type	Value	Units
SBP	131	mmHg
DBP	82	mmHg
HR	66	beats/min
RR	16	breaths/min
HT	69	Inches
WT	162	Pounds
BMI	23.92	kg/mm
BSA	1.89	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:	Drinks 1-2 a week 3-4 drinks at a time. No SX of fever or chills.	

Date: 04 Jan 2017 Facility: WRNMMC Clinician: TEKELENBURG, JAAP

Type	Value	Units
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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

SBP	138	mmHg
DBP	99	mmHg
HR	89	beats/min
RR	14	breaths/min
T	97.2	Fahrenheit
Pain Scale	0/10	Adult
Comments:		

Date: 24 Oct 2016 Facility: WRNMMC Clinician: HAWKINS, DEREKSHEA J

Type	Value	Units
SBP	133	mmHg
DBP	85	mmHg
HR	78	beats/min
RR	16	breaths/min
T	97.3	Fahrenheit
Pain Scale	0/10	Adult
Comments:		

Date: 04 Oct 2016 Facility: WRNMMC Clinician: THOMPSON, DEREK J

Type	Value	Units
SBP	145	mmHg
DBP	86	mmHg
HR	65	beats/min
RR	18	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	158	Pounds
BMI	23.33	kg/mm
BSA	1.87	square meters
Pain Scale	4/10	Adult
Pain Scale Comments	abd	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 28 Sep 2016 Facility: WRNMMC Clinician: HAWKINS, DEREKSHEA J

Type	Value	Units
SBP	139	mmHg
DBP	91	mmHg
HR	74	beats/min
RR	16	breaths/min
T	97.6	Fahrenheit
Pain Scale	3/10	Adult
Pain Scale Comments	intestinal pain	Adult
Comments:		

Date: 22 Jun 2016 Facility: WRNMMC Clinician: THOMPSON, DEREK J

Type	Value	Units
SBP	146	mmHg
DBP	87	mmHg
HR	74	beats/min
RR	14	breaths/min
T	98.2	Fahrenheit

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

HT	69	Inches
WT	165	Pounds
BMI	24.37	kg/mm
BSA	1.9	square meters
Oxygen Saturation	99	Percent Saturation
Pain Scale	4/10	Adult
Pain Scale Comments	Sharp Pain in Chest when taking deep breaths on inhale.	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 11 May 2016 Facility: WRNMMC Clinician: THOMPSON, DEREK J

Type	Value	Units
SBP	118	mmHg
DBP	72	mmHg
HR	68	beats/min
RR	10	breaths/min
T	98.4	Fahrenheit
HT	69	Inches
WT	167	Pounds
BMI	24.66	kg/mm
BSA	1.91	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	6/10	Adult
Pain Scale Comments	Cramping intermittent pain in the Intestines	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 22 Apr 2016 Facility: WRNMMC Clinician: WOOTEN, LORI A

Type	Value	Units
SBP	114	mmHg
DBP	73	mmHg
HR	72	beats/min
RR	14	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	170.4	Pounds
BMI	25.16	kg/mm
BSA	1.93	square meters
Pain Scale	0/10	Adult
Vision Uncorrected Right Eye	40	None
Vision Uncorrected Left Eye	40	None
Vision Uncorrected Both Eyes	40	None
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	2 or 3 drinks 2 or 3 times a week	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None
Comments:	PRK 2011	

Merwin, Daniel Dennis

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1985

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Page

Medical Record

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1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Epworth Study 15 Pt went to Sleep Clinic and was told he didn't meet the threshold to have a sleep study.

Date: 11 Apr 2016 Facility: WRNMMC Clinician: KIPTOO, ALEX

Type	Value	Units
SBP	121	mmHg
DBP	79	mmHg
HR	70	beats/min
RR	16	breaths/min
T	98.5	Fahrenheit
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:	4105625345 nkda	

Date: 16 Feb 2016 Facility: WRNMMC Clinician: WOODS, CHARLESLENE N

Type	Value	Units
SBP	129	mmHg
DBP	80	mmHg
HR	78	beats/min
RR	20	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	175	Pounds
BMI	25.84	kg/mm
BSA	1.95	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	LEFT ANKLE	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 02 Feb 2016 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH NO VITALS TAKEN AT SARP TREATMENT	

Date: 19 Jan 2016 Facility: WRNMMC Clinician: BROWN, CYNTHIA E

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language: English Contact Number: [REDACTED] No vitals taken at SARP treatment	

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Date: 05 Jan 2016 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 29 Dec 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 22 Dec 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 15 Dec 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 08 Dec 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 01 Dec 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use	No	None
Alcohol Use	No	None
Comments:	VITALS: LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 24 Nov 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	VITALS: LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 17 Nov 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	VITALS: LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 12 Nov 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 10 Nov 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	VITALS: LAUNGUAGE: ENGLISH CONTACT NUMBER: [REDACTED] NO VITALS TAKEN AT SARP TREATMENT	

Date: 09 Nov 2015 Facility: WRNMMC Clinician: TRAN, CAT D

Type	Value	Units
SBP	113	mmHg
DBP	78	mmHg
HR	69	beats/min
RR	18	breaths/min

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

T	97.6	Fahrenheit
HT	69	Inches
WT	167	Pounds
BMI	24.66	kg/mm
BSA	1.91	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 03 Nov 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments: VITALS: LAUNGUAGE: ENGLISH
 CONTACT NUMBER: [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

Date: 03 Nov 2015 Facility: WRNMMC Clinician: NEFF, JOANNE S

Type	Value	Units
SBP	125	mmHg
DBP	73	mmHg
HR	76	beats/min
RR	12	breaths/min
T	97.2	Fahrenheit
Pain Scale	0/10	Adult
Comments:		

Date: 27 Oct 2015 Facility: WRNMMC Clinician: MAPLES, MICHAEL J

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments: LAUNGUAGE: ENGLISH
 CONTACT NUMBER: [REDACTED]
 NO VITALS TAKEN AT SARP TREATMENT

Date: 01 Oct 2015 Facility: WRNMMC Clinician: ERICKSON, NANCY A

Type	Value	Units
SBP	132	mmHg
DBP	76	mmHg
HR	70	beats/min
RR	16	breaths/min
T	97.8	Fahrenheit

Comments:

Date: 28 Sep 2015 Facility: WRNMMC Clinician: TRAN, CAT D

Type	Value	Units
SBP	122	mmHg

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

DBP	87	mmHg
HR	79	beats/min
RR	16	breaths/min
T	97.8	Fahrenheit
HT	69	Inches
WT	165	Pounds
BMI	24.37	kg/mm
BSA	1.9	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 15 Sep 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments: Language:English		
Contact #: [REDACTED]		
No vitals taken at SARP treatment.		

Date: 08 Sep 2015 Facility: WRNMMC Clinician: HERNANDEZ, DARROCQUES D

Type	Value	Units
SBP	132	mmHg
DBP	90	mmHg
HR	94	beats/min
RR	16	breaths/min
T	97.8	Fahrenheit
HT	69	Inches
WT	158	Pounds
BMI	23.33	kg/mm
BSA	1.87	square meters
Pain Scale	4/10	Adult
Pain Scale Comments	throat	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 27 Aug 2015 Facility: WRNMMC Clinician: NEFF, JOANNE S

Type	Value	Units
SBP	137	mmHg
DBP	79	mmHg
HR	80	beats/min
RR	12	breaths/min
T	99.3	Fahrenheit
Pain Scale	0/10	Adult
Comments:		

Date: 25 Aug 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 18 Aug 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 11 Aug 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 11 Aug 2015 Facility: WRNMMC Clinician: NEWMAN, BRENDA W

Type	Value	Units
SBP	122	mmHg
DBP	82	mmHg
HR	73	beats/min
RR	16	breaths/min
T	98.2	Fahrenheit
HT	69	Inches
WT	163.8	Pounds
BMI	24.19	kg/mm
BSA	1.9	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	Headache	Adult
Comments:		

Date: 28 Jul 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 21 Jul 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Alcohol Use	No	None

Merwin, Daniel Dennis

DOB: [REDACTED]

1985 SSN: ***-**-****

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Comments: Language:English
 Contact #: [REDACTED]
 No vitals taken at SARP treatment.

Date: 15 Jul 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 30 Jun 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 23 Jun 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 16 Jun 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 09 Jun 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 02 Jun 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 27 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken for SARP Treatment.	

Date: 22 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 20 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 18 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 15 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 14 May 2015 Facility: WRNMMC Clinician: NEFF, JOANNE S

Type	Value	Units
SBP	121	mmHg

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

DBP	79	mmHg
HR	69	beats/min
RR	16	breaths/min
T	97.2	Fahrenheit

Comments:

Date: 13 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Date: 11 May 2015 Facility: WRNMMC Clinician: BROWN, CYNTHIA E

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments: Language: English

Contact Number: [REDACTED]

No vitals taken at SARP

Date: 08 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments: Language: English

Contact #: [REDACTED]

No vitals taken at SARP treatment.

Date: 07 May 2015 Facility: WRNMMC Clinician: OYAWALE, BIDE MI R

Type	Value	Units
SBP	122	mmHg
DBP	72	mmHg
HR	76	beats/min
RR	16	breaths/min
T	97.8	Fahrenheit
HT	69	Inches
WT	161	Pounds
BMI	23.78	kg/mm
BSA	1.88	square meters
Oxygen Saturation	99	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments:

Date: 06 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 06 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 04 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken for SARP Treatment.	

Date: 01 May 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken for SARP Treatment.	

Date: 29 Apr 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 28 Apr 2015 Facility: WRNMMC Clinician: PONDS, BRANDON J

Type	Value	Units
SBP	129	mmHg
DBP	76	mmHg
HR	61	beats/min
RR	14	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	150	Pounds
BMI	22.15	kg/mm
BSA	1.83	square meters

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

Pain Scale	0/10	Adult
Vision Uncorrected Right Eye	25	None
Vision Uncorrected Left Eye	25	None
Vision Uncorrected Both Eyes	25	None
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	EPWORTH SLEEP: 8	

Date: 27 Apr 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken for SARP Treatment.	

Date: 23 Apr 2015 Facility: WRNMMC Clinician: ERICKSON, NANCY A

Type	Value	Units
SBP	122	mmHg
DBP	68	mmHg
HR	70	beats/min
RR	16	breaths/min
T	96	Fahrenheit
HT	69	Inches
WT	160	Pounds
BMI	23.63	kg/mm
BSA	1.88	square meters
Comments:	PT weighed in uniform and boots.	

Date: 22 Apr 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken for SARP Treatment.	

Date: 23 Mar 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 20 Mar 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None

Merwin, Daniel Dennis

DOB: [REDACTED] 1985 SSN: ***-**-**** DoD ID: 1286180538

Created: 16 Aug 2017

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Alcohol Use	No	None
Comments:	Language:English Contact #: [REDACTED] No vitals taken at SARP treatment.	

Date: 19 Mar 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English No vitals taken at SARP treatment.	

Date: 17 Mar 2015 Facility: WRNMMC Clinician: PATSOS, ASHLEY N

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:	Language:English No vitals taken at SARP treatment.	

Date: 26 Sep 2014 Facility: WRNMMC Clinician: NEWMAN, BRENDA W

Type	Value	Units
SBP	118	mmHg
DBP	76	mmHg
HR	84	beats/min
RR	16	breaths/min
T	97.8	Fahrenheit
HT	69	Inches
WT	158.4	Pounds
BMI	23.39	kg/mm
BSA	1.87	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	2/10	Adult
Pain Scale Comments	Left ankle	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 27 Jun 2014 Facility: WRNMMC Clinician: LAI, PHILOMENA C

Type	Value	Units
Comments:	Patient has falls in the past 6 months, minor injury to L ankle. Patient is not a fall risk.	

Date: 16 Jun 2014 Facility: WRNMMC Clinician: OWENS, ANGELA M

Type	Value	Units
SBP	137	mmHg
DBP	84	mmHg
HR	80	beats/min
RR	18	breaths/min
T	98.2	Fahrenheit
HT	69	Inches
WT	155	Pounds
BMI	22.89	kg/mm

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

BSA	1.85	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	2/10	Adult
Pain Scale Comments	left ankle	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	socially	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None

Comments:

Date: 04 Jun 2014 Facility: WRNMMC Clinician: PEREZ, DULCE C

Type	Value	Units
SBP	119	mmHg
DBP	82	mmHg
HR	81	beats/min
T	97.9	Fahrenheit
HT	69	Inches
WT	155	Pounds
BMI	22.89	kg/mm
BSA	1.85	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	4/10	Adult
Pain Scale Comments	left ankle	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	occassional	None

Comments:

Date: 19 May 2014 Facility: WRNMMC Clinician: SNOWDEN, HEATHER

Type	Value	Units
SBP	127	mmHg
DBP	68	mmHg
HR	66	beats/min
RR	16	breaths/min
T	98.3	Fahrenheit
HT	69	Inches
WT	153.6	Pounds
BMI	22.68	kg/mm
BSA	1.85	square meters
Pain Scale	0/10	Adult
Vision Uncorrected Right Eye	30	None
Vision Uncorrected Left Eye	50	None
Vision Uncorrected Both Eyes	50	None
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	2-3 month	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None

Comments:

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Date: 06 May 2014 Facility: WRNMMC Clinician: COLEMAN, AUDREY G

Type	Value	Units
SBP	130	mmHg
DBP	82	mmHg
HR	79	beats/min
RR	18	breaths/min
T	97.5	Fahrenheit
HT	69	Inches
WT	153	Pounds
BMI	22.59	kg/mm
BSA	1.84	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	3/10	Adult
Pain Scale Comments	LEFT ANKLE	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:	UNIFORM	

Date: 07 Aug 2013 Facility: WRNMMC Clinician: SMITH, PRISCILLA E

Type	Value	Units
SBP	106	mmHg
DBP	60	mmHg
HR	88	beats/min
RR	14	breaths/min
T	98.1	Fahrenheit
HT	69	Inches
WT	149	Pounds
BMI	22	kg/mm
BSA	1.82	square meters
Oxygen Saturation	96	Percent Saturation
Comments:		

Date: 10 Apr 2013 Facility: WRNMMC Clinician: OLAWUMI, OMOWUMI D

Type	Value	Units
SBP	110	mmHg
DBP	72	mmHg
HR	77	beats/min
RR	16	breaths/min
T	98.7	Fahrenheit
HT	69	Inches
WT	153.4	Pounds
BMI	22.65	kg/mm
BSA	1.85	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 28 Jan 2013 Facility: WRNMMC Clinician: OLAWUMI, OMOWUMI D

Type	Value	Units
SBP	124	mmHg
DBP	72	mmHg

Merwin, Daniel Dennis

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1985

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[REDACTED]

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

HR	73	beats/min
RR	18	breaths/min
T	97.3	Fahrenheit
HT	69	Inches
WT	156.4	Pounds
BMI	23.1	kg/mm
BSA	1.86	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 30 Nov 2012 Facility: WRNMMC Clinician: OLAWUMI, OMOWUMI D

Type	Value	Units
SBP	120	mmHg
DBP	76	mmHg
HR	66	beats/min
RR	18	breaths/min
T	97.5	Fahrenheit
HT	69	Inches
WT	145	Pounds
BMI	21.41	kg/mm
BSA	1.8	square meters
Oxygen Saturation	100	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:		

Date: 05 Nov 2012 Facility: WRNMMC Clinician: SPINKS, JEAN M

Type	Value	Units
SBP	122	mmHg
DBP	84	mmHg
HR	65	beats/min
RR	18	breaths/min
T	97.7	Fahrenheit
Oxygen Saturation	97	Percent Saturation
Comments:		

Date: 05 Nov 2012 Facility: WRNMMC Clinician: SPINKS, JEAN M

Type	Value	Units
HT	69	Inches
WT	152	Pounds
BMI	22.45	kg/mm
BSA	1.84	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	1 DRINK A DAY	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None

Merwin, Daniel Dennis

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1985

SSN: ***-**-****

DoD ID: 1286180538

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Comments:

Date: 23 Oct 2012 Facility: WRNMMC Clinician: FARRINGTON, SHAUN C

Type	Value	Units
SBP	114	mmHg
DBP	66	mmHg
HR	79	beats/min
T	95.4	Fahrenheit
HT	69	Inches
WT	147	Pounds
BMI	21.71	kg/mm
BSA	1.81	square meters
Oxygen Saturation	97	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	COUPLE DRINKS/WEEK	None
Alcohol Eye Opener	No	None
Alcohol Annoy Others	No	None
Alcohol Feel Guilty	No	None
Alcohol Cut Down	No	None

Comments:

Date: 14 May 2012 Facility: NH Pensacola FL Clinician: GARZA, OMAR

Type	Value	Units
SBP	120	mmHg
DBP	76	mmHg
HR	90	beats/min
RR	14	breaths/min
T	98.5	Fahrenheit
HT	69	Inches
WT	146	Pounds
BMI	21.56	kg/mm
BSA	1.81	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None

Comments: NKDA
POC -8506028501

Date: 10 May 2012 Facility: NH Pensacola FL Clinician: MACLUNNY, TONYA M

Type	Value	Units
SBP	112	mmHg
DBP	68	mmHg
HR	72	beats/min
RR	12	breaths/min
T	98.4	Fahrenheit
HT	69	Inches
WT	146	Pounds
BMI	21.56	kg/mm
BSA	1.81	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Comments: NKDA
POC:850-602-8501

Date: 06 Mar 2012 Facility: NH Pensacola FL Clinician: JOHNSONCRUTCHFIELD, ANDREA C

Type	Value	Units
SBP	110	mmHg
DBP	70	mmHg
HR	70	beats/min
RR	17	breaths/min
HT	69	Inches
WT	151	Pounds
BMI	22.3	kg/mm
BSA	1.83	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments:

Date: 02 Nov 2011 Facility: NH Pensacola FL Clinician: STANDLEY, CHAD J

Type	Value	Units
Comments:	N/A	

Date: 27 Jul 2011 Facility: NH Pensacola FL Clinician: CONLEY, KARLA E

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments:

Date: 26 Jul 2011 Facility: NH Pensacola FL Clinician: CURRY, JEREMY T

Type	Value	Units
SBP	104	mmHg
DBP	64	mmHg
HR	72	beats/min
RR	16	breaths/min
T	98	Fahrenheit
HT	68	Inches
WT	150	Pounds
BMI	22.81	kg/mm
BSA	1.81	square meters
Oxygen Saturation	96	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments:

Date: 16 Mar 2011 Facility: NH Pensacola FL Clinician: SCHUSTER, ELIZABETH D

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Comments:

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

Date: 17 Feb 2011 Facility: NH Pensacola FL Clinician: KIRK, CAMERON P

Type	Value	Units
Pain Scale	0/10	Adult
Tobacco Use	No	None
Comments:		

Date: [REDACTED] 2011 Facility: NH Pensacola FL Clinician: LEE, BRANDON G

Type	Value	Units
SBP	123	mmHg
DBP	74	mmHg
HR	85	beats/min
RR	15	breaths/min
HT	69	Inches
WT	157	Pounds
BMI	23.18	kg/mm
BSA	1.86	square meters
Oxygen Saturation	98	Percent Saturation
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 08 Feb 2011 Facility: NH Pensacola FL Clinician: JOHNSONCRUTCHFIELD, ANDREA C

Type	Value	Units
SBP	120	mmHg
DBP	74	mmHg
HR	58	beats/min
RR	20	breaths/min
HT	69	Inches
WT	156	Pounds
BMI	23.04	kg/mm
BSA	1.86	square meters
Pain Scale	0/10	Adult
Vision Corrected Right Eye	25	None
Vision Corrected Left Eye	25	None
Vision Corrected Both Eyes	25	None
Tobacco Use	No	None
Alcohol Use	No	None
Comments:		

Date: 24 Jan 2011 Facility: NH Pensacola FL Clinician: STANDLEY, CHAD J

Type	Value	Units
SBP	120	mmHg
DBP	60	mmHg
HR	64	beats/min
RR	14	breaths/min
T	98.3	Fahrenheit
HT	69	Inches
WT	147	Pounds
BMI	21.71	kg/mm
BSA	1.81	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	No	None

Merwin, Daniel Dennis

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1985

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-

[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

Comments:

Date: 15 Nov 2010 Facility: NH Pensacola FL Clinician: DAYS, LATAIJA W

Type	Value	Units
Comments:	n/a	

Date: 01 Sep 2010 Facility: NH Pensacola FL Clinician: STANDLEY, CHAD J

Type	Value	Units
SBP	120	mmHg
DBP	84	mmHg
HR	76	beats/min
RR	16	breaths/min
T	98	Fahrenheit
HT	69	Inches
WT	145	Pounds
BMI	21.41	kg/mm
BSA	1.8	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:	850-292-7149	

Date: 14 Jun 2010 Facility: NH Pensacola FL Clinician: STANDLEY, CHAD J

Type	Value	Units
SBP	114	mmHg
DBP	68	mmHg
HR	72	beats/min
RR	16	breaths/min
T	98.5	Fahrenheit
HT	69	Inches
WT	145	Pounds
BMI	21.41	kg/mm
BSA	1.8	square meters
Pain Scale	5/10	Adult
Pain Scale Comments	forehead	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments:	850-292-7149	

Date: 21 Apr 2010 Facility: NH Pensacola FL Clinician: MERRELL, SHAUNTE R

Type	Value	Units
Pain Scale	0/10	Adult
Comments:		

Date: 17 Mar 2010 Facility: NH Pensacola FL Clinician: WHITE, PAMELA J.

Type	Value	Units
SBP	102	mmHg
DBP	60	mmHg
HR	72	beats/min
RR	20	breaths/min
HT	69.5	Inches
WT	150	Pounds
BMI	21.83	kg/mm

Merwin, Daniel Dennis

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1985

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Page

Medical Record

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

SSN: ***-**-****

DoD ID: 1286180538

Created: 16 Aug 2017

BSA	1.84	square meters
Pain Scale	0/10	Adult
Vision Corrected Right Eye	30	None
Vision Corrected Left Eye	20	None
Vision Corrected Both Eyes	20	None
Tobacco Use	No	None
Alcohol Use	Yes	None
Alcohol Usage	OCC.	None
Comments:		

Date: 09 Mar 2010 Facility: NH Pensacola FL Clinician: WILLIAMS, TREVOR MICHAEL

Type	Value	Units
Comments: n/a		

Date: 22 Dec 2009 Facility: NH Pensacola FL Clinician: SONNIER, KRISTIE L

Type	Value	Units
Comments: n/a		

Date: 23 Sep 2009 Facility: NH Pensacola FL Clinician: BELKNAP, CHARLES HOWARD

Type	Value	Units
Last Menstrual Date	0	None
Comments: n/a		

Date: 20 Aug 2009 Facility: NH Pensacola FL Clinician: COLE, ASHLEY A

Type	Value	Units
SBP	120	mmHg
DBP	79	mmHg
HR	82	beats/min
RR	16	breaths/min
T	98.2	Fahrenheit
HT	68	Inches
WT	145	Pounds
BMI	22.05	kg/mm
BSA	1.78	square meters
Pain Scale	0/10	Adult
Tobacco Use	No	None
Alcohol Use	Yes	None
Comments: aac		

Date: 07 May 2009 Facility: NH Pensacola FL Clinician: THORNTON, JAMES MATHEW

Type	Value	Units
Last Menstrual Date	0	None
Comments: n/a		

Date: 06 Mar 2006 Facility: NH Pensacola FL Clinician:

Type	Value	Units
SBP	120	mmHg
DBP	64	mmHg
HR	60	beats/min
RR	12	breaths/min
T	97.6	Fahrenheit
HT	5' 8"	yd
WT	126	Pounds

Merwin, Daniel Dennis

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1985

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Page

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Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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[REDACTED]

DoD ID: 1286180538

Created: 16 Aug 2017

BMI		kg/mm
BSA		square meters
Pain Scale	0/10	
Pain Scale Comments	none	
Tobacco Use	No	None
Alcohol Use	No	None
Last Menstrual Date	0	None
Comments:	allergies:nkda	

***** End of Vitals *****

Merwin, Daniel Dennis

DOB: [REDACTED]

1985

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[REDACTED]

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Page

MERWIN, DANIEL D
 LAST NAME FIRST NAME MI
 (Print name above)

INPATIENT/EXTENDED AMBULATORY RECORD

☐ Inpatient Record
 Discharge Date(s)

27 APR 2017

☐ Extended Ambulatory Record
 Discharge Date(s)

27 APR 17

MERWIN, DANIEL DENNIS

FMP/SSN: 20/

DOB: 1985 PAT CAT: N11

NATIONAL CAPITAL AREA

4105625345 APV#

APPT DATE/TIME:



N001681001688193

VOL: 2

Check all that apply to the patient:

☐ Latex Allergy

☐ Oxygen Needed

☐ Crutches

☐ Wheelchair

☐ Special Needs

☐ Other

*B508
 consent*

SENSITIVITIES



ALLERGIES



*Feathers
 Cat dander*

**WARNING: PROPERTY OF U.S. GOVERNMENT
 DO NOT REMOVE FROM HOSPITAL
 RETURN TO INPATIENT RECORDS DEPARTMENT**

**IF FOUND, RETURN TO ANY
 U.S. POST OFFICE.
 POSTMASTER - FORWARD TO:
 NAVY DEPARTMENT
 WASHINGTON, D.C. 20372**

HOLD-PRE Merwin, Daniel		Age Sex Unit Name	BED	Allergies	DODID	Billing Num	DOB	ADMIT DATE	PHYSICIAN	Rank
		32 M PREADMIT	HOLD-PRE	Feathers Cat dander	1286180538		1985	04/12/2017		

Patients Views A B C D E

Essentris

☐ Unsign'd ☐ DC'd ☐ Pending DC

ADT Orders										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
Admit to 3E/APU		Attending: (Jensen, Damon) Service: (OMS) MEPRS Code: () Dx: (maxillary hypoplasia) Procedure: (Lefort I 3 piece) DOS: (27Apr2017) Pin#: ()	1000 12 Apr 2017		Jensen,					
OMS Service Contact Info:		Staff: (Jensen, Damon) Resident: (Cervenka) (On-call pgr 2037555)	1500 22 Apr 2017		Jensen,					

Allergies										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
List all allergies:		NKDA	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ

Medications										
Name	Dose	Route	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK
ampicillin/sulbactam (UNASYN) INJ Soln	3 GRAM	IV PIGGY BACK	X1	On call to MOR	1500 22 Apr 2017		CERVENKA, PETER D 0736		D	JH
dexamethasone (DECADRON) INJ Soln	10 MG	IV PIGGY BACK	X1	On call to MOR	1500 22 Apr 2017		CERVENKA, PETER D 0736		D	JH

Isolation										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
Standard Precaution (No Infectious Disease or MDRO)	Continuous		1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ

Treatments										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
Activity:		As tolerated pre-op	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ
Anesthesia:		GNETA	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ
Informed consent:		To be signed and witnessed	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ
Pre-op teaching:		Completed in originating clinic	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ

Labs										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
BMP	X1	Pre-operatively	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ
CBC	X1	Pre-Operatively	1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ

Diet Orders										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
NPO After Midnight		DOS	1500 22 Apr 2017		CERVENKA, PETER D 0736		D	JH		D

Resuscitation Orders										
Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	CS
Full Code	Continuous		1000 12 Apr 2017		Jensen, Damon T 2878		DTJ	JH		DTJ

Anesthesia Preoperative Questionnaire

Patient's Name: Last, First, MI MERWIN, DANIEL	Age: 32	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Ht: 5'9 in	Wt: 160 lbs
Sponsor's SSN: [REDACTED]	Rank: E6	Primary Phone: [REDACTED] Secondary Phone: [REDACTED]		

1. Do you have, have you ever had, or been told you had any of the following:

	Y	N		Y	N		Y	N
1. Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	13. Pacemaker	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Thyroid Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. COPD/Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	14. Any Heart Stent Placements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Home Oxygen Use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	15. Atrial Fibrillation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Any Bleeding Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Recent Flu/Cold	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16. Other Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Post Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Sleep Apnea	<input type="checkbox"/>	<input checked="" type="checkbox"/>	17. Any Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Any Psychiatric Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CPAP Use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18. Stroke/TIA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Significant Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Significant Snoring	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Seizures/Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Born Prematurely	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Other Lung Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Frequent Heartburn	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Developmental Delay/ADD/ADHD	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Esophageal/Stomach Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33. Any Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Congestive Heart Failure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. Liver/Gallbladder/Pancreatic Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34. Difficult Airway or Failed Intubation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Heart Valve Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Kidney/Bladder Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	35. Any Personal or Family History of Malignant Hyperthermia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Heart Attack	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Any Spinal/Back Disease/Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	36. Females Only: Any Gynecological Disease	<input type="checkbox"/>	<input type="checkbox"/>

2. Please explain any "Yes" answers with corresponding number above in detail.

3. Do you have any specific concerns or questions regarding the anesthesia portion of your surgery? YES ☐ NO ☒.

If yes, please explain: _____

4. Would you like to be contacted by an anesthesia provider prior to the day of your surgery? YES ☐ NO ☒.

See reverse to complete questionnaire

Signature

APU Prescreen Personnel

For Admin P.

20 [REDACTED]
MERWIN, DANIEL DENNIS
SEX: M DOB: [REDACTED] 985 AGE: 32
USN N11 PO1 NRP

Provider

Revised OC AR 3082

Anesthesia Preoperative Questionnaire

5. Have you had any type of surgery or anesthesia before? YES ☒ NO ☐. If YES, please list the surgery, type of anesthesia (General, Spinal, Epidural, Local, Sedation) and any problem, if any, you had with anesthesia.

YEAR	Type of Surgery/Procedure	Type of Anesthesia	Problem?
2003	TONSILLECTOMY	?	NO
2015	MAXILLO FACIAL	?	NO
	↳ SEE RECORD		

6. Have you taken any medication (prescription, over the counter, herbal) for any reason in the last 6 months? YES ☒ NO ☐. If YES, PLEASE list those medications.

Medication	Dose	How Often?
LEXAPRO	20 mg	Daily
VALTREX	?	Daily

no
coughed
+ AFIB

7. Do you or have you ever smoked? YES ☐ NO ☒. ____ Packs per day for ____ years?

OR when did you quit? _____

8. Do you drink alcohol? YES ☒ NO ☐. If YES, how much and how often? 3-4 DRINKS A WEEK

9. Have you ever been hospitalized for ANY reason (other than surgery listed previously)? YES ☒ NO ☐. If YES, please provide approximate dates and reason(s).

TONSILLECTOMY 2003, 2005 IBS ISSUES

10. Can you climb stairs? YES ☒ NO ☐. If YES, how many flights? 1 ☐ 2 ☐ 3 ☐ 4 ☒

If NO, please explain. _____

11. FEMALES ONLY. Is there any possibility you could be pregnant?

Date of last menstrual period. _____

Thank you for completing the Anesthesia Preoperative Questionnaire!

Revised Oct 2013

AR 3083

PATIENT REGISTRATION FORM

(Please fill out this form completely)

Registration Clerk: _____

Date: 12 APR 17

Patient Information:

Name (Last, First Middle): MERWIN, DANIEL

Sponsor's SSN: [REDACTED] Your SSN: [REDACTED] Sex: M

Religious Preference: NWP DOB: [REDACTED] 85

Ethnicity (check one) ☐ Filipino ☐ Hispanic ☐ Southeast Asian ☐ Asian/Pacific Islander ☒ Other: _____Race (check one) ☐ Asian ☐ Black ☐ Western Hemisphere Indian ☒ White ☐ Other: _____Marital Status (check one) ☐ Annulled ☐ Divorced ☐ Interlocutory ☐ Legally Separated ☐ Married ☒ Single ☐ Widowed

Home Address: [REDACTED], GLEN BURNIE

State: MD Zip Code: [REDACTED] Home Phone: [REDACTED] Work Phone: (850) 696-7239

Emergency Contact Information:

Name (Last, First MI): RUPP, JESSICA Relationship: FRIEND

Address: [REDACTED], BALTIMORE

State: MD Zip Code: [REDACTED] Home Telephone: [REDACTED]

Next-of-Kin Information:

Name (Last, First MI): CHOUANIC, LEAH Relationship: MOTHER

Address: [REDACTED]

State: SC Zip Code: [REDACTED] Home Telephone: [REDACTED]

Sponsor Information:Name (Last, First MI): _____ Flying Status: ☐

Service: _____ Rank: _____ MOS/Rate/Designator: _____

Command: _____ Length of Service: _____

Duty Address: _____

State: _____ Zip Code: _____ Duty Telephone: () _____

Other Health Insurance: (Please do not include TRICARE)Are you covered by private health insurance: ☐ If Yes, please complete DD FORM 2569.

I certify that the information on this form is complete and correct to the best of my knowledge.

Patient Signature

Date

12 APR 17

20/615122489
 MERWIN, DANIEL DENNIS
 SEX: M DOB: 2/16/1985 AGE: 32
 USN N11 PO1 NRP

AR 3084



**THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES
ACCOUNT/ OTHER HEALTH INSURANCE**
(Read Privacy Act Statement before signing this form.)

Alternate form for
OMB No. 0704-0323
DD FORM 2569 MAR
2007

☐ Initial Submission

☐ Change / Update Status

☐ Annual Update

1. PATIENT NAME (Last, First, Middle Initial)

MERWIN, DANIEL D

2. SSN

██████████

3. DATE OF BIRTH (MM/DD/YYYY)

██████████ 1985

4. HOME TELEPHONE NO.

██████████

5. MAILING ADDRESS

██████████

6. CITY

GLEN BURNIE

7. STATE

MD

8. ZIP

██████████

9. FAMILY MEMBER PREFIX

10. SPONSOR SSN
(Last 4)

XXX-██████████

11. PATIENT'S EMPLOYER'S NAME

NAVY

**12. EMPLOYER
TELEPHONE #**

619 852 7158

13. DO YOU HAVE OTHER HEALTH INSURANCE?

Title 32, CFR Part 220.9 Rights and obligations of beneficiaries. (c) Uniformed Services beneficiaries are obligation to disclose information and cooperate with collection efforts. (This includes employer health insurance benefits, other commercial health insurance coverage, Medicare, and Medicare Supplement.)

a. YES. (Complete sections 14, 16, and 17 below and present insurance card to staff.)

☒ b. NO. I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. (Proceed to Item 15.)

c. NO. I am not a DoD beneficiary. (Proceed to Item 16.)

14. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

a. Yes (If yes, complete sections c. – f.)

b. No ☒

c. Dependant Type

d. List all Prefix Covered

e. Dependant Type

f. List all Prefix Covered

Example: 01-19 Dependent children

01, 02, 03

50-54 Mother-in-law of sponsor

01-19 Dependent children

55-59 Father-in-law of sponsor

20 Sponsor

60-69 Other dependents

30-39 Spouse of sponsor

90-95 Beneficiary authorized by statute

40-44 Mother of sponsor

98 Civilian Humanitarian

45-49 Father of sponsor

99 All others not elsewhere classified

15. MEDICARE OR MEDICAID INFORMATION (Check all that apply and present card(s) to staff)

a. MEDICARE PART A

d. MEDICARE PART D

b. MEDICARE PART B

e. MEDICAID

16. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

b. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of \$250,000 or imprisonment for five years, or both.

c. NON-DoD PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the facility of the Uniformed Service for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles.

e. DoD BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

17. PATIENT OR ADULT FAMILY MEMBER SIGNATURE

[Signature]

20
MERWIN, DANIEL DENNIS
SEX: M DOB: ██████████
USN N11 PO ██████████ 1985 AGE: 32

MM/DD/YYYY

2/17

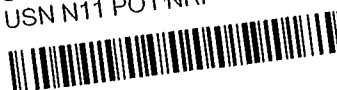


AR 3085

PLEASE INITIAL THE FOLLOWING TO INDICATE YOUR UNDERSTANDINGDo you now have an Advance Directive on file at this facility? Yes _____ No *N* Would you like to be an organ donor? Yes *X* No _____ Undecided _____Are you covered by private health insurance? Yes *X* No _____ (If yes, please complete a Third Party Collections form DD FORM 2569 with a copy of your insurance card to facilitate the billing of your private health insurer as required by law.) *DM* I also understand that my private health insurer (if applicable) will be notified of this admission and the provisions of my health care coverage will apply. *DM* I have been informed that by law I am responsible for the daily rate based on my patient category as listed below. *DM* I understand that based on my patient category and/or if I am found not to be eligible to receive care at the Walter Reed National Military Medical Center Bethesda, financial reimbursement for all medical care rendered will be required. *DM* I further understand that billing for this care will be at the FULL REIMBURSIBLE RATE as directed by law. *DM* I acknowledge that I am responsible for all health care charges or any portion thereof not covered by my health insurance company. *DM* I have been informed that I am solely responsible for my valuables and that I must notify the admissions clerk if I have any small valuables for deposit in the Patient Valuables Program.Printed Name: *Daniel Merwin* Signature: *[Signature]* Date: *12 APR 17* **Inpatient Rates**

No Charge	Active Duty and Retired U. S. Military personnel, Active Duty U.S. Military Family Members Enrolled in TRICARE Prime, Newborn children of Active Duty U.S. Military, SECNAVDES (NC)
Subsistence Rate \$9.05	Foreign Military Members covered by a Reciprocal Health Care Agreement including: Argentina, Bolivia, Canada, Chile, Columbia, Dominican Republic, Ecuador, El Salvador, Georgia, Germany, Guatemala, Honduras, Mexico, Peru, Romania, Tunisia, Ukraine, United Kingdom, and Uruguay, SECNAVDES (SR)
Family Member Rate \$16.85	Active Duty U.S. Military Family Members not Enrolled in TRICARE Prime, All Retired Family Members, Ex-Service Maternity Care patients, Foreign Military Family Members covered by a Reciprocal Health Care Agreement excluding Canada, SECNAVDES (FMR)
Full Reimbursable Rate	All Other Eligible patients including NATO and Non-NATO Foreign military personnel and their families, Civilian Emergencies, SECNAVDES (FRR) (Please see an Admissions Clerk for details or Questions)

20 *[Redacted]* *[Redacted]* DENNIS
 MERWIN, DA *[Redacted]* 985 AGE: 32
 SEX: M DOB: *[Redacted]*
 USN N11 PO1 NRP



AR 3086

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.***1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

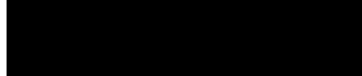
This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR



SSN OF MEMBER OR SPONSOR



DATE

4/12/17

DD FORM 2005, FEB 76 (EG)

PREVIOUS EDITION IS

USAPPC V1.00

20/61
MERWIN, DANIEL DENNIS
SEX: M DOB: /1985 AGE: 32
USN N11 PO1 NRP



AR 3087

WALTER REED NATIONAL MILITARY MEDICAL CENTER**Inpatient Medical Record Department****APV Chart Processing Form****Patient Name: MERWIN, DANIEL****MR#: 20** [REDACTED]**Service code: CAA5****Discharge Date: 27APR17**

<u>Function</u>	<u>Employee</u>	<u>Date Completed</u>	<u>Comments</u>
Chart Pick Up/Receipt	TC	5/1/17	
Charts Assembly			
Record Creation-CHCS			
Labs/Paths/Rads Filed			
CIS Printing			
First Analysis			
Chart Location: Initial Data Entry			
APV Has Appointment	YES _____ NO _____		
APV Appointment was made			
Second Analysis			
Final Analysis			
Chart Location: Archived			

Note Type: SURG Master Note *
 Note Time: N/A
 Last Stored: 0643 28 Apr 2017
 Stored By: Jensen, Damon T 2878 CERVENKA, PETER D 0736

SURG Master Note

- PATIENT DATA AND INFORMATION -

Age: 32 Gender: M Information Source(s): Patient;
 Clinical Service: Oral-Maxillofacial Surg/ABAA Surgeon/Provider: Jensen, Damon T 2878

Signature:

Time/Date:

X ATTACH IMAGE OR EXTERNAL FILE

X Add Image 1

Add Image 2

1

1

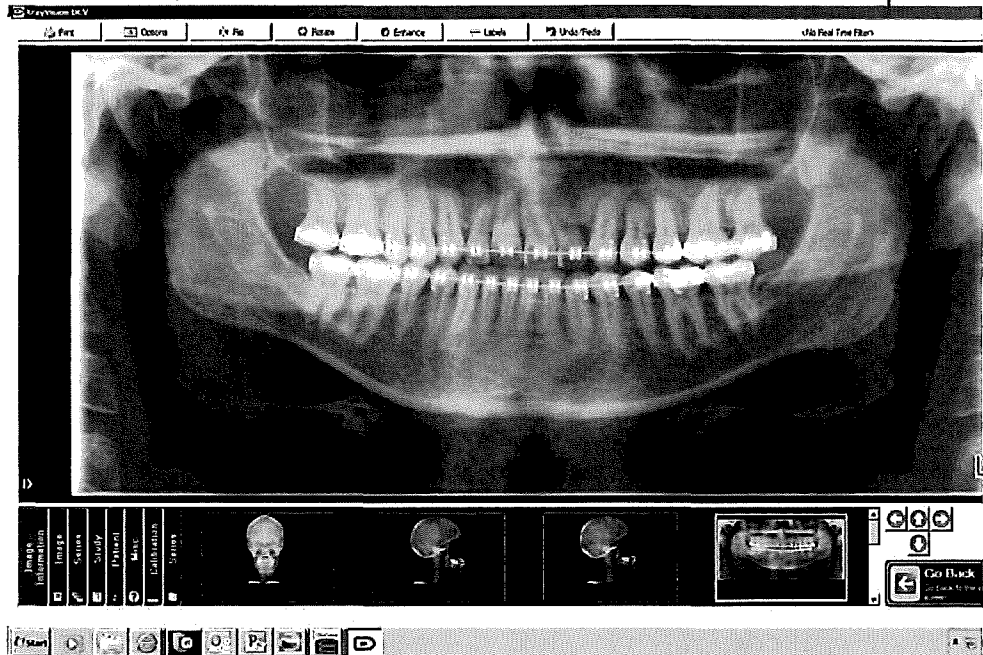


Image 1 Comment: Questionable periapical region over #12

X TEMPLATE HISTORY **Select to build History: CC, HPI, PMHx, PSHx, etc**

Chief Complaint

"Teeth don't come together"

History of Present Illness

Pt in ortho tx. Teeth do not come together on left side when pt bites. Feels like midline is off. Pt does not snore.

Past Medical History

Irritable Bowel Syndrome;

Past Surgical History

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3089

wisdom teeth extraction	?	
Corneal Refractive Surgery (PRK/LASIK);	?	
Tonsillectomy:	2003	
expose and bond #11	?	
Maxillo facial	2015	
Other Surgical History:		
SEE H&P		
Social History		
Special Duty Status: None.		
Tobacco Use: Never	Type: N/A	
Alcohol Use: Active	Type: Social: 3-4/week	
Drinks/Day: SEE TYPE	Last Drink: 1 week ago	
Recreational Drug Use: N/A	Type: N/A	
Employment History: USN		
Living Situation: Lives with roommate		
Other Social History:		
Family History		
cancer		
HTN		
diabetes		
heart disease		
X REVIEW OF SYSTEMS (ROS) **AHLTA copy/paste, Expanded ROS, etc**		
X Review of Systems negative and within normal limits		
Airway/EENT:		
Cardiovascular:		
Musculoskeletal:		
ALLERGY INFORMATION		
#1 Type: MISC.	Name: Feathers	Symptoms: UserSpecifiedSymptom
Onset: 04/24/2017	Severity: SEVERE	Other Symptom: Dyspnea
Date:		
SNAME		
D		
Code:		
RxNorm	Last Modification Date: 04/24/2017	Inactive:
m		
Code:		
#2 Type: MISC.	Name: Cat dander	Symptoms: UserSpecifiedSymptom
Onset: 04/24/2017	Severity: SEVERE	Other Symptom: Dyspnea
Date:		
SNAME		
D		
Code:		
RxNorm	Last Modification Date: 04/24/2017	Inactive:
m		
Code:		
MEDICATIONS ON ADMISSION		
X Admission Medications: to include home, non prescription, herbals, medications taken in another care facility and illicit drugs.		
Active CHCS Medication:	Dosing Instructions (No abbreviations)	
Additional Medications:	Dosing Instructions (No abbreviations)	
multivitamin (DAILY VITE) ORAL Tab	X	

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 27Apr2017
PERSONAL/PRIV ACT 1974
Clinical Notes

PAIN

Pain Score: 0

PHYSICAL EXAMINATION **Ht/Wt, VS, Focused/Expanded Exam, if applicable**

Admission Height: 175.3 cm = in
 Admission Weight: 76.80 kg = lbs
 BMI: 24.97 BSA: 1.925

Latest Vital Signs:

HR: 80 BP: 120 / 79 mmHg
 Temp (F): 97.7 Temp Source: forehead
 Pulse Ox(%): 96 O2 Source: Room Air

X Focused Exam Facial 3rds: 51mm/58mm/68mm
 tooth show repose: 2mm animation: 10mm
 Midline max:MSP 1mm to right man:max 1mm to left

DODID:**MERWIN, DANIEL DENNIS****FMPL6SSN:** [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

AR 3091

Angle class canine: Class III right and left
 Angle class molar: Class III right and left
 Overjet: 0mm
 Overbite: 0mm
 Transverse: adequate (no crossbite)
 Cant: None
 Alar: 30mm
 Upper lip: 21mm
 Lower lip: 42mm

#12 clinically tests delayed sensitivity no mobility no percussion pain 4 mm pockets

RADS: Maxillary hypoplasia radiolucency around 12

HEART: RRR

LUNG :CTAB

Airway: MP II

Left (Small)

MULTI-DRUG RESISTANT ORGANISM (MDRO) **Current Status and Precautions**

X VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT **Required if 18yrs and older**

Select VTE Risk Stratification: VTE Low Risk
 VTE Prophylaxis to Order: Early and Frequent Ambulation
 Contraindications to consider with Pharmacologic VTE Prophylaxis
 NONE.
 VTE Prophylaxis Planned
 SCD in MOR early ambulation

X ACTIVE CODE STATUS/RESUSCITATION PLAN **Required for ALL patients**

Initial Resuscitation Status: Full
 X I have personally discussed and reviewed this patient's admission circumstances and Code Status with the patient. The patient has medical decision making capacity at this time and has chosen to be "Full Code" status and understands they may change this care decision at any time. An advance directive document, if available, was a part of this discussion.

X ASSESSMENT AND PLAN **Pre-Op Diagnosis/Planned Procedure**

Assessment: maxillary AP hypoplasia
 Pre-Op Diagnosis: maxillary AP hypoplasia
 X Check box for additional Diagnosis
 Pre-Op Diagnosis 2: possible necrosis 12
 Planned Procedure: Maxillary Lefort I advancement

X PRE-OPERATIVE INSTRUCTIONS/COUNSELING

Patient was given verbal and written instructions.
 X Provider Specific Instructions:
 given by resident
 Provider Name: Jensen, Damon T 2878 Date: 12Apr2017
 Scheduled Procedure Time/Date: 27APR2017@0800 With => Jensen, Damon T 2878
 Phone Number(s): 307-203-9044

X REVIEWED (H&P) PRIOR TO SURGERY/PROCEDURE **Required for ALL patients**

Patient assessed/re-examined and history and physical reviewed prior to surgery/procedure requiring anesthesia services. The changes found in patient's condition since history and physical exam were completed are listed below: PT had root canal started on #12 which currently has IRM in it. Pre op pt reports 5/10 pain after RCT started. Pt to have RCT completed after surgery. Comfortable proceeding with surgery as no s/s of infection feel pain is post extirpation tenderness. Ortho set up ran by COL Terp discussed right posterior opening (right posterior molars are not in contact as per set up).

Reviewed By: Jensen, Damon T 2878

Time/Date: 0825 27Apr2017

Intern Addendum:

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3092

Resident

Resident Addendum:

Staff Attending

Signature:

Time/Date:

OPERATIVE REPORT **To include the Brief Operative Report required before the next level of care...USE 'standalone' SURG Operative Report* Note!**

X POST PROCEDURE RELEASE/DISCHARGE SUMMARY **Required for ALL patients**

Staff Provider: Jensen, Damon T 2878

Clinical Service: Oral-Maxillofacial Surg/ABAA

Admission Diagnosis: Maxillary AP hypoplasia

Discharge Diagnosis: Maxillary AP hypoplasia

Admission Date: 27Apr2017

Discharge Date:

Procedure Performed 1: Lefort I osteotomy

Date: 27Apr2017

Check box for Additional Procedures

Clinical Course: Unremarkable

Disposition: Discharged Home

Condition on Discharge: Stable

Convalescent Day(s): 14

X POST-OP DISCHARGE MEDICATION RECONCILIATION **Required for ALL patients**

New Home Medications

Medication Name: Ibuprofen 100mg/5ml SUSP

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 40ml (800mg) every eight hours for baseline pain control.

Special Instructions:

Medication Name: Oxycodone 5mg/5ml SOLN

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 5-10ml every 4 hours as needed for breakthrough post surgical pain.

Special Instructions:

Medication Name: SODIUM CHL (SEA MIST) 0.65% NASAL SPRAY

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): 2 puffs each nostril 4 x daily to keep nose moist

Special Instructions:

Medication Name: Pseudoephedrine 30mg/5ml

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 10ml every 6 hours for congestion

Special Instructions:

Medication Name: ONDANSETRON (ZOFTRAN-ODT)--4MG TAB

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): dissolve 1 tab under tongue every 12 hours as needed for nausea

Special Instructions:

Medication Name: Augmentin 400mg/5ml SUSP

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 10ml, twice a day, until finished, (5 days).

Medication Name: WHITE PETROLATUM 30GM TUBE

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

AR 3093

Patient Friendly Discharge apply to lips as needed to keep moist
Dose, Route, Freq (REQUIRED):

Medication Name: OXYMETAZOLINE (AFRIN EQ)--NAS 0.05% SPRA
Patient Friendly Discharge 2 puffs each nostril 2 x daily for 3 days
Dose, Route, Freq (REQUIRED):

Medication Name: CHLORHEXIDINE (PERDIEX) 15ML UNIT DOSE
Patient Friendly Discharge Swish 15ml and spit, twice daily
Dose, Route, Freq (REQUIRED):

Pre-Admission Home Medications

X Medication Name: multivitamin (DAILY VITE) ORAL Tab
Patient Friendly Discharge
Dose, Route, Freq (REQUIRED):
Special Instructions: Continue taking this medication as previously prescribed.

PHARMACY **Completed by PHARMACY, if required per facility policy**

X PATIENT DISCHARGE INSTRUCTIONS

X Discharge Instructions:

The patient was admitted to the APU and taken to the operating room for a lefort osteotomy of the maxilla. They tolerated the procedure well. There were no complications during surgery. The patient was extubated in the OR and transported to the PACU in stable condition where they made an uneventful recovery overnight and obtained radiographic imaging. The following morning the patient was transferred to the APU for routine post operative care. Before discharge the patient's pain was well controlled with oral pain medications, they were voiding spontaneously without issue, tolerating oral intake, and ambulating safely. The patient remained afebrile with stable, normal vital signs and was discharged home with appropriate follow up.

MEDICATIONS: Continue all home medications. New medications listed below. Be sure to eat soft nutritious food prior to taking any medications (see DIET below). This will decrease the chances of post surgical nausea.

Discharge Meds:
-As listed above

SINUS PRECAUTIONS: Due to the nature of the surgical procedure in relation to your maxillary sinus cavity it is essential you follow the guidelines below to maximize your chances for a successful and uneventful healing process:

- Take the medications your surgeon prescribed, as prescribed.
- Do not blow your nose for two-weeks. It is best to wipe away nasal secretions carefully. After 2 weeks, if you must blow your nose, blow gently through both sides at the same time. Do not pinch your nose; do not blow just one side at a time.
- Do not pinch your nose and forcefully clear ears.
- If you must sneeze, keep your mouth open while doing so without pinching your nose.
- Avoid sucking. Do not drink through a straw. Do not smoke.
- Avoid blowing. Do not play a wind instrument. Do not blow up balloons. No forceful or projectile spitting.
- Do not lift or push objects weighing more than 20 pounds.
- No bending over - Keep your head above the level of your heart. Sleep with your head slightly elevated with two pillows.

WHAT TO EXPECT: The first 2-3 days after surgery, are generally the most uncomfortable and there is usually significant swelling. After the first week, you should be more comfortable. For the first 14 days it is normal to experience a little amount of everything. This includes swelling, bleeding, soreness, tightness, bruising/yellowing and a little pain or discomfort. Your nose may feel stiff, congested and mildly ooze with blood, use gauze to gently dab this away. With taking your prescribed medications and strictly following recommendations, this should all be tolerable. It is not uncommon for the anesthesia team to nasally intubate (place a tube through your nose and into your trachea) for oral surgical procedures. This can cause your nose to be sore and even bleed a little after the surgery for the first few days. Dark red-brown blood may come out of nose after 1 week, this is normal. If bleeding is bright red and heavy, this is abnormal, notify your surgical team. Saline nasal rinses (over the counter) can be used to help with nasal congestion as needed. The remainder of your postoperative course should consist of gradual, steady improvement.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

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PERSONAL/PRIV ACT 1974

Clinical Notes

ACTIVITY RESTRICTIONS: Please do not drive for 24 hours after your surgery. Until that time, you will still be affected by the anesthesia medications you were given during your surgery, and it is not safe for you to drive. Starting 24 hours after surgery you may drive limited amounts. Avoid heavy lifting and mildly strenuous activity/exercises that will significantly elevate blood pressure and heart rate for at least three days. You should limit yourself to light activity for one week following the surgery. However, spending as much time as comfortably possible out of bed sitting up and moving around the house helps speed recovery to daily activities.

SLEEPING: Please keep your head elevated while sleeping. This will minimize swelling and discomfort and reduce pain while allowing you to breathe more easily. One or two pillows may be placed beneath your mattress at the head of the bed to prop the bed into a more vertical position.

SWELLING: Swelling is common after surgery for two weeks. For the first 48 hours place an ice pack (or frozen peas/corn) on your face near the surgical site for 10-20 minutes every 2-3 hours. (Do not put ice in direct contact with the skin). 48 hours after surgery, we suggest switching to warm moist heat to decrease swelling (use a clean facecloth and tap water).

DIET: In the past, but very unusual at the present time, teeth were wired together after jaw surgery. This allows the bones to heal while they are being held still. In the majority of cases today, we use small bone plates and screws to hold the bones still to assist in healing. Support is also given by the splint and elastic traction (elastic bands placed onto your teeth.) This allows the jaw to move and function during the healing period of 8-12 weeks. It must be remembered, however, that the bones are not completely healed and are being stabilized only by the screws and plates. Therefore, we encourage a gradual progression of movement and use of the jaws, keeping in mind that adequate healing does not take place until approximately 6-8 weeks. **REMEMBER:** Your jaws are weakest at 10 days after your surgery. No alcoholic beverages should be consumed for at least twenty-four hours following general anesthesia or as long as you are taking narcotic pain medications.

Initially, it will be difficult to eat adequate amounts of food in only three meals per day. Try to eat five or six times a day, eating smaller portions each time. The following guidelines may be of help to you:

DIET: IMMEDIATELY FOLLOWING SURGERY UNTIL OTHERWISE INSTRUCTED (USUALLY 6 WEEKS)

During this period the diet should be essentially non-chewing. This will minimize the stress on the plates and screws. This may consist of either blenderized food or fluids that don't require chewing. This can include soups, milkshakes, baby food, or any blenderized food just avoid hot food/liquids that could injure/irritate your surgical sites. Some sort of diet supplement such as Ensure, Boost, protein shakes, smoothies or similar liquid meal replacements may be used once or twice a day to increase calorie intake. Plenty of clear fluids, water, etc. will help clean the thicker fluids from your mouth and throat. **REMEMBER:** It is very important to eat as much as possible to help your wounds heal properly. No straws!!

DIET: 6 - 8 WEEKS AFTER SURGERY

Chewing can start during this period of time. Initially begin with soft foods that require minimal chewing. This can consist of mashed potatoes, scrambled eggs, soft pasta that is cut into small pieces, soft rice dishes, or soft sandwiches that are cut into small pieces. One can also eat the foods that were eaten during the initial period. **SLOWLY** advance your diet, progressing into softer meats such as hamburger and soft chicken. The portions should be small so as not to place too much force on the healing bones. Soft fish dishes are also excellent. You will find that your jaw will tire easily. This will continue for the first 2-3 months until your jaw muscles have accommodated for your new jaw position. Avoid eating food which requires chewing for prolonged periods of time.

INTRAORAL SUTURES/STITCHES: Your sutures dissolve on their own. You may notice that they are loose after the swelling of your gum tissue decreases. This is completely normal. They commonly dissolve within the first month following surgery.

WOUND CARE FOR EXTRA-ORAL SURGICAL SITE: You may shower beginning 24 hours after the surgery.

SURGICAL SITES WITH GLUE/TAPE: The extraoral incision site has a dressing affixed in place with glue that will eventually come off on its own. If the edges peel up simply trim them with scissors. You may remove the dressing once it has loosened but do not attempt to remove early. The dressing will be removed at one of your scheduled follow up appointments.

SURGICAL SITES WITH SUTURES ONLY: The extraoral incision site was closed with sutures or "stitches." These will stay in place until the surgeon removes them, do not attempt to remove them on your own. It is important to keep the incision site clean. Wash your hands thoroughly with antibacterial soap, or use hand sanitizer, before cleaning the site. To clean, dilute a 1:1 solution of hydrogen peroxide and water, using a Q-tip gently clean the surgical site. Using a soft clean cloth, gently pad the area dry and apply a thick amount of Vaseline or the prescribed ointment.

Report to an emergency room or OMFS clinic immediately if you have any of the following:

1) Temperature greater than 101.5 F

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

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PERSONAL/PRIV ACT 1974

Clinical Notes

- 2) Swelling that makes it difficult to breath, speak, or swallow
- 3) Pain not controlled by prescribed meds
- 4) Nausea and vomiting not controlled by prescribed meds
- 5) Excess bleeding or oozing from wounds

Contact the OMS clinic during normal working hours for any questions or concerns, (301) 295-4340. The Duty section at the OMS clinic is available 24 hours a day for emergencies, call or report to the WRNMMC emergency department (301) 295-4810.

For non-emergent after hours concerns call the Walter Reed National Military Medical Center quarterdeck at (301)295-4611 and ask for the oral surgeon on call.

You have a scheduled follow up appointment as below. Please call (301)295-4340 if you need to reschedule. Follow up is at Bldg 1 deck 2 oral surgery. call 307-203-9044 if you need to reschedule

Follow-up appointment will be Time/Date: 01MAY2017@0900 with Jensen, Damon T 2878

follow up is at building 1 deck 2 oral surgery cell contact 307-203-9044

Follow-up appointment will be Time/Date: 10MAY2017@1300 with Jensen, Damon T 2878

6 week follow up at Building 9 deck 2 (arrowhead) for pano, pa cep, lat cep. Please note your third/june follow up is at a different location than your 01MAY and 10 MAY follow ups

Follow-up appointment will be Time/Date: 07JUN2017@1100 with Jensen, Damon T 2878

Report any of the following to your Surgeon/Provider
OR

NEAREST Emergency Room IMMEDIATELY

- Fever over 101 degrees by mouth
- Nausea or vomiting for more than 24 hours
- Pain unrelieved by medication.
- Separation of wound edges.
- Increasing bleeding or drainage from wound
- Swelling that does not subside after 7 days.
- Redness around the surgical site that is warm to the touch or is accompanied by drainage or foul odor.
- For General Surgery; if you experience Nausea and Worsening Abdominal Pain.

X DISCHARGE CONVALESCENCE INFORMATION **Use for ANY patient, if applicable**

***Convalescence information entered below will populate to the Discharge Convalescence Memo *, ***

Admitted to the hospital from 27Apr2017 to

Recommend a period of 14 days of convalescence after the date of discharge from the hospital.

Additional Restrictions/Comments:

See Discharge Instructions

Please feel free to call our facility with questions at the number(s) listed below.

See Discharge Instructions

- FINAL SIGNATURES -

Intern

Name of Supervising Resident:

Name of Supervising Staff/Attending: Jensen, Damon T 2878

Signature: Cvelich, Michael K LT 6793

Time/Date: 1047 12Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

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WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

AR 3096

X Resident

I have discussed the patient with my supervising Staff/Attending. The supervising Attending for this patient care encounter is:

Name of Supervising Staff/Attending: Jensen, Damon T 2878

Resident Addendum:

Signature: CERVENKA, PETER D 0736

Time/Date: 0643 28Apr2017

Fellow/Consultant Addendum:

Nurse Practitioner Addendum:

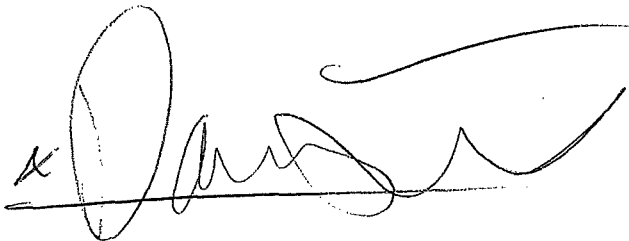
other Provider Addendum:

Staff Attending (Signature Required)

I have reviewed the documentation, examined the patient, discussed the case with the multidisciplinary team and agree with findings and plan of care. Agree with above pt referred to endo for eval of 12. Scheduled 20APR for endo eval.

Signature: Jensen, Damon T 2878

Time/Date: 1059 12Apr2017



DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

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PERSONAL/PRIV ACT 1974

Clinical Notes

AR 3097

Informed Consent for Anesthesia

Walter Reed National Military Medical Center Anesthesia Department

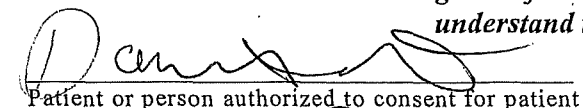
Information: There are several ways to administer anesthesia. **Local Anesthesia** is administered by the surgeon in the procedure area and is combined with **Monitored Anesthesia Care (MAC)** provided by an anesthetist. **MAC** involves the presence of a credentialed anesthetist, for monitoring purposes, who may provide a spectrum of sedation and analgesia ranging from light sedation to deep sedation. Usually light sedation does not affect ventilator or cardiovascular function; whereas individuals treated with deep sedation may require assistance in maintaining a patent airway and adequate ventilation—cardiovascular function is usually not affected. **Regional Anesthesia** refers to nerve block, epidural, and spinal anesthesia and involves the injection of a local anesthetic near major nerves to “numb” specific areas of the body and may be combined with **MAC**. **General Anesthesia** is a technique using intravenous medications and gases to keep you deeply asleep. This technique is often combined with medications to relax muscles and methods such as a breathing tube to provide adequate oxygenation.

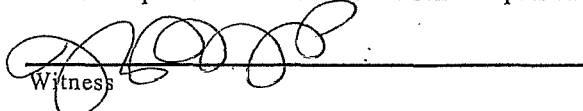
Complications and Risks: In addition to the risks of surgery, anesthesia of any type carries its own risks. More common complications that may arise include, but are not limited to the following: Sore throat, Nausea and Vomiting, Headache, and Dental damage. Less common complications that may arise include but are not limited to the following: Damage to blood vessels, Back pain, Damage to eyes / nose / skin, Vocal cord injury, Windpipe injury, Respiratory problems, Drug reaction, Infection, Nerve injury, Paralysis, Kidney damage, Brain damage, Heart injury, Awareness during surgery, Damage to baby if pregnant, and Death.

Understanding: I understand that my anesthetic plan will be GENERAL ANESTHESIA. I have been given an explanation of the proposed anesthetic plan and have been given the opportunity to ask questions about it as well as alternative forms of anesthesia; the risks and hazards have been explained to me to my satisfaction, and I feel I have sufficient information to give informed consent. I understand that my anesthetic will be given by or under the supervision of a staff WRNMMC Anesthesiologist or Certified Registered Nurse Anesthetist. Realizing that this is a teaching facility, I understand that other personnel such as residents, interns, medical students, and student registered nurse anesthetists may be involved in my anesthetic care and will be supervised by a credentialed staff member. I understand that during my procedure invasive monitoring may be necessary; the risks and benefit of this type of special monitoring have been fully explained to me. I understand that during the administration of my anesthetic, conditions may arise which require modification or extension of the anesthetic plan; I therefore authorize modification or extension of this consent as indicated by the professional judgment of my anesthesia team. I understand that during the procedure a transfusion of blood or blood products may become necessary and have been informed of the possible risks involved and understand these risks.

Consent: I consent to have anesthesia provided by appropriate medical personnel. I further consent to procedures that good medical judgment considers wise and prudent if it is medically undesirable to delay the procedure until after my further written consent has been obtained.

*Please do not sign this form unless you have read it or had it read to you,
understand it, and agree with what it says.*


Patient or person authorized to consent for patient


Witness

4/27/17 0650
Date / Time

4/27/17 0650
Date / Time

ELISEO G. BUNDOC LT, NEC, USN
Anesthesia counselor: 4/27/17 0650
Date / Time

Anesthesiologist / CRNA / Resident / SRNA

PATIENT STAMP

20/
MERWIN, DANIEL DENNIS
SEX: M DOB: 1985 AGE: 32
USN N11 PO1 NRP



AR 3098

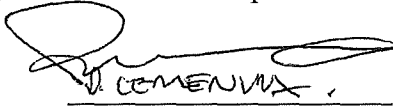
BLOOD TRANSFUSION PATIENT INFORMATION AND CONSENT FORM

ESTIMATED RISKS OF SOME TRANSFUSION COMPLICATIONS

TRANSFUSION RISK FOR EACH UNIT RECEIVED	RISK	REFERENCES
Febrile reaction ¹	1 : 60 ^a	^a Estimated to be 1:91 with prestorage leukoreduction and 1:46 with poststorage leukoreduction.
Transfusion-associated circulatory overload (TACO) ²	1 : 100 ^b	
Allergic reaction ³	1 : 250	^b Indicates the estimated risk per recipient rather than unit.
Bacterial Sepsis (from platelets) ⁹	1 : 2,000 to 1 : 3,000	
Delayed hemolytic transfusion reaction ¹¹	1 : 2,500 to 1 : 11,000	^c The estimate is variable depending on the length of the infectious period.
Transfusion related acute lung injury (TRALI) ⁴	1 : 12,000	
Acute hemolytic transfusion reaction ¹⁰	1 : 76,000	1, 2, 3, 4, 5, 6, 7, 8 – Clinical Practice Guidelines From the AABB Red Blood Cell Transfusion Thresholds and Storage, <i>JAMA</i> .doi: 10.1001/jama.2016.9185
Hepatitis C virus infection ⁵	1 : 1,149,000	
Hepatitis B virus infection ⁶	1 : 1,208,000 to 1 : 843,000 ^c	⁹ AABB Association Bulletin #14-04, 18 Jul 2014.
Human immunodeficiency virus infection ⁷	1 : 1,467,000	
Fatal hemolysis ⁸	1 : 1,972,000	^{10, 11} AABB Technical Manual, 18 th ed., 2014

The alternatives to transfusion include: (1) not receiving a transfusion, (2) pre-surgical autologous donation, and (3) intraoperative red cell salvage. If you have any questions about transfusion risks, benefits, complications, or alternatives, please discuss them with your doctor **BEFORE** you agree to have any blood transfusion.

1. COUNSELING PROVIDER OR DENTIST: I have counseled this patient as to the proposed procedure(s), attendant risks involved, the expected need for transfusion, and the use of intraoperative red cell salvage (if appropriate).


 Provider/Dentist Signature Date 2/28/2017 Time 0640

2. PATIENT: I understand the risks associated with blood transfusion and the reasons why my doctor(s) may wish to transfuse me. Should my doctor(s) deem a transfusion necessary, I agree to be transfused. For surgical patients only - I understand that intraoperative red cell salvage will / will not (initial one) be used.

 Date Time
  Date 4/27/17 Time 0643

3. PARENT/LEGAL REPRESENTATIVE: (When a patient is a minor or unable to give consent)
 I, _____, parent/legal representative of _____, understand the nature of the proposed procedure(s), attendant risks involved, and the expected need for transfusion and red cell salvage (if appropriate). I hereby request that such procedure(s) be performed. Should the doctor(s) taking care of this patient deem a transfusion necessary, I agree with their decision.

Witness Signature Date Time
 Parent/Legal Representative Signature Date Time

Patient Identifier
 [REDACTED]
 MERWIN, DANIEL DENNIS
 SEX: M DOB: [REDACTED] 1985 AGE: 32
 USN N11 PO1 NRP



WRNMMC FC

ATION WILL BE USED.

Page 2 of 2

BLOOD TRANSFUSION PATIENT INFORMATION AND CONSENT FORM

Dear Patient,

During the course of treatment you may need to receive blood or blood products. You should feel free to ask your doctor why you may need a transfusion. Benefits of transfusion include: (1) to improve oxygen delivery to your organs, (2) to replace factors or cells that help stop bleeding, or (3) to provide proteins (called globulins) to help your immune system, or (4) other reasons your doctor will explain. While many precautions are taken to make blood products safe, there are some well-known risks, including but not limited to, those listed below.

1. Transmission of infectious diseases: All blood for transfusion in the U.S. is tested for the following infectious diseases: HIV 1 & 2, HTLV I & II, Hepatitis B & C, syphilis, Chagas, and West Nile Virus. Only units that are negative for all of these tests are allowed to be transfused. Although these tests are extremely sensitive, on very rare occasions, a unit will contain a low level of virus that cannot be detected with current testing methods. There are diseases for which no approved test yet exists or there may be infectious risks, as yet unknown to us, that could be transfusion-transmitted. There is no way to guarantee a zero-risk transfusion, however, research and development of more sensitive tests are ongoing. As better testing methods are introduced into the blood banking industry, it is possible that transfusion recipients could be contacted in the future by their blood bank for follow-up information or blood samples. Your cooperation, should this occur, would be completely voluntary, and your participation could contribute to improvement in the safety of the nation's blood supply.

2. Fever: Transfused blood products can cause fever in some individuals.

3. Allergic reactions: After blood transfusion a person may occasionally experience wheezing, itching, low blood pressure, swelling in the throat, or breathing problems.

4. Hemolytic reactions: A potentially serious reaction can occur if you receive a unit of blood that is of a different ABO type from your own. Even when ABO-compatible blood is given, delayed hemolytic reactions can occur if the transfused red blood cells stimulate your immune system to make antibodies against them a few days to weeks following transfusion. This usually causes the transfused red blood cells to be destroyed in your spleen, resulting in a mild temporary jaundice (yellowing of the skin).

5. Transfusion-related acute lung injury (TRALI): A potentially fatal reaction involving lung damage has been reported in some recipients of cellular blood products and fresh frozen plasma. This reaction is not well understood and is being actively studied. It is believed the reaction is related to either an agent in the blood of certain donors, particularly females who have been pregnant in the past, or an agent that accumulates in some units of blood as they age. TRALI is manifested by difficulty breathing and fever within 1 to 6 hours after transfusion. Most victims fully recover, but in some cases the reaction is severe enough to cause death.

The above complications are rare, but potentially life-threatening. The estimated risks of these complications are shown in the table on the next page.

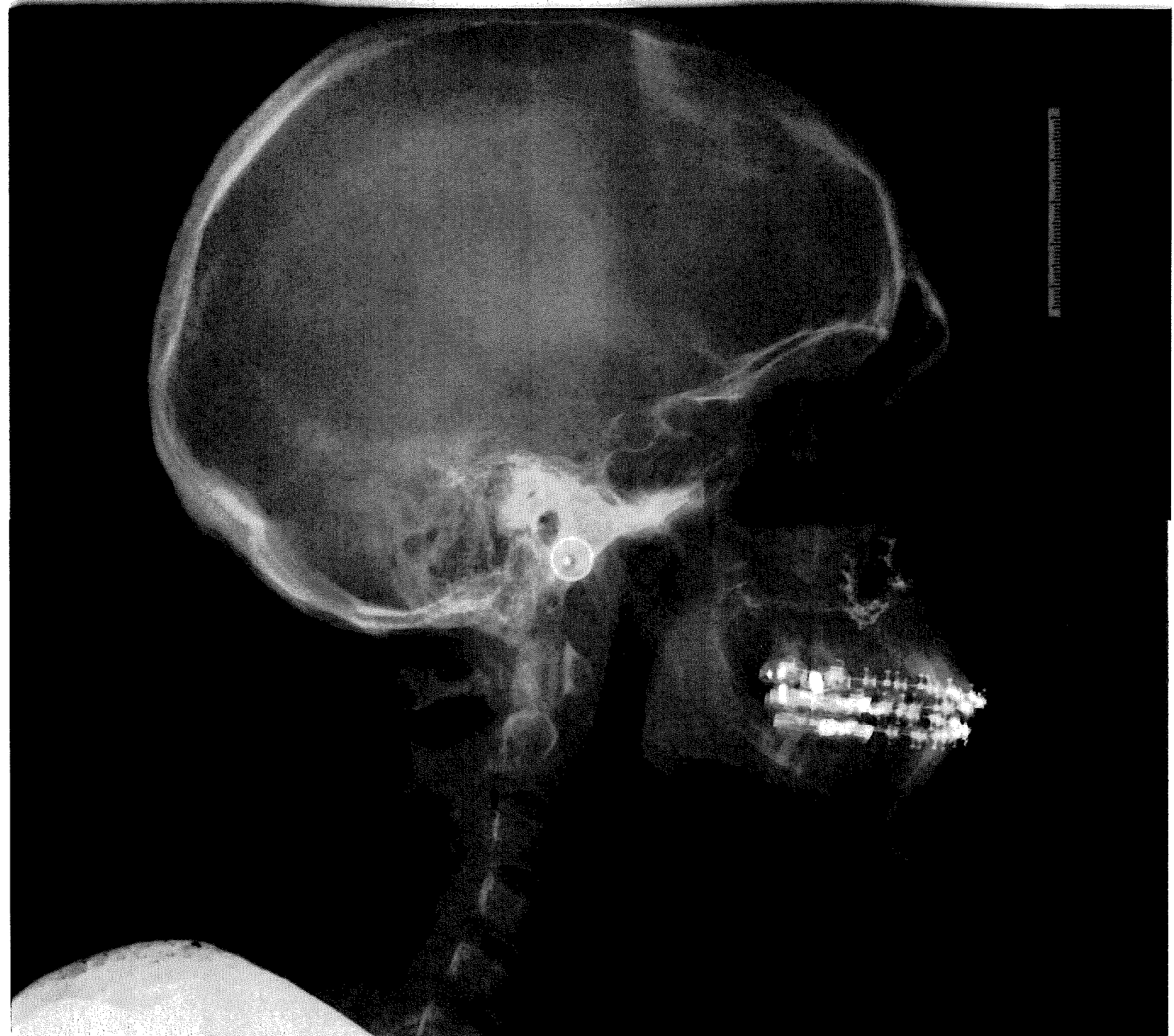
6. For surgical patients: Under special circumstances, your surgeon may determine that it is necessary or desirable to use a technique called Intraoperative Red Cell Salvage. This technique uses specialized equipment that harvests and washes your lost surgical blood and prepares it for transfusion. Use of this blood is an effective means to reduce the use of banked blood, decreasing the likelihood of transfusion reactions and spread of infectious disease. Drawbacks to this method include the need for anticipated large blood loss volumes, non-applicability to all types of surgery, and the potential spread for certain types of malignancy.

MERWIN^DANIEL

Printed 2017/04/27 03:17PM

Printed from 'WRNMWKXL03003WY' by 'Equus.Sanchez'

Patient Name MERWIN^DANIEL
Patient ID [REDACTED]
Patient Gender M
Patient DOB/Age 1985 [REDACTED] (032Y)



AR 3101

MERWIN^DANIEL

Printed 2017/04/27 03:17PM

Printed from 'WRNMWKXL03003WY' by 'Equus.Sanchez'

atient Name MERWIN^DANIEL
atient ID [REDACTED]
atient Gender M
atient DOB/Age 1985 [REDACTED] (032Y)



UNV80102

Laser / Inkjet printer labels

20/ [REDACTED]
MERWIN,DANIEL DENNIS
SEX: M DOB: [REDACTED] 1985 AGE: 32
USN N11 PO1 NRP



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MERWIN,DANIEL DENNIS
SEX: M DOB: [REDACTED] 1985 AGE: 32
USN N11 PO1 NRP



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USN N11 PO1 NRP



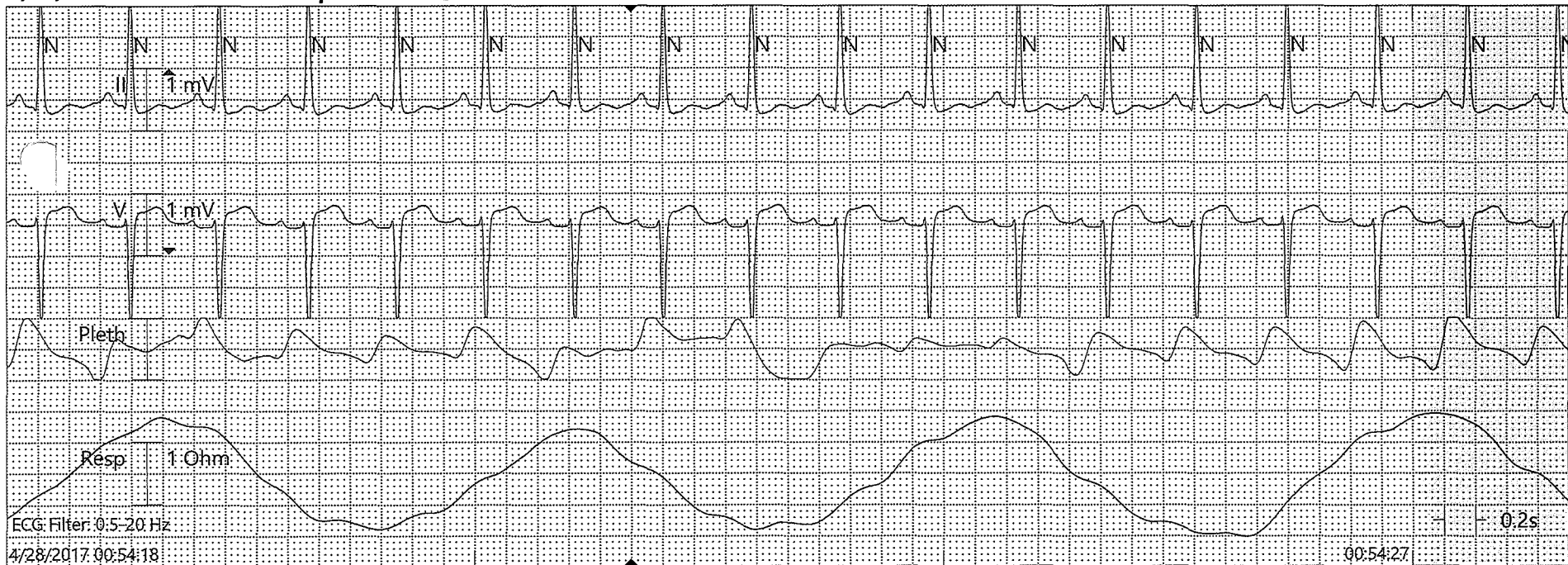
NEED
AR
LABEL

AR 3103

Vitals:

HR 103	PVC 0	SpO ₂ 97	Pulse (SpO ₂) 103
Perf 6.4	RR 23	ST-I 0.2	ST-II 0.1
ST-III -0.2	ST-aVR -0.2	ST-aVL 0.2	ST-aVF 0.0
ST-V 1.2	ST-MCL 1.0		

4/28/2017 00:54:22 Saved strip PR 0.15 QRS 0.09 RR 0.58 QT 0.31 QTc 0.41

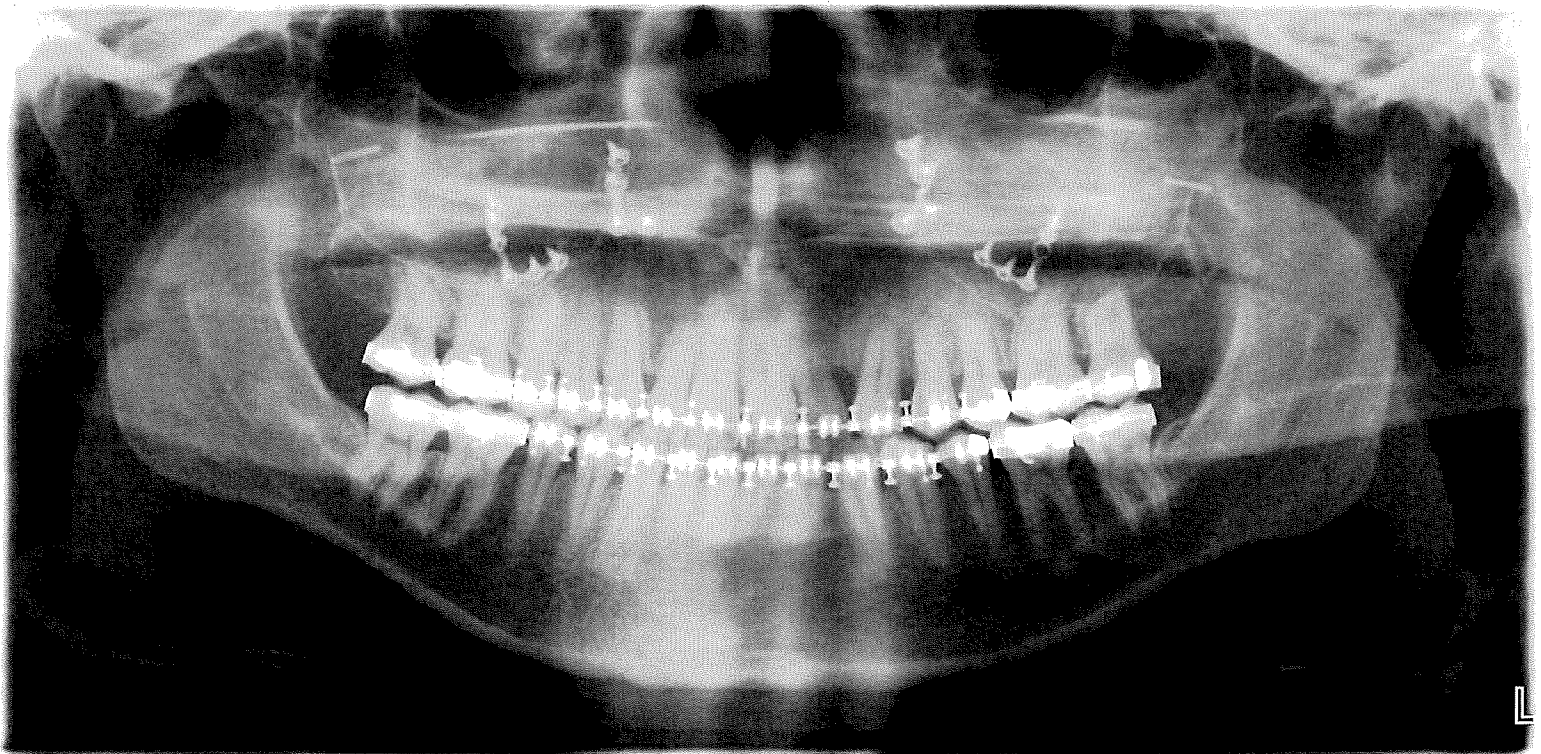


MERWIN^DANIEL

Printed 2017/04/27 03:17PM

Printed from 'WRNMWKXL03003WY' by 'Equus.Sanchez'

Patient Name MERWIN^DANIEL
Patient ID [REDACTED]
Patient Gender M
Patient DOB/Age 1988 [REDACTED] (032Y)



AR 3105

APR-28-2017 04:50 FROM:

TO: APU

P.1/1

(50) RKL

ILLNESS OR # 2 TO: RPK ETA: 25 AGE: 32 KG: 77 ALLERGIES: NKDA
IDENTITY NAME: Merwin, Daniel Dennis ASA: II CONTACT PREG.: YES (NO)
P2318 PROCEDURE: Leport I. Ostetmry
ATTENT SURGEON: Cervinka SERVICE: On FS ANES: MD CRNA:
SURVIVY ANESTHESIA: ET LMA (NT) SPINAL MAC (LOCAL) BLOCK: Xylo/Marc

HISTORY: Anxiety IBS
 VERSED 2 MG FENTANYL 150 MCG DILAUDID 4 MG ZOFRAN 4 MG DECADRON 10 MG
 TORADOL 0 MG @ TYLENOL 1g MG @ 0830 OTHER MG
 ANTIBIOTICS: 3g Unasyn @ 08/10 NEXT DOSE DUE:
 IV 16g (18g) 20g 22g OTHER: LEFT/RIGHT (HAND) WRIST FOREARM AC FOOT
 MOR: FLUID TYPE/AMOUNT: 1200 EBL: 120 GU OUTPUT: 600
 OTHER: FOLEY CATH I/O C'd N

Nasal - Aferin
 PRE-OP HR: 72 BP: 125/80 TEMP: 98.6 RR: 16 O₂ SAT: 98 PAIN SCALE:
 (LOW) HR: 84 BP: 113/75 TEMP: 98.6 RR: 16 O₂ SAT: 96% PAIN SCALE: 3/10

ROS: PLEASE WRITE BRIEF ASSESSMENT
 NEURO: Intact

RESP: C/A

CV: Sinus

GI:

GU:

MS:

SURGICAL DRESSING:

FLUIDS: Y N TYPE/AMOUNT:

LABS: Y N TYPE:

X-RAYS: Y N TYPE: Panor x @

DRAIN: Y N TYPE/AMOUNT:

PACU MEDS: Fent 5mg

Dilaudid 3mg

OTHER: Zofran 4mg

ACTION LIST

SITUATION

ATTENDING & CONTINGENCY PLAN

DTV: 1730

SYNTHESIS

TY RECEIPT

PACU RN: OPD

FLOOR RN:

BAY #:

RM:

FOR APLI USE ONLY

AMR: Y/N 11.4

MEDS: Y/N 42.3

D/C ORDERS: Y/N 262

PARKED ON: Ca 9.9

140 / 99 / 16 / 12
 4.4 / 29 / .88

AUTHORIZED FOR LOCAL REPRODUCTION

Medical Record	WRNMMC Request for Administration of Anesthesia and for Performance of Operations and Other Procedures
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1. OPERATION or PROCEDURE (Describe)

A. IDENTIFICATION

SIDE (MARK ONE)

Lefort osteotomy, possibly segmental, possible maxillo-mandibular fixation and any other indicted procedures

☐ Right ☐ Bilateral
☐ Left ☐ Not Applicable

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):

Under general anesthesia the surgeons will cut the gums of my upper jaw then cut and separate the bone, possibly into multiple pieces. They will then reposition my upper jaw into a proper relationship and it with plates and screws. Risks to surgery include facial and jaw swelling, bleeding which may sometimes be severe enough to require blood transfusion, allergic reaction to medications, delayed healing of the bony segments; rarely requiring a second surgery and/or bone graft to repair, relapse, bruising and discoloration of the skin around the jaws, eyes and nose, diminished sense of smell and a change in my cosmetic appearance.

which is to be performed by or under the direction of Dr. Jensen and associates

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any, are (if "none", so state): none

6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and the observation of the operation by authorized personnel, subject to the following conditions:

- The name of the patient and his/her family is not used to identify said pictures.
- Said pictures be used only for purposes of medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.
(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in parts A & B must be completed before signing.)

9. COUNSELING Provider: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

Provider's Signature:

Peter D. Cervenka
LCDR, DC, USN

Provider's Printed Name:

OMFS Resident
WRNMMC BETHESDA
NPI: 1922239250

10. PATIENT/Guardian: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Patient/Guardian's Signature:

[Signature]

1985
Date (MM/DD/YYYY)

0830
Time (HH:MM)

Witness' Signature:

[Signature]

D. UNIVERSAL PROTOCOL / TIME OUT

"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:

- CORRECT PATIENT (Full Name / Birth Date)..... ☒ YES
- CORRECT PROCEDURE ☒ YES
- CORRECT SITE** ☒ YES
- REQUIRED EQUIPMENT AVAILABLE..... ☒ YES N/A ☐
- IMAGES / LABS AVAILABLE, PROPERLY LABELED ☒ YES N/A ☐

** The site must be marked and verified for procedures involving right/left distinction, multiple structures (e.g. digits), or multiple levels (as in spinal procedures) per WRNMMC policies.

Signature below indicates the procedure may be started. If any element is not completed as required, procedure may NOT be started.

Timeout Verified by:

Jensen
Printed Last Name

[Signature]
Signature

27 APR 24
Date (MM/DD/YYYY)

0830
Time (HH:MM)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - Last, First Middle; ID no. (SSN or other) Hospital or Medical Facility)

20, MERWIN, DANIEL DENNIS
SEX: M DOB: 1985 AGE: 32
USN N11 PO1 NRP



Register #

Ward #

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES

Medical Record
LOCAL FORM 522 (Rev. 2/2012)
Prescribed by GSA/ICMR FMR (41 CFR) 102-119.300
DoD Exception to OF 522 approved by GSA

AR 3107

Clear Form

10H OUTPATIENT ACTIVE MEDICATIONS LIST

NNMC 6000 06/13/08

Current Prescriptions List

PATIENT: MERWIN, DANIEL DENNIS

20/

Age: 32

DOB:

1985

MALE

+++++

AHFS CLASSIFICATION: EMPTY

1. NALTREXONE--PO 50MG TAB

REFILLS REMAINING: 1 #: 30

SIG:

EXPANDED SIG: TAKE 1/2 TABLET BY MOUTH EVERY DAY X 1 WEEK, THEN
INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLERATED

2. ESCITALOPRAM--PO 20MG TAB

REFILLS REMAINING: 3 #: 70

SIG:

EXPANDED SIG: TAKE ONE TABLET BY MOUTH EVERY DAY

ALLERGIES:

*dysphagia, throat
bleeding, sweets
Cats/Feathers*

----- End of Active Prescriptions -----

OTHER [Comment: Reaction(s): Unknown; Note: SEE MED RECORD]

OTHER [Comment: SEE MED RECORD]

OTHER [Comment: Allergen: OTHER; Reaction(s): Unknown; Note: SEE MED R

...]

----- End of Allergies -----

Annotate all other medications taken by patient (OTCs, Herbals) below. None: _____

MVI 1 tab PO Daily

SIGN AND STAMP

[Signature]

DATE/TIME:

4/27/17

***** (END OF REPORT) *****

20/ *[Redacted]*
MERWIN, DANIEL DENNIS
SEX: M DOB: *[Redacted]* 1985 AGE: 32
USN N11 PO1 NRP*T-CON*

AR 3108

Patient escorts must have transportation arranged for themselves and the patient (either they drive you home or they have arranged for a reliable form of transportation prior to surgery date). **FAILURE TO HAVE AN ESCORT MAY RESULT IN CANCELLATION OF YOUR PROCEDURE!!**

- **** Patients from Building 62 will still require an escort prior to being discharged to Building 62.**
- DO NOT bring any jewelry (including wedding bands), cash, credit cards, or other items of high value on your day of surgery. The APU and its staff are not responsible for lost or misplaced belongings.
- Please wear appropriate and comfortable clothing suitable for the procedure you will have. Children having surgery may wear their pajamas to the APU and Operating room, unless otherwise indicated.
- Do not wear make-up, lotions, perfumes, deodorants, or fingernail polish.
- All piercings, adornments, dentures, hearing aids, contact lenses/ glasses must be removed prior to going to the OR.
- Do not shave or wax, on or near, your surgery site 24 hours prior to your procedure.

On the day of surgery, please bring the following items:

- ☒ Military or government issued picture ID
- ☐ "Prep Check" Sticker sheet if directed to perform surgical skin wipes from surgeon.
- ☐ Crutches if required
- ☐ CPAP Machine if required
- ☐ Any inhalers, if prescribed. Otherwise please do not bring your home medications.
- ☐ Additional assistive devices that will be needed after surgery, such as walkers, canes, or wheelchairs
- ☐ **Copy of Advance directive, living will, 5 Wishes, or power of attorney (Optional)
- ☐ **Females of child bearing age: Urine specimen cup with urine sample; or be prepared to provide a sample in APU.
- ☐ Other: _____

Post-Operative Instructions:

- Anesthetics may affect your sense of balance for a short time. Please ask for assistance when you get out of bed/chair for the first time after surgery.
- ****For Patients receiving block anesthesia (i.e. knee or hip surgery), please DO NOT attempt to get out of bed/chair without the assistance of a nurse or any health care provider.** During your entire stay in the APU you are at a much higher risk for falling post-surgery.

IF YOU ARE STAYING IN THE APU OVERNIGHT:

- Patients who will be staying overnight in APU will be discharged by 0800.
- Please ensure your escort/ride is in the APU no later than 0745 to facilitate a prompt discharge time.
- Family and other visitors are not permitted to stay overnight with patients. Visiting hours end at 2200.

GUESTS AND VISITORS:

- This is the President's hospital so guest/visitors/escorts without base access must accompany the patient in their vehicle the day of surgery and remain with the patient until discharge, or be pre-vetted through security 3-4 days before surgery date.
- Contact your surgeon's clinical nurse coordinator ASAP if they will not be accompanying you in your car the day of surgery to get the access request in. Please note: Security has the right to refuse entry to any non-ID'd individual.

INCLEMENT WEATHER INFORMATION:

- During adverse weather condition, please check the Walter Reed Bethesda website to verify operating status.
- If the clinics are CLOSED all non-emergent surgeries are cancelled for that day. Please call your clinic the next business day to reschedule your elective surgery date and/or prescreen appointment.
- If there is a DELAYED opening, please report to your APU Prescreen appointment or your surgery appointment on time as scheduled.

All information on this form has been reviewed by the patient. The patient has verbalized understanding of all instructions given on this form.

Staff Name JoAnn Highsmith Staff Signature JoAnn Highsmith, R.N. Date 24 APR 2017
 Patient Name X Daniel Moeun Patient Signature Daniel Moeun Date X 04/27/17

WRNMMC APU STANDARDIZED PRE-PROCEDURE TEACHING SHEET**BEFORE LEAVING WRNMMC THE DAY YOU HAVE YOUR PRE-PROCEDURAL APPOINTMENT:**

- Turn in completed package to APU Prescreen Area (Building 9, 3rd floor, across from the Stone Center).
- Pick up pre-procedural medications or prep materials if ordered by your physician.
- Complete labs, EKG, or X-rays as ordered by your doctor. Complete all paperwork **before** your appointment.

ADHERE TO YOUR MEDICATION REGIME AS OUTLINED BY YOUR DOCTOR OR MODIFIED BY ANESTHESIA

- Medication instructions also include the following, unless otherwise directed:
- Do not take aspirin-containing medications, or Motrin/Aleve/Advil/Ibuprofen type medications, including over the counter, for **2 weeks prior to and 2 weeks after your surgery**, unless otherwise instructed.
- Do not take herbal/dietary supplements such as ginkgo biloba, garlic, ginger, fish oil, or vitamin E. These can prevent blood from clotting and have been associated with prolonged bleeding.
- Tylenol is OK, however, please make staff aware if you have taken it for cold symptoms or fever.

THE BUSINESS DAY PRIOR TO YOUR SURGERY:Date: 26 APR 2017

- Call the APU Chart Manager at **301-295-2563** in the afternoon between **1:30pm-4:00pm** for your Arrival. Arrival times are approximately **2 hours** before your SCHEDULED Surgery time and are determined by the main operating room, **not** the surgeon. Please do not come any earlier than your scheduled Arrival Time.
 - If you were not scheduled to be seen by a nurse during your APU Prescreen appointment, **one of our TCON Nurses will call you for a telephone consultation within 72 hours prior to your surgery date.** If our TCON Nurse has not called you by 1000 on the day before your surgery, please call the APU Prescreen at **301-295-2319**.
- If you wish to cancel your procedure, contact your physician in their respective clinic. If after hours, please call the CDO desk at **301-295-4611** to have the surgeon on call paged to speak with you.
- Emergencies and wounded warriors take priority in the operating room. Please keep this in mind if there is a delay or cancellation to your procedure. Your patience is appreciated.
- Patients scheduled as "time and space available (TSA)" are given times based on estimated surgery time. These times can vary dramatically, and we kindly ask for your patience.

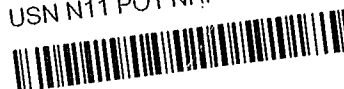
THE EVENING BEFORE YOUR PROCEDURE:Date: 26 APR 2017

- Unless otherwise directed, **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT** on the night before your procedure. *This includes water, coffee, tea, toast, ice chips, candy, or gum.*
- If instructed to take oral medication on the morning of your procedure, please do so with a small sip of plain water.
- Do not consume any alcohol 24 hours prior to your procedure.
- Do not use any tobacco products after midnight the night before your surgery.
- Complete surgical skin preparation the night before and the morning of surgery as directed.
- ****For GI Patients**:** Complete your entire bowel preparation (Moviprep) if ordered by your physician.

FOR CHILDREN LESS THAN 13 YEARS OLD ONLY:

1. No solid food after midnight the evening prior to the procedure.
2. Clear liquids up to two hours prior to arrival time.
3. Breast milk up to four hours prior to arrival time.
4. Infant formula up to six hours prior to arrival time.
5. All Non-human milk up to six hours prior to arrival time.

20 [REDACTED] DENNIS
 MERWIN, DA [REDACTED] 985 AGE: 32
 SEX: M DOB: [REDACTED]
 USN N11 PO1 NRP

**THE DAY OF THE SURGERY:**

- Please report to Main APU Day of Surgery "Check In" in Building 10, Eagle Building, 3rd Floor (3 East). It is recommended that you park in the Arrowhead Patient Parking Garage across Building 10.
- **A responsible adult, age 18 or older, must accompany you when you arrive at APU Check In on the day of surgery and must accompany you home after discharge (unless you are pre-scheduled to be admitted to inpatient ward).**

Patient Needs Assessment Form

Answering the questions will help us provide you the best possible care both before and after your procedure. All information is confidential and will only be used to contact you with regards to your procedure.

Please check or circle the most appropriate answer:

1. Who is providing this information today? Patient/Self Other: _____
(Please provide name and relationship)
2. Primary language: English Other: _____
3. Do you have any difficulty: Hearing Reading Both
4. Do you learn best by: Vision Hearing Doing or a Combination
5. What is your highest level of education? Some COLLEGE
6. Describe your current level of anxiety: None Mild Moderate Severe
7. Are you familiar with *The Patient Bill of Rights*? Yes No
8. Do you wish to see the Chaplain on the day of your procedure? Yes No
9. Are you familiar with the *Pain Assessment Scale*? Yes No

It is very important that we have legibly written phone numbers so that we can complete the pre-screen process.

If you do NOT have an escort on the day of your procedure or the day you are to be discharged from the APU, your procedure will be cancelled or delayed.

Your escort home will be: Name: JESSICA RUPP ✓

Telephone Number [REDACTED]

I give my permission for you to leave a message regarding information about my procedure on my: (Please circle choices.)

Home phone

Cell phone

Email address

Work phone

(If you do not circle any choice and we are unable to contact you, your surgery may be delayed or cancelled.)

Patient Signature and Date: [Signature]

A [REDACTED]
MERWIN, DANIEL DENNIS
SEX: M DOB: [REDACTED] 1985 AGE: 32
USN N11 PO1 NRP



APU Staff Signature: [Signature]
RN

Merwin, Daniel D.
LAST NAME FIRST NAME
(Print name above)

MERWIN, DANIEL DENNIS
FMP/SSN: 20 [REDACTED]
DOB: [REDACTED] 1985 PAT CAT: N11
NATIONAL CAPITAL AREA
[REDACTED] APV#
APPT DATE/TIME:

INPATIENT/EXTENDED AMBULATORY RECORD

☐ Inpatient Record
Discharge Date(s) _____
☒ Extended Ambulatory Record
Discharge Date(s) 9.18.14



VOL: 1

<input type="checkbox"/> NAVY	<input type="checkbox"/> ACTIVE DUTY
<input type="checkbox"/> MARINE CORPS	<input type="checkbox"/> RETIRED
<input type="checkbox"/> ARMY	<input type="checkbox"/> FAMILY MEMBER
<input type="checkbox"/> AIR FORCE	
<input type="checkbox"/> COAST GUARD	
<input type="checkbox"/> NATO _____ (Enter Country)	
<input type="checkbox"/> OTHER _____ (Write in Other Categories)	

ALERT	
SENSITIVITIES	<input type="checkbox"/>
ALLERGIES	<input type="checkbox"/>

WARNING: PROPERTY OF U.S. GOVERNMENT
DO NOT REMOVE FROM HOSPITAL
RETURN TO INPATIENT RECORDS DEPARTMENT

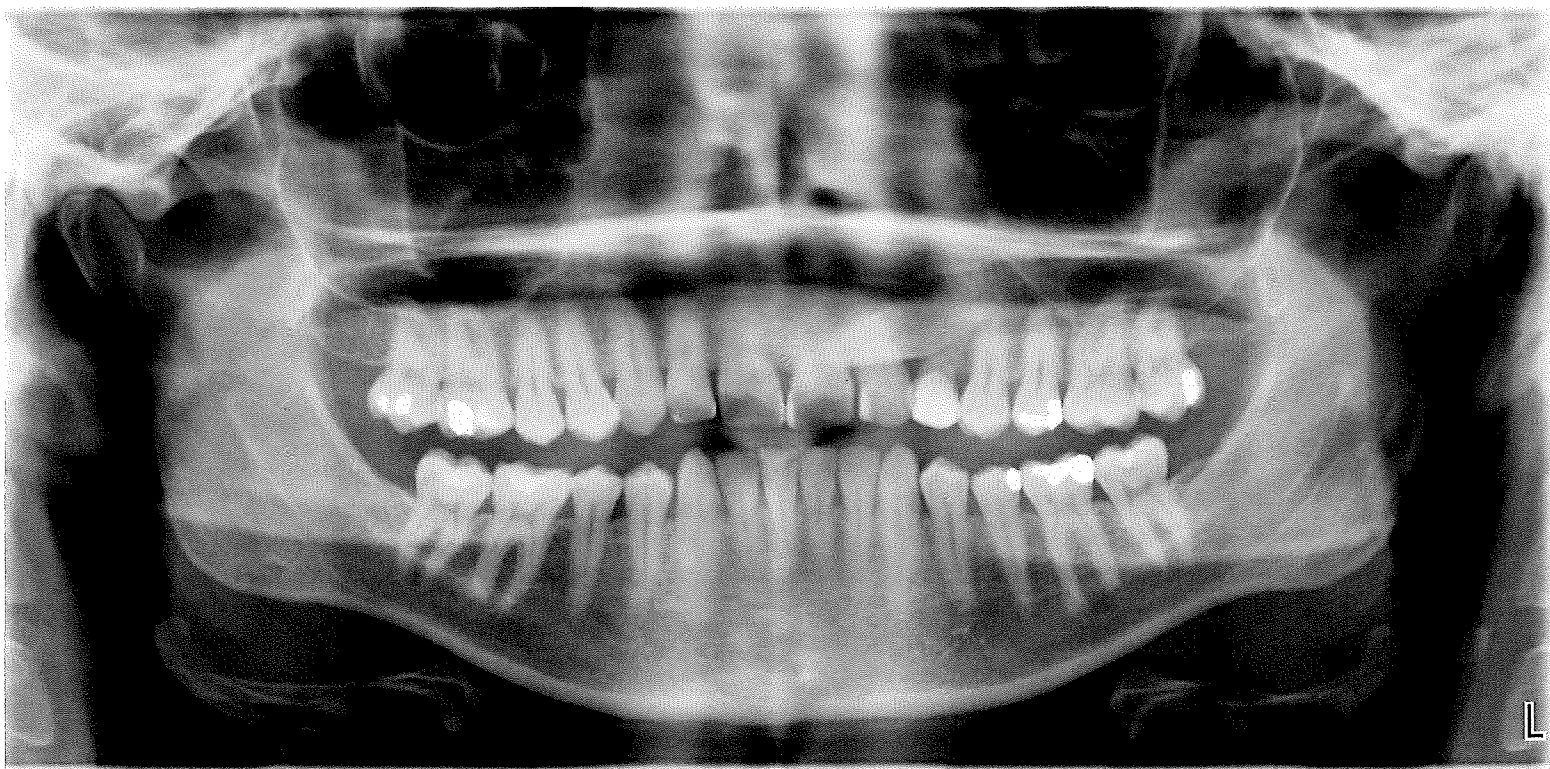
IF FOUND, RETURN TO ANY
U.S. POST OFFICE.
POSTMASTER - FORWARD TO:
NAVY DEPARTMENT
WASHINGTON, D.C. 20372
AR 3112

MERWIN^DANIEL

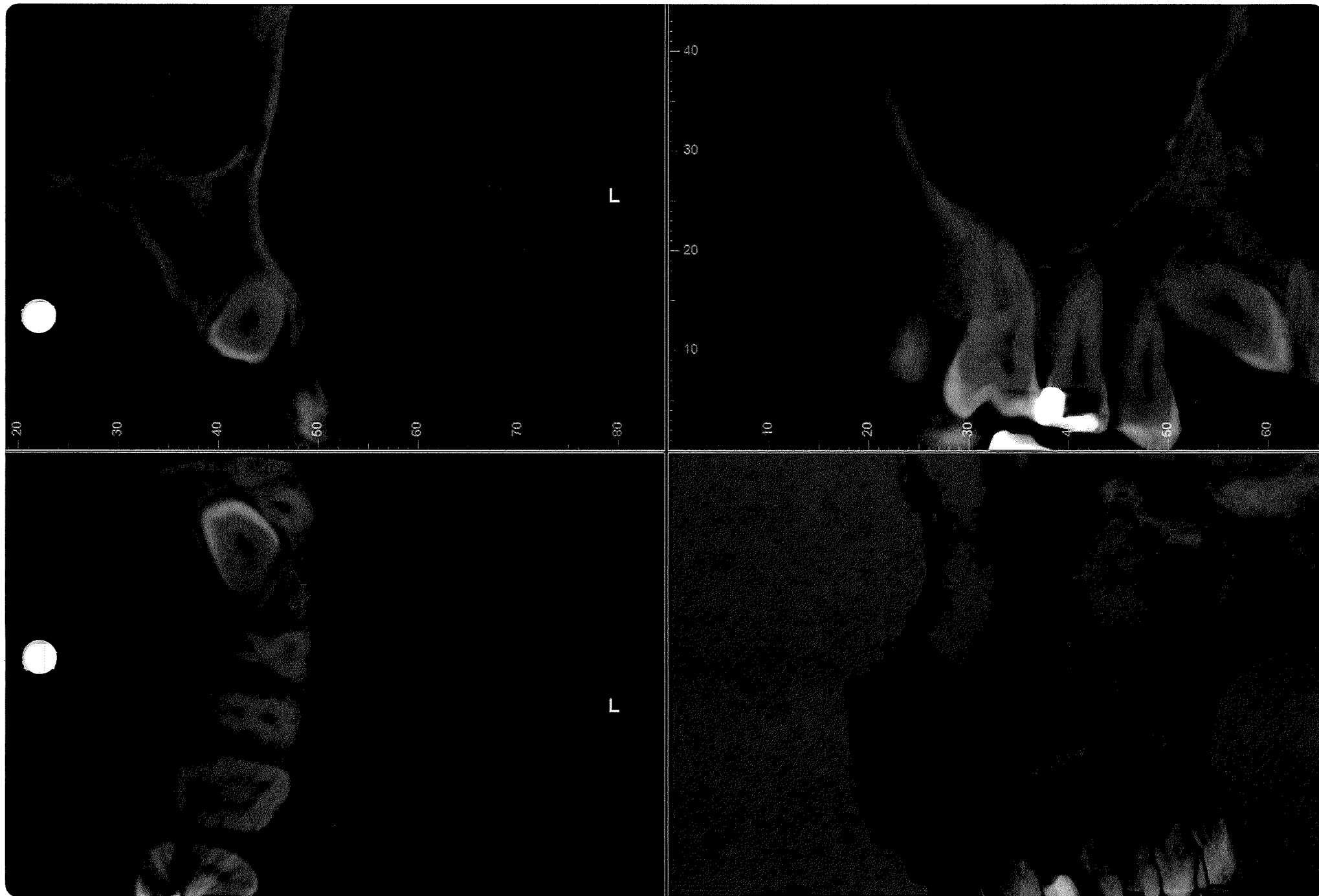
Printed 2014/09/18 10:21AM

Printed from 'NNMCAMXL03003J9' by 'Amy.Respondek'

Patient Name MERWIN^DANIEL
Patient ID [REDACTED]
Patient Gender M
Patient DOB/Age 1985 [REDACTED] (029Y)



Daniel Merwin, , Progress 9/18/2014, Printed: 9/18/2014



Brief Operation Note

Date of Operation: 9/18/14Procedure: Ext H, Expose/Bond #11Time of Operation: 1045IVF: 400ccPreop Diagnosis: FBI #11, Retained #Blood Loss: 5ccPost-Op Diagnosis: Exposed/Bonded #11Urine Output: ØSurgeon: QuitmeyerDrains: ØStaff: QuitmeyerSpecimen: ØAnesthesia: IV Sed - RespondexComplications: None

Description of operation

RBA discussed and understood: ☒ Y ☐ N Consent signed: ☒ Y ☐ N Monitors: ☒ Y ☐ N O2 ☒ Y ☐ N IV ☒ Y ☐ N ☒ See IV Sedation FormLocal: 2 carp Lidocaine 2% w/epi 1:100K 1 carp Marcaine 0.5% w/epi 1:200K 1 Other: Procedure: Time Out Throat screen Bite block Jaw stabilized for TMJ proph# 11: MP flap Bone removal w/drill, NS Crown section Root section Manual alveoloplasty ☒ Elevator ☒ Forceps Follicle rem Sinus exposure Root tip removed Nerve visualized/intact ☒ Saline Irrig. Suture: Other: # 11: ☒ MP flap Bone removal w/drill, NS Crown section Root section Manual alveoloplasty Elevator Forceps Follicle rem Sinus exposure Root tip removed Nerve visualized/intact ☒ Saline Irrig. ☒ Suture: 3-0 (G x 2) Other: etch / Bond / Bracket @ Chain Placed# : MP flap Bone removal w/drill, NS Crown section Root section Manual alveoloplasty Elevator Forceps Follicle rem Sinus exposure Root tip removed Nerve visualized/intact Saline Irrig. Suture: Other: # : MP flap Bone removal w/drill, NS Crown section Root section Manual alveoloplasty Elevator Forceps Follicle rem Sinus exposure Root tip removed Nerve visualized/intact Saline Irrig. Suture: Other:

Notes:

☒ Throat Screen removed ☒ Hemostasis ☒ Oral gauze packs placedRx: ☒ Ibuprofen 800mg po q8h, # 30☒ Percocet 5/325, 1-2 po q4-6h prn pain, # 30☒ Peridex, swish and spit 15 ml bld: 1 bl(s) Other: ☒ Post-op Instructions reviewed w/ escort/patientF/U: 1 wk

Special Instructions:

AARON E. QUITMEYER, DDS
LCDR, DC, USN
ORAL & MAXILLOFACIAL SURGERY
WRNMMC-BETHESDA
NPT: 1306958582



Staff

Resident

Patient Information:

20/
MERWIN, DANIEL DENNIS
SEX: M DOB: 1985 AGE: 29
USN N11 PO1 NRPSTAFF PATIENT 

Moderate/Deep Sedation Flow Sheet		Procedure		PATIENT INFO	
Date: 9/18/2014 Location: OMS Clinic Provider: Monitor:		Procedure: <u>Extraction H, exposed hand #11</u>		Age: <u>29</u> M <input checked="" type="checkbox"/> F <input type="checkbox"/> HT: <u>5'8"</u> WT: <u>148</u> kg Allergies: <u>NKA</u> Diagnosis: <u>impacted #11 retained #4</u>	
H&P within 30 days <input checked="" type="checkbox"/> H&P updated within 24 hrs <input checked="" type="checkbox"/> Consent for procedure <input checked="" type="checkbox"/> Consent for sedation <input checked="" type="checkbox"/> Patient has Advanced Directive <input type="checkbox"/> Time Out: <u>10:49</u> (time)		Route: <input type="checkbox"/> PO <input checked="" type="checkbox"/> IV Site: <u>(R) L</u> Moderate <input type="checkbox"/> Deep <input type="checkbox"/> Arm / Hand: <u>206</u> Gauge: <u>20G</u>		PRE-OP MEDICATIONS Medication: <u>Pericidex</u> Dose: Time Given: Local Anesthetics: <u>2% Lidocaine with 1:100K epi</u> <u>2</u> x 1.7 ml <u>0.5% Bupivacaine with 1:200K epi</u> <u>1</u> x 1.7 ml Other: <u>_____</u> x 1.7 ml	
PATIENT'S VITALS <input checked="" type="checkbox"/> Oxygen <input type="checkbox"/> Suction <input checked="" type="checkbox"/> Ambu Bag <input checked="" type="checkbox"/> Airway Equipment <input checked="" type="checkbox"/> BP Cuff <input checked="" type="checkbox"/> Capnography <input checked="" type="checkbox"/> Pulse Oximetry <input checked="" type="checkbox"/> EKG <input checked="" type="checkbox"/> Rescue Drugs <input checked="" type="checkbox"/> Crash Cart		Other:		Time: <u>0930</u> B: <u>27/85</u> P: <u>80</u> HR: <u>71</u> O2 Sat: <u>100</u> RR: <u>18</u> Temp: <u>97.7</u> Preg. Test: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A NPO Status verified: <input checked="" type="checkbox"/> (LOC) Level of Consciousness: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2	
Time: <u>10:45</u> <u>11:15</u> <u>11:45</u> <u>12:15</u> Midazolam (mg): <u>2.5</u> Fentanyl (mcg): <u>50</u> Propofol (mg): <u>10</u> Ketamine (mg): <u>8</u> Decadron (mg): <u>8</u> Toradol (mg): <u>30</u> Z-Clonidine (mcg): <u>4</u>		LR/NS: <input type="checkbox"/> Valsalva <input checked="" type="checkbox"/> EKG: <u>NSR</u> <u>NSR</u> RR: <u>15</u> <u>14</u> O2 (L/min) NG/FM: <u>3</u> <u>3</u> O2 Sat: <u>99%</u> <u>98</u> EICO: <u>4</u> <u>8</u> Temperature: <input type="checkbox"/> C <input checked="" type="checkbox"/> F Pain Score (0-10): <u>2-1</u> LOC: <u>2-1</u> EBL: <u>(ml)</u> Urine: <u>(ml)</u>		TOTALS Drug: U W Initials Midazolam (mg): <u>3</u> <u>1</u> <u>40</u> Fentanyl (mcg): <u>50</u> <u>50</u> <u>40</u> Ketamine (mg): <u>8</u> Propofol (mg): <u>8</u> Decadron (mg): <u>8</u> Toradol (mg): <u>30</u>	
VITAL SIGNS V SBP A DBP HR O2 therapy RA Room Air NC Nasal Cannula FM Face Mask ET ETT		Discharge Checklist Procedure site: <input checked="" type="checkbox"/> Valsalva <input type="checkbox"/> see note <input checked="" type="checkbox"/> IV discontinued, site VNL <input type="checkbox"/> Inpatient <input type="checkbox"/> Return to pre-procedure VS <input type="checkbox"/> Transferred to <input type="checkbox"/> Report to receiving unit <input type="checkbox"/> Patient monitored for 1 hour or 2 hours if reversal agents given <input type="checkbox"/> Outpatient <input type="checkbox"/> Return to pre-procedure VS <input type="checkbox"/> Aldrete score > 8 <input type="checkbox"/> No need for parenteral pain/nausea medications <input type="checkbox"/> Patient monitored for 1 hour or 2 hours if reversal agents given <input type="checkbox"/> Provided written &/or verbal post procedure instructions <input type="checkbox"/> Discharged with a responsible adult escort		Room: <u>1045</u> Time-out: <u>10:49</u> Start: <u>10:53</u> End: <u>11:15</u> Recovery: <u>11:19</u> Discharge: <u>11:40</u>	
Recovery Time: <u>11:22</u> <u>11:30</u> <u>11:40</u> <u>11:50</u> <u>12:00</u> EKG: <u>NSR</u> <u>NSR</u> <u>NSR</u> <u>NSR</u> <u>NSR</u> HR: <u>68</u> <u>76</u> <u>70</u> <u>78</u> <u>76</u> O2 (L/min): <u>3</u> <u>3</u> <u>3</u> <u>3</u> <u>3</u> O2 Sat: <u>100</u> <u>100</u> <u>100</u> <u>100</u> <u>100</u> BP: <u>138/78</u> <u>120/72</u> <u>120/71</u> <u>120/71</u> <u>120/71</u> Pain Score (0-10): <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u> Circulation (BP): <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u> Consciousness: <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u> Color: <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u> Respiration: <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u> Activity: <u>2</u> <u>2</u> <u>2</u> <u>2</u> <u>2</u>		Aldrete (A total discharge score of 8-10 is necessary for discharge) 2= Moves 4 extremities 1= Moves 2 extremities 0= Moves 0 extremities 2= Fully awake 1= Awake on call 0= Non responsive 2= Breather deep & cough 1= Dyspnea 0= Apnea 2= Pink 1= Pale, dusky, blotchy, other 0= Cyanotic 2= UP 41-20% Pre-op 1= 20-50% 0= >50%		PROVIDER SIGNATURE: <u>Greg (Responsible)</u> RECOVERY ASSISTANT SIGNATURE: <u>Merwin, Daniel Dennis</u> Patient Identification: <u>206</u> DOB: <u>1985</u> Name (Last, First, MI): <u>Merwin, Daniel Dennis</u> SSN: <u>_____</u> DOB: <u>1985</u>	
PROVIDER SIGNATURE: <u>Greg (Responsible)</u> RECOVERY ASSISTANT SIGNATURE: <u>Merwin, Daniel Dennis</u> Patient Identification: <u>206</u> DOB: <u>1985</u> Name (Last, First, MI): <u>Merwin, Daniel Dennis</u> SSN: <u>_____</u> DOB: <u>1985</u>		Staff Signature: <u>Dr. Hartzel</u> Print Name/Stamp: <u>Dr. Hartzel</u> Aaron E. Quittmeyer, D.D.S. F.D.R., D.C., U.S.N. ORAL & MAXILLOFACIAL SURGERY WASHINGTON, D.C.		Discharge: <u>10/10</u> Discharge: <u>10/10</u>	

PRE-SEDATION EVALUATION		Age	Sex	Height	Weight
Proposed Procedure: EXT #1 / expose + BWD #11		29	M	69 in/cm	150 lb/kg
Previous Anesthesia / Operations: TONSILLECTOMY		Pre-Procedure Vital Signs: BP 131/91 P 71 R 15 T 97.9 SpO2 99		Current Medications: NONE	
Airway Evaluation: Mallampati: <input type="checkbox"/> Class I <input checked="" type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV OOOO		Vitamins / Herbs / Diet Supplements: NKDA			
Neck: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Decreased ROM <input type="checkbox"/> TMJ <input type="checkbox"/> Short Neck		Allergies: Drugs, Latex, Food: NKDA			
Teeth: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Protruding Incisors <input type="checkbox"/> Loose teeth <input type="checkbox"/> Other:					
Mouth: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Limited Opening <input type="checkbox"/> Other:					
Family History of Anesthesia Complications: NONE		History Source: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Significant other <input type="checkbox"/> Chart <input type="checkbox"/> Post-History			
SYSTEM	COMMENTS	PERTINENT STUDY RESULTS			
RESPIRATORY Asthma Bronchitis COPD Dyspnea Orthopnea Productive Cough Tuberculosis Recent Cold	<input checked="" type="checkbox"/> WNL Tobacco Use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pack/Day for _____ Years	Chest X-Ray Pulmonary Studies			
CARDIOVASCULAR Angina Arrhythmia CHF Exercise Tolerance Hypertension Rheumatic Fever MI Murmur	<input checked="" type="checkbox"/> WNL MVP Pacemaker	EKG			
HEPATO/GASTROINTESTINAL Bowel Obstruction Choleliths Hepatitis Hepatic Hematoma N&V	<input checked="" type="checkbox"/> WNL Ethanol Use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Frequency: _____				
NEURO/MUSCULOSKELETAL Arthritis Back Problems CVA/Stroke DJD Headaches Loss of Consciousness Neuromuscular Disease	<input checked="" type="checkbox"/> WNL Paresthesia Syncope Seizures TIA's Weakness				
RENAL/ENDOCRINE Diabetes Renal Failure/Dialysis Thyroid Disease Urinary Retention Urinary Tract Infection	<input checked="" type="checkbox"/> WNL	ASA Classification <input checked="" type="checkbox"/> ASA 1 <input type="checkbox"/> ASA 4 <input type="checkbox"/> ASA 2 <input type="checkbox"/> ASA 5 <input type="checkbox"/> ASA 3 <input type="checkbox"/> E KEY ASA 1: Healthy Patient ASA 2: Mild systemic disease, no functional limitations ASA 3: Severe systemic disease, functional limitations ASA 4: Severe systemic disease, constant threat to life ASA 5: Moribund patient unlikely to survive 24 hours E: Emergency procedure			
OTHER Anemia Bleeding Tendencies Sickle Cell Trait Transfusion History	<input checked="" type="checkbox"/> WNL Hemophilia Pregnancy				
Physical Examination		LAB STUDIES Hgb/Hct/CBC Electrolytes			
General: <input checked="" type="checkbox"/> WNL WDWN					
HEENT: <input type="checkbox"/> WNL EXT #1 / expose + BWD #11		HCG: PT / INR / PT			
CV: <input checked="" type="checkbox"/> WNL R2R2		Other:			
Pulm: <input checked="" type="checkbox"/> WNL CTAB					
GI: <input checked="" type="checkbox"/> WNL SN7ND					
Neuro: <input checked="" type="checkbox"/> WNL CN II - XII grossly intact					
MSK: <input checked="" type="checkbox"/> WNL S/S Str					
Provider Signature: [Signature] Date: 4AUG 2014		Patient Identification			
Staff Signature: [Signature]		20 [Redacted] MERWIN, DANIEL DENNIS SEX: M DOB: [Redacted] 1985 AGE: 29 USN N11 PO1 NRP STAFF PATIENT 			
*PI. Reassessed, HX / PE / Anesthetic plan unchanged. Patient agrees to proceed. All questions answered. Date/Time: 18 SEP 2014 140645		(NAME: Last, First, MI.) (SS#) (DOB) AR 3117			
Provider Signature: [Signature]					

Date: 9/18/24 Arrival time: 0926 Appointment time: 1000

WRNMMC OMFS Procedure Note

HR 71

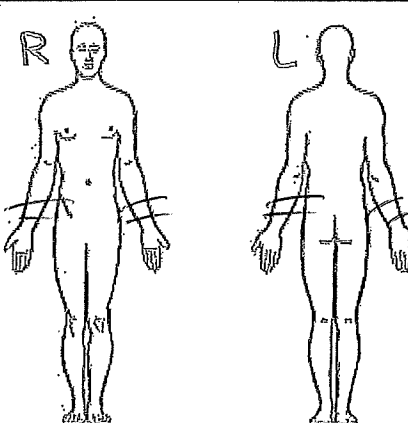
Pre procedure Interview: Name _____ Time: _____ Ht: <u>69</u> Wt: <u>150</u> BP: <u>127/85</u> Resp: <u>18</u> O2 sat: <u>100</u> % T <u>97.7</u>				
From: <input type="checkbox"/> APU <input type="checkbox"/> Home <input type="checkbox"/> Other _____	Patient Identification: <input checked="" type="checkbox"/> Arm band verified with: Patient/parent/other <input checked="" type="checkbox"/> Allergy/Arm band in place	Allergies: <input checked="" type="checkbox"/> NKDA Medication: _____ Reaction: _____ Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No	Limitations: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Language <input type="checkbox"/> Mobility <input type="checkbox"/> Prosthesis <input type="checkbox"/> Other _____	Pre-op Lab Results/Tests: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A HCG: <input type="checkbox"/> N/A <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Age specific and Cultural Needs Addressed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Advance Directive in Chart: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Pre-Op Pain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ (0-10 scale) Location _____ <input type="checkbox"/> Anesthesia Notified
Comments: _____				

Circulator Pre-procedure Interview: Name <u>Dr. Khan</u> Time <u>10:30</u>
--

Patient Identification: <input checked="" type="checkbox"/> Verbal <input checked="" type="checkbox"/> Chart <input type="checkbox"/> Arm band confirmed with patient <input type="checkbox"/> Other _____	Surgical/Anesthesia Consent: <input type="checkbox"/> Procedure verified <input type="checkbox"/> Consent Signed/Dated <input checked="" type="checkbox"/> Surgical Safety Check list Complete	H&P complete: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Pre-Op teaching Completed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No NPO: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes @ time _____	Mental/Emotional Status: <input type="checkbox"/> Alert <input checked="" type="checkbox"/> Calm <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Anxious <input type="checkbox"/> Disoriented <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <input checked="" type="checkbox"/> Age appropriate	Current Health Status: (circle) (1 = healthy 10 = very sick) <u>2</u> 3 4 5 6 7 8 9 10 Why 6 or greater _____ <input type="checkbox"/> Anesthesia Notified
Allergies Verified: <input type="checkbox"/> With patient <input checked="" type="checkbox"/> Against arm band Correct <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Corrected	Accompanying Adult: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Other <u>friend</u>	Location: <u>OMFS wing 2</u> Name: <u>Christina</u> Number: <u>[REDACTED]</u>		

Personal Items: <input type="checkbox"/> None <input type="checkbox"/> Dentures <input type="checkbox"/> Jewelry <input type="checkbox"/> Glasses/contacts <input checked="" type="checkbox"/> other Location of personal items: <u>with escort</u>	Metal in body from previous surgeries: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ESU precautions taken Comments: _____
--	---

Procedure times: In room <u>1040</u> TOTS <u>1050</u> Time out <u>1049</u>	<input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C <input type="checkbox"/> Bed/Gurney
--	--

Positioning and comfort measures: Bed: <input type="checkbox"/> OR Table <input type="checkbox"/> Dental Chair <input type="checkbox"/> Other _____ Body: <input checked="" type="checkbox"/> Supine <input type="checkbox"/> Semi Fowlers <input type="checkbox"/> High Fowlers <input type="checkbox"/> Shoulder Roll Other _____ Head: <input type="checkbox"/> Gel doughnut <input type="checkbox"/> Foam <input type="checkbox"/> Pillow Arms: <input type="checkbox"/> Resting at side BIL/R/L <input type="checkbox"/> Tucked BIL/R/L <input type="checkbox"/> Arm boards <90° BIL/R/L Legs: <input type="checkbox"/> straight <input type="checkbox"/> flexed <input type="checkbox"/> other _____ Bear hugger: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Monitored by anesthesia Temp <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High Warm Sheets: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Egg crate Padding: <input type="checkbox"/> Arms <input type="checkbox"/> Heels <input type="checkbox"/> Head <input type="checkbox"/> Elbows <input type="checkbox"/> Other _____ Safety strap in place: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	 <div style="display: flex; flex-direction: column; align-items: flex-end;"> <div> Safety Strap</div> <div> Skin Lesion</div> <div> Prep Area</div> <div> ESU Pad</div> <div> IV Site</div> <div> SCD's</div> </div>	OR Prep: <input type="checkbox"/> Betadine scrub <input type="checkbox"/> Betadine paint <input type="checkbox"/> Chlorhexidine By: <u>[Signature]</u> Shave Prep: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Shaver <input type="checkbox"/> Clippers Area: _____ By Whom: _____ Foley: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Fr _____ <input type="checkbox"/> Output Noted By whom: _____
SCD: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right		

20/ [REDACTED]
 MERWIN, DANIEL DENNIS
 SEX: M DOB: [REDACTED] 1985 AGE: 29
 USN N11 PO1 NRP

Comments: _____

AR 3118



Intra procedure: Start time: 1053 Anesthesia: ☐ Local ☐ IV Sedation ☒ OPGA ☐ Other _____ Wound Class: (I) II III IVProcedure consented: Extraction of #14's Exs; Bond #1-11

Circulator #1 M. Hartzel IN 1045 OUT 1120 IN _____ OUT _____
 Circulator #2 _____ IN _____ OUT _____ IN _____ OUT _____
 Circulator #3 _____ IN _____ OUT _____ IN _____ OUT _____
 Scrub #1 M. Ortiz IN 1030 OUT 1120 IN _____ OUT _____
 Scrub #2 _____ IN _____ OUT _____ IN _____ OUT _____
 Scrub #3 _____ IN _____ OUT _____ IN _____ OUT _____
 Others: _____ IN _____ OUT _____ IN _____ OUT _____

Staff: Dr. Quintana IN 1045 OUT 1119 IN _____ OUT _____
 Resident: _____ IN _____ OUT _____ IN _____ OUT _____
 Resident: _____ IN _____ OUT _____ IN _____ OUT _____
 Anesthesia: Dr. Rasmussen IN 1045 OUT 1120 IN _____ OUT _____
☐ Staff ☒ Resident ☐ CRNA
 Others: _____ IN _____ OUT _____ IN _____ OUT _____
 Others: _____ IN _____ OUT _____ IN _____ OUT _____

ESU # _____ PAD Lot# _____
 Cut _____ Coag _____ Bipolar _____

Implants: ☒ N/A ☐ log complete
 By whom: _____
 Implant Stickers: _____

Solutions and medications on field:
NaCl Bacitracin ophthalmic oint
 Sterile Water Gelfoam BSS
 Betadine 5% Ophthalmic Prep
 2% Marcaine w/epi ml
 0.5% Marcaine w/epi ml
 0.5% Xylocaine w/epi ml
 0.5% Sensorcaine w/epi ml
 3% Polocaine plain ml
2% Lidocaine w/epi 1.7 ml x 2
 Other _____

Counts: Initial Closing Final
 Sponges: 10 10 0 10 10 10
 Sharps: 6 16 7 17 7 17
 Outcome: Correct MD Notified
☐ N/A ☐ Not Correct ☐ X-ray

Packing Placed in OR: ☐ Yes ☒ No
☐ Throat time in 1056 time out 11:12
☐ Other time in _____ time out _____
 Location nurs

Dressing:
 Dermabond Bacitracin Oint Benzoin Mastisol
 Steri-strips Band aid Jaw Bra
Ghosties Gauze pads ABD Binder
 Other _____

Laser used: ☒ N/A ☐ Log completed Laser operator _____

Family Member Contacted During
 Procedure: No Yes Time: _____

Drains Placed in OR:
N/A Penrose Other _____
 Location _____

Post Procedure Assessment: Stop time: 1115 Out of room: 1120 Arrive Stage II: 1121

Procedure Performed: Extraction of #14's Exs

Bovie Pad site: N/A
 Clear & intact Other _____
 Comments _____

Skin Integrity: (other than incision)
Clear & Intact
 Other _____

Transported from OR:
Dental Chair Bed Walked
 Gurney w/side rails up x2
 With Oxygen Other _____

Cath removed at end of Case:
 Yes No N/A
 By Whom: _____

Post-procedure Condition
Satisfactory Unsatisfactory
 Complications _____
 Comments _____

Transferred TO:
PACU Stage II
 X-ray _____

Patient care turned over to:
 RN: CDR Hartzel

Recovery Tech: _____
 Report Given by:
 RN Circulator Anesthesia

Comments: Dr. Rasmussen stayed w/ pt to talk initial vitals & monitor

Circulator Signature [Signature]
 Recovery Signature _____
 AR 3119

AUTHORIZED FOR LOCAL REPRODUCTION

Medical Record	WRNMMC Request for Administration of Anesthesia and for Performance of Operations and Other Procedures
----------------	--

1. OPERATION or PROCEDURE (Describe)	A. IDENTIFICATION	SIDE (MARK ONE)
Extraction of Teeth # RETAINED H / EXPOSE + BOND #11 And all necessary procedures		<input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input checked="" type="checkbox"/> Left <input checked="" type="checkbox"/> Not Applicable

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):

Doctor will numb my mouth, gums, and teeth. Doctor may cut my gums, bone, and/or teeth. Doctor will remove my specified teeth. Doctor may place sutures to close.

It has been explained to me that during the course of the procedure(s) unforeseen conditions may be revealed which will necessitate extension of the original procedure(s) or different procedure(s) form set forth on this form. I authorize my doctor(s) and their staff to perform those procedure(s) deemed necessary and desirable in the exercise of professional judgment.

Your extracted teeth may be used for research or other teaching purposes.

which is to be performed by or under the direction of **JACKS**

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any, are (if "none", so state):

NONE

6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and the observation of the operation by authorized personnel, subject to the following conditions:

- The name of the patient and his/her family is not used to identify said pictures.
- Said pictures be used only for purposes of medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.
(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in parts A & B must be completed before signing.)

9. COUNSELING Provider: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

Provider's Signature:

[Signature]

Provider's Printed Name:

HARRIS

10. PATIENT/Guardian: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Patient/Guardian's Signature:

[Signature]

18 Sept 2014

0945

Date (MM/DD/YYYY)

Time (HH:MM)

Witness' Signature:

[Signature]

D. UNIVERSAL PROTOCOL / TIME OUT

"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:

- CORRECT PATIENT (Full Name / Birth Date)..... ☒ YES
- CORRECT PROCEDURE ☒ YES
- CORRECT SITE** ☒ YES
- REQUIRED EQUIPMENT AVAILABLE..... ☒ YES N/A ☐
- IMAGES / LABS AVAILABLE, PROPERLY LABELED ☒ YES N/A ☐

** The site must be marked and verified for procedures involving right/left distinction, multiple structures (e.g. digits), or multiple levels (as in spinal procedures) per WRNMMC policies.

Signature below indicates the procedure may be started. If any element is not completed as required, procedure may NOT be started.

Timeout Verified by:


Repondik *[Signature]*

9/18/2014

1049

Date (MM/DD/YYYY)

Time (HH:MM)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - Last, First Middle; ID no. (SSN) or other; Hospital or Medical Facility)		Register #	Ward #
20/ MERWIN, DANIEL DENNIS SEX: M DOB: 1985 AGE: 29 USN N11 PO1 NRP STAFF _____ PATIENT _____ 		REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES Medical Record LOCAL FORM 622 (Rev. 2/2012) Prescribed by GSA/ICMR FMR (41 CFR) 102-193.30(i) DoD Exception to OF 622 approved by GSA	

Taking teeth out is a permanent procedure. Whether the procedure is easy or difficult, it is still a surgical procedure. All surgeries have some risks. They include the following, and others:

1. Swelling, bruising and pain. Stretching of the corners of the mouth that may lead to cracking or bruising.
2. Possible infection that might need more treatment.
3. Dry socket - jaw pain that begins a few days after surgery, that may need more care.
4. Possible damage to other teeth close to the ones being taken out, more often those with large fillings or caps.
5. Numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may need more treatment or may be permanent.
6. Trismus - you can only open your mouth a little. This is most common after wisdom teeth are taken out. Sometimes it happens because of jaw joint (TMJ) problems already there. Damage can occur to the ligaments of the jaw joint (TMJ) from having your mouth open wide and/or for a period of time. This is more common if you already have symptoms or signs. This may need separate additional treatment.
7. Bleeding - oozing can often happen for several hours, but a lot of bleeding is not common.
8. Sharp ridges or bone splinters may form later at the edge of the hole where the tooth was taken out. These may need another surgery to smooth or remove.
9. Sometimes tooth roots may be left in to avoid harming important things such as nerves or a sinus (a hollow place above your upper back teeth).
10. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment (medications or surgery.)
11. It is very rare that the jaw will break, but it is possible in cases where the teeth are buried very deep in their sockets.
12. When donated, processed, or artificial bone substitutes are placed to preserve a socket the pieces might not join together with the natural bone and could be lost.
13. FEMALE PATIENTS ONLY: I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

ANESTHESIA:

1. The anesthetic I have chosen for my surgery is:
- ☐ Local Anesthesia
 - ☐ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
 - ☒ Intravenous Sedation with Local Anesthesia
 - ☐ General Anesthesia with Local Anesthesia

2. ANESTHETIC RISKS include: pain, swelling, bruising, or infection of the vein area where the anesthesia or sedation was given. This could last a long time or make it hard for you to use your arm. This might need special care. There might be numbness that lasts a long time and allergic reactions. You might have nausea and vomiting from the IV Sedation or General Anesthesia, but this doesn't happen often. IV Sedation and General Anesthesia are serious medical procedures.

They are safe, but the rare risks of heart irregularities, heart attack, kidney damage, stroke, brain damage or death are present. I also understand there is a risk of an unintentional deep plane of anesthesia might be obtained that may require interventions to maintain my respiratory and cardiovascular status.

3. YOUR OBLIGATIONS FOR IV SEDATION OR GENERAL ANESTHESIA ARE:

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
- B. During recovery time you should not drive, operate complicated machinery or devices, or make important decisions.
- C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!
- D. However, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications directed by us, with only a small sip of water.

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

Note Type: Free Text Narrative Summary
 Note Time: N/A
 Last Stored: 1314 12 Oct 2012
 Stored By: SALTER, CAROLYN A CPT 1890

THREE COPIES WILL AUTOMATICALLY PRINT
 OUT. PATIENT SIGNED COPY FOR INPATIENT
 RECORD. TWO COPIES FOR PATIENT - ONE
 FOR OUTPATIENT RECORD AND ONE FOR
 PERSONAL REFERENCE.

WRNMMCB NARRATIVE SUMMARY & DISCHARGE INSTRUCTIONS

ADMISSION DATE: 11Oct2012
 DISCHARGE DATE: 12Oct2012
 Primary Care Manager: UDE, ASSUMPTA O
 ADMITTING DIAGNOSIS: COLON MASS
 DISCHARGE DIAGNOSIS:
 1. colonic inflammation

CONDITION AT DISCHARGE

Comment on the physical and cognitive function of patient:

The patient was afebrile with normal and stable vital signs, tolerating regular diet, ambulating without problems and pain was well controlled on oral pain medicine.

Clinic Follow Up

CLINIC NAME/PHONE #	LOCATION	APPT. (DATE/TIME)	Clinic Physician	NEXT
.1 Gastroenterology Clinic 295-4600	WRNMMC	TUE 23 OCT at 0800		
.2				
.3				
.4				
.5				
.6				
.7				
.8				

 Patient is responsible for calling the clinic directly to
 schedule and confirm each of these appointments. You may also
 schedule/confirm appointments through the Appointment Call
 Center at (301)295-NAVY (301-295-6289).

Pending Test Results

Name of pending test results	Follow up appointment to discuss final results
1.	

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Discharge Medications				
Drug Name	Dose	Route	Frequency	Discharge Plan for Medication
DIET - ACTIVITY RESTRICTIONS - WOUND CARE - INSTRUCTIONS				
DIET: REGULAR ACTIVITY RESTRICTIONS: none WOUND CARE INSTRUCTIONS: N/A SPECIAL INSTRUCTIONS: none Symptoms that warrant seeking medical attention: Go the ER (301-295-4810) or call the General Surgery clinic 301-295-4442 or AFTER HOURS call CDO desk at 301-295-4611 and have them page the Surgery resident on call for: <div style="margin-left: 400px;"> -Temperature >101.4 F, chills/sweats -Pain not controlled on oral medications -Intractable nausea or vomiting -Anything you believe warrants the attention of a physician </div>				
Heart Failure Instructions				
Heart Failure	Yes	X	No	
DISPOSITION/RECEIVING ACTIVITY (ACTIVE DUTY ONLY)				
ACTIVE DUTY: X YES RECOMMENDED CONVALESCENT LEAVE: 0 DAYS IN THE LINE OF DUTY? X YES DISPOSITION: FULL DUTY MEDICAL BOARD: X NO RECEIVING ACTIVITY: PARENT COMMAND				
ADMISSION DATA				
HISTORY: <p>HPI: 27 yo M with recent URI symptoms presents to ER last evening after sharp attack of epigastric abdominal pain after eating 3 slices of pizza. He reports feeling back pain early this afternoon, which he treated with a nap. Last evening, he ate 3 slices of pizza and took a shower when he experienced severe epigastric, sharp, throbbing abdominal pain that caused him to become nauseated. He drove himself to the ER describing that the position of sitting up made the pain worse. He did not vomit, reports passing flatus, last BM was just prior to this at 2100 last night, which was non-bloody and normal.</p> <p>He reports intermittent abdominal pain throughout his life. The pain was as frequent as daily, when he exercised regularly, but has since tapered to twice a week vague abdominal pain that resolves. Family physicians have told him he has "IBS" without any other diagnosis. Most notably, he had an attack of abdominal pain with 1 bloody bowel movement during boot camp at Great Lakes for which he was admitted, CT scanned and underwent sigmoidoscopy to transverse colon, which could not be completed due to discomfort. Demonstrated normal findings with internal hemorrhoids. He has soft regular bowel movements once a day.</p> <p>PMH: childhood asthma, internal hemorrhoids; intermittent sun-related rash PSH: PRK, tonsillectomy Allergy: cats MEDs: non, aleve and Dayquil this weekends</p>				

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
USN ACTIVE DUTY ABAA
WRNMMC Bethesda 11Oct2012
PERSONAL/PRIV ACT 1974
Clinical Notes

Family: no history of colon cancer, IBS/IBD or Crohn's disease; DM and Heart dz
 Social: no tobacco use, occasional alcohol use; runs 20-30 miles per day, this has decreased over the last month.

PERTINENT PHYSICAL EXAM FINDINGS ON ADMISSION:

AFVSS - 97.4, 82, 111/61, 15, 96% ra
 Gen A&Ox3, NAD now that received pain medication. Non toxic appearing.
 Heart: RRR no mrg
 Lungs: ctab
 Abd: soft, flat, tenderness in epigastrium, no tympany, no hernias, bowel sounds normal
 Ext: no rash, no edema
 Back: no CVA tenderness, no rash

PERTINENT LAB DATA ON ADMISSION:

10.1>14.2/40.9<246 143/4.3/105/32/14/0.88<106 9.8

Colitis at the level of the hepatic flexure with stool filled cecum and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease or ulcerative colitis. Clinical correlation is recommended.

HOSPITAL COURSE

HOSPITAL COURSE:

The PT presented to the ER with abdominal pain on the evening of 10 OCT 12 - 11 OCT 12. He initially had an acute abdominal series, which revealed nonspecific, nonobstructive bowel gas pattern. He then had an abdominal CT, which revealed non-specific focal colitis at the level of the hepatic flexure with proximal stool retention and fecalization of small bowel. The Pt was admitted for further evaluation. On 11 OCT, he was placed on a clear liquid diet and started bowel prep. On 12 OCT he underwent a colonoscopy, which was normal. Biopsies were obtained and results are pending. Pt was discharged home in stable condition with appropriate follow-up.

DID AN ADVERSE DRUG REACTION OCCUR DURING THIS PATIENT STAY? No

DRUG: none

PROCEDURES PERFORMED: X YES

#1 colonoscopy DATE: 12Oct2012 RESPONSE: no complications

CONSULTATIONS: X NONE

#1

Pneumovax Given this YES/NO
 Hospitalization?

IF "YES", GIVE DATE;
 IF "NO" GIVE REASON:

WRNNMC Guidelines for Administration of 23-Polyvalent Pnuemococcal Vaccine: Check box to right to read instructions:

Td Given?

Tobacco use within last 12 months? Yes/No No Diabetes: Yes/No No

SIGNATURES

Sign Name and Date below as appropriate role and chck box as electronically signed

ATTENDING:	DATE:	Electronically Signed
RESIDENT:	DATE:	Electronically Signed
INTERN: Carolyn Salter	DATE: 12Oct2012	X Electronically Signed
SUB INTERN:	DATE:	Electronically Signed

X COPY OF NARRATIVE SUMMARY/DISPOSITION GIVEN TO PATIENT.

I understand the discharge instructions as written above and have no further questions.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNNMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

PATIENT/SIGNIFICANT OTHER SIGNATURE _____

RN REVIEWING DISCHARGE INSTRUCTIONS WITH PATIENT _____

Health Promotion Classes from the Integrated Health Services

Free Classes for Active Duty and their Family, Retirees, Reservists, Staff and Contractors. Call 301-295-0105 for more information.

*Anger Management
Cholesterol Control Class
Diabetes Survival Skills Class
High Blood Pressure Class
Pain Management
Pre-Diabetes Class
Surviving Change/Stress
Tobacco Cessation
Walk It Out!
Weight Management Basics*

Note Version Date:10-27-2011

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

Note Type: Teaching Note
 Note Time: N/A
 Last Stored: 1145 12 Oct 2012
 Stored By: THOMAS, KRISTA C 2LT 1546 Crum, Katelynn R 3432

TEACHING NOTE*Support Services to Consult For Discharge***Educational Reassessment**Learner(s): Patient ☒ Significant Other

Patient

Any difficulty reading? Yes No ☒

Primary Language: ENGLISH

Readiness/Motivation to learn:

Asks for resources Asks questions

Barriers to learning:

None Identified

Education Level:

Technical School

Learns best by:

Doing Listening Instruction

Discussion Written Instructions

Repetition Demonstration Audiovisual

Diagnosis/Condition	Diet/Nutrition	Meds/DC Meds	Wound Care	Procedure
Chemotherapy	Ostomy/Drains	Central Lines	Social Services	Equipment
Community Resources	Activity/Lifestyle Mod		<input checked="" type="checkbox"/> Miscellaneous	Infection Control

Miscellaneous

#1 Teaching Topic: Welcome to 5E: Policies, ordering meals, call bell, orientation to floor Date 11Oct2012

Method of Teaching: DISCUSSION,

Evaluation of Teaching: Patient able to verbalize. states understanding of information given

Reassessment of Teaching: ☒ Teaching Complete Needs Reinforcement

#2 Teaching Topic: POC night shift 1900-0700: medication review, IVF, VS, AM labs, NPO at midnight, completing moviprep. Date 11Oct2012

Method of Teaching: DISCUSSION,

Evaluation of Teaching: Patient able to verbalize.

Reassessment of Teaching: ☒ Teaching Complete Needs Reinforcement

#3 Teaching Topic: Plan of care for shift to include NPO until colonoscopy completed, ambulate often, VS, IVF, and comfort rounds Date 12Oct2012

Method of Teaching: DISCUSSION,

Evaluation of Teaching: Patient able to verbalize. states understanding of information given

Reassessment of Teaching: ☒ Teaching Complete Needs Reinforcement**From Nursing Hx & Assessment**

Patient

Significant Other

Primary Language:

Primary Language:

Yes No ☒

Any difficulty reading?

Yes No

Asks for Resources. Asks Questions.

Readiness/Motivation to learn:

Barriers to learning:

Technical School

Education Level:

Doing Listening Instruction

Learns best by:

Discussion Audiovisual

Demonstration Repetition

Written Instructions

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

BIOGRAPHICAL INFORMATION

Admission Date: 11Oct2012 Primary Diagnosis: COLON MASS
 Hospital Days: 2 Reason for Adission: Colon Mass
 Admitting Physician: Attending Physician: KINDELAN, TAMARA JEAN
 Allergies: OTHER
 Religion: NoPreference DOB: 16Feb1985 Age: 32 Sex: M Race: OTHER
 Military Status: USN ACTIVE DUTY Rank: PO2 Marital Status: SINGLE

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: Nursing Admission Hx & Assess
 Note Time: N/A
 Last Stored: 1853 11 Oct 2012
 Stored By: Crum, Katelynn R 3432

NURSING ADMISSION HX & ASSESS

Date and Time Initiated: 1030 11Oct2012

Rank, Svc: P02

Military Status: USN ACTIVE DUTY

Duty station: NIOC PCOL/CYBDEF

Admitted From: E.R.

Mode: Wheelchair

Accompanied By: ER Staff

Admission Type: Emergent

Admitting Dr: MD O'Donnell

Religion: NoPreference

Command Interest:

Emergency Contact: CTRI Guterrez

Emergency Phone: 850-375-8207

Patient has the appropriately labeled armbands in place: yes

ALLERGIES

#1 Type: NONE

Name:

Symptoms:

Onset

Severity:

Other Symptom:

Date:

SNO ME

D

Code:

RxNor

Last Modification Date:

Inactive:

m
Code:**Unit Orientation****X 5 East**

X Patient provide unit orientation including operation of call bell, bathroom, bed controls, telephone, TV/Radio/Lights, Visiting hours, Smoking policy.

Significant other provided unit orientation including visiting hours and smoking policy.

Patient prefers to be addressed as: Daniel

X Call bell tested with the patient and found to be working.

X Valuables policy Valuables status: with pt, pt accepts responsibilities

X Unit Policies Pt aware of and discussed \" Pt Bill of Rights\" Pt aware last named displayed on Unit's Status Board 5E Welcome Booklet given to patient

Advanced Directives

Patient's situation at the time of admission precludes the discussion of advance directives. (i.e., suicidal ideations, confused, coma, under the influence of alcohol or drugs.)

Do you have an advance directive? Yes X No

Does the patient want information on advance directives? Yes X No

Tobacco

Yes No X Are you currently using or have you used tobacco?

If PRIOR use, enter when quit Date

Yes No X Do you drink alcohol?

Yes No X Do you use any Illicit Drugs?

Yes X No Do you drink caffeine products i.e. Coffee, coke?

Type, quantity, and frequency 2 cups coffee daily

Pneumococcal Vaccination Screening

Yes No X Age: 32 Is patient age 65 or older?

Yes/No No Patient has previously received the pneumococcal vaccination (pneumovax)?

If NO please select: Patient Refuses

Yes/No

Pharmacy

Yes No X Do you have any drug allergies/intolerances?

Yes No X Are you currently taking any medications?

Yes No X Are you taking any over the counter herbs or herbal supplement?

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Pharmacy Consult Assessment	
Yes	No <input checked="" type="checkbox"/> Age: 32 Is patient age 65 or older?
Yes	No <input checked="" type="checkbox"/> Is the admission due to a possible adverse drug reaction (ADR)?
Yes	No <input checked="" type="checkbox"/> Is the patient taking five or more regularly scheduled medications?
Yes	No <input checked="" type="checkbox"/> Is the patient currently receiving anticoagulant therapy?
N	Are there any yes answers in the Pharmacy Consult Assessment?
Nutrition	
Yes	No <input checked="" type="checkbox"/> Is patient using enteral or parenteral nutrition support?
Yes/No	No Does patient have NEW onset diabetes?
Yes	No <input checked="" type="checkbox"/> Has patient had an unintentional weight loss >10 lbs.in the last three months?
N	Are there any yes answers in this area?
Social Work	
Yes	No <input checked="" type="checkbox"/> Has patient or family requested referral to a social worker?
Yes	No <input checked="" type="checkbox"/> Has patient been living outside of the continental US (OCONUS)?
Yes	No <input checked="" type="checkbox"/> Does the patient live alone and/or is the patient unable to care for him/herself or is the patient the primary caregiver for a family member or significant other?
Yes	No <input checked="" type="checkbox"/> Was the patient admitted because of suspected abuse, neglect or medical non-compliance?
Yes	No <input checked="" type="checkbox"/> Has the patient sustained multiple traumas, have multiple medical problems or had 2 or more unscheduled hospital admissions within a 2 month period?
Yes	No <input checked="" type="checkbox"/> Is the patient HIV+ or have AIDS?
Yes	No <input checked="" type="checkbox"/> Has the patient had or is the patient scheduled to have an amputation, total joint replacement, radiation therapy, cardio-thoracic surgery or chemotherapy?
Yes	No <input checked="" type="checkbox"/> Will the patient need, after discharge from NNMCM, referral to a nursing home, extended care or assisted living facility or the following home care: skilled nursing care, physical therapy, durable medical equipment, oxygen, intravenous therapy or TPN?
Yes	No <input checked="" type="checkbox"/> Is the patient pregnant and unmarried or wanting to place a newborn for adoption?
Yes	No <input checked="" type="checkbox"/> Has the patient been admitted because of intrauterine demise or known fetal anomalies or does the patient have an infant in the NICU?
N	Are there any yes answers noted in this area?
Physical / Occupational Therapy	
Yes	No <input checked="" type="checkbox"/> Does pt require assistance with ambulation or ADL's at the time of admission?
Yes	No <input checked="" type="checkbox"/> Does the patient have a recent history of FALLS?
Yes	No <input checked="" type="checkbox"/> Is the patient's sitting balance, standing balance or gait UNSTEADY?
N	If YES then consult Physical Therapy via MD.
Physical Exam and History	
Admission Vital Signs:	
T 98.8	F P 94 R 16 BP 142 / 84
Height: 5.00 ft 9.0 in 175.3 cm	BMI: 21.65
Weight: 147 lbs 0.0 oz 66.56 kg	Dry Weight (For Drug Calc): 66.56 kg BSA: 1.811 m ²
Reason for Admission: Colon Mass	DOB: 16Feb1985
Primary Diagnosis: COLON MASS	Patient's chief complaint LLQ pain
History obtained from: X Patient	Family member/Significant other
Neurological / Psychological	
History: Headache: 2-3 per week	
Orientation: Alert and oriented to person, place, and time	Sleeping patterns Normal
Speech: Clear	EOM's: Intact, six cardinal positions
Visual Changes: None	Sensation: Touch and sensation intact s numbness or parathesia.
Auditory Changes: No reported hearing loss	
Admitted with restraints applied.	
Teaching Learning Assessment	

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
USN ACTIVE DUTY ABAA
WRNMMC Bethesda 11Oct2012
PERSONAL/PRIV ACT 1974
Clinical Notes

Patient Primary Language: English		Significant Other Primary Language:	
Any difficulty reading?	Yes	No	X
Readiness/Motivation to learn:	Asks for Resources. Asks Questions.		
Barriers to learning:	None Identified		
Education Level:	Technical School		
Learns best by:	Doing Listening Instruction Discussion Audiovisual Demonstration Repetition Written Instructions		
Respiratory			
Yes/No	No	CURRENT Pneumonia Diagnosis (or suspected)?	
Yes/No	No	Persistant Asthma Diagnosis (or suspected)?	
Yes/No	No	COPD (emphysema or chronic bronchitis) Diagnosis?	
History Asthma			
Respiration	Normal	Thoracic Expansion: Bilateral and Equal	
Lung Sounds	CLBI	Cough character/quality Non-productive, no secretions.	
Oxygen Device and Flowrate	Room Air		
Tracheostomy:			
Chest Tubes/Mediastinals:			
Cardiovascular			
History No known problems			
Admitted with CHF exacerbation?	Yes	X	No
Heart Sounds	+	Edema	None
All Extremities warm & dry and all peripheral pulses strong & equal		X	Yes No
Are SCDs/TEDS ordered for the patient?		X	Yes No N/A
Are the SCDs/TEDS On/Off?		X	On Off
Comment: Pt denies chest pain			
Gastrointestinal			
Last time eat or drink? 1900 11OCT2012			
History Nausea; Pt reports having GI issues throughout his life. MD's r/o IBS and thought to be d/t dairy and pt's extensive running habits. Pt reports that he has not had GI issues for about a year.			
Oral Health: X Teeth Dentures:			
Trouble Chewing Carries:			
Abdomen	S,NTND	Bowel Activity	BS+
Nasogastric/Enteral Feeding Tubes:		Bowel patterns within normal? X Yes No	
Stoma:			
Abdominal Drains:			
Genito-urinary			
Gender: M	Male	X	Female
History No known problems			
Monthly Testicular exam?	Yes	X	No
Last prostate exam?		2005	
Foley Cath			
Urine Output Voiding spontaneously without difficulty			
Continuous Bladder Irrigation:			
Urostomy:			
Ureteral Stents:			
Suprapubic:			
Endocrine			
History No known problems			
DIABETES?	YES	X	NO
Integumentary (skin)			
History Intact			

DODID:	
MERWIN, DANIEL DENNIS	
FMPL6SSN:	■■■■■■■■■■
USN ACTIVE DUTY ABAA	
WRNMMC Bethesda	11Oct2012
PERSONAL/PRIV ACT 1974	
Clinical Notes	

Skin Color	Normal for race	Skin Temp	Warm & dry	Skin Intact	X	Skin Integrity	Impaired
BRADEN SCALE- Skin Breakdown Assessment Tool							
Braden Scores: [15-18 Low Risk] [13-14 Moderate Risk] [12 or less High Risk]							
Sensory perception	4	No impairment					
Moisture	4	Rarely moist					
Activity	3	Walks occasionally					
Mobility	3	Slightly limited					
Nutrition	2	Probably inadequate					
Shear and friction	3	No Apparent problem					
Braden Scale Score	19	Score > or = 13 hospital mattress appropriate, Patient must turn or be turned every 2 hours. Then skip next question.					
Is the Braden Score 12 or less? Yes							
Musculo-Skeletal							
History No known problems							
Fall Risk Precautions							
CALL BELL WORKING AND WITHIN REACH yes							
Assess patient's fall risk upon admission and every shift, change in status, transfer to another unit and discharge.							
NMMC Fall Risk Assessment							
FALL RISK FACTOR CATEGORY							
Scoring NOT completed for the following reason(s.) (please check yes or no)							
				Yes	No		
Complete paralysis or completely immobilized.							X
Implement basic safety (low fall risk)							
Patient has a history of more than one fall within 6 months before admission.							X
Implement HIGH fall risk throughout hospitalization.							
Patient has experienced a fall during hospitalization.							X
Implement HIGH fall risk throughout hospitalization.							
Patient is deemed high fall risk per protocol. (e.g. seizure precautions)							X
Implement HIGH fall risk throughout hospitalization.							
Complete the following and calculate Fall Risk Score							
Choose ONE (1) in each category						Points	
1. Age:	<=60 years					0	
2. Fall History:	N/A					0	
3. Medications:	None prescribed					0	
Includes PCA/Opiates, Anti-convulsants, Diuretics, Hypnotics, Laxatives, Sedatives, and Psychotics							
4. Elimination: (Bowel and Urine)	N/A					0	
5. Patient care equipment: Any equipment that tethers patient. (i.e. IV infusion, chest tube, idwelling catheter, SCDs, etc.)	One present					1	
Choose ALL that apply							
6. Mobility:	Ambulates/Transfers with STEADY gait					0	
	Ambulates/Transfers with STEADY gait					0	
	Ambulates/Transfers with STEADY gait					0	
7. Cognition:	No mental status changes					0	
	No mental status changes					0	
	No mental status changes					0	
Total Score:						1	
Fall Risk Score 0-5 Points = Low Risk							

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
USN ACTIVE DUTY ABAA
WRNMMC Bethesda 11Oct2012
PERSONAL/PRIV ACT 1974
Clinical Notes

Fall Prevention Interventions:

Basic Fall Risk interventions (ALL PATIENTS):

Direct Care:

1. Obtain patient history of falls and mobility impairments in a language the patient understands.
2. Assess the patient's coordination and balance before assisting with transfer and mobility activities.
3. Orient patient to surroundings, include bathroom, location, use of bed and call light.
4. Ensure call light and frequently used items are within reach of patient.
5. Use non-slip footwear.
6. Answer call lights promptly.
7. Saline lock all IV's, except if infusion is in progress.
8. Display special instructions signs for vision and hearing devices. Encourage patients to wear eyeglasses and hearing devices.

1. Noted: Above measures were implemented

Education:

1. Instruct patient about medication that may affect balance or cause orthostatic hypotension.
2. Encourage patient an family to call staff when assistance is needed.

1. Noted: Above measures were implemented

Equipment:

1. Request for the family to bring in home mobility assist devices as appropriate.
2. Keep bed in lowest possible position.
3. Keep top two side rails up on wards and all side rails up in ICU.
4. Secure locks on bed, stretcher, and wheelchair.

1. Noted: Above measures were implemented

Environment:

1. Provide adequate lighting, especially at night.
2. Remove excess equipment, supplies, furniture from rooms and hallways. Keep floors clutter and obstacle free. (Special attention to path between bed and bathroom or bedside commode.)
3. Coil and secure excess electrical and telephone wires.

1. Noted: Above measures were implemented

Invasive Devices Screen

X Peripheral Line #1 (PIV)

Management (Mgmt) Assessment

Placement 18G RAC

Gauge 18G

Site Eval Norm

Start Date 10OCT2012

Days In 0

Central Line/Cordis

Dialysis Cath

Comfort

Is patient in pain? Yes X No

PCA

Epidural

Summary Statement by Registered Nurse

PLAN OF CARE INITIATED WITH PATIENT?

Yes X No

PLAN OF CARE INITIATED WITH SIGNIFICANT OTHER?

Yes No X Indicate Reason: Not at bedside

Education Provided to patient and/family and comprehension evaluated by:

verbalize understanding

Other education comment:

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: Admission Data Screen
 Note Time: N/A
 Last Stored: 0927 11 Oct 2012
 Stored By: HILLARD, CRYSTAL L CIV 9790

Admission Information

Name: MERWIN, DANIEL DENNIS Admit Date: 11Oct2012 Time: 0925
 FMP-SSN: 20- [REDACTED] Hospital Register Number: 438363
 Patient Type: In-Patient Out-Patient
 Sex: M Race: OTHER
 Rank: PO2
 Military Status: USN ACTIVE DUTY
 Religion: NoPreference DOB: 16Feb1985 Age: 32
 Marital Status: SINGLE

ALLERGIES

#1 Type: NONE Name: Symptoms:
 Onset Severity: Other Symptom:
 Date:
 SNAME
 D
 Code:
 RxNor Last Modification Date: Inactive:
 m
 Code:

Reason for Admission: Colon Mass
 Primary Diagnosis: COLON MASS Hospital Days: 2
 Attending Physician: KINDELAN, TAMARA JEAN
 MEPRS Code: ABAA MEPRS Code Description: INPATIENT GENERAL SURGERY
 Primary Care Manager: UDE, ASSUMPTA O

Duty Station/Office Phone: NIOC PCOL/CYBDEF Home Phone: 8506028501
 Patient Address: 7789 ARUNDEL MILLS BLVD
 City: HANOVER State: MARYLAND Zip: 21076

Emergency Contact: CTRI Guiterrez

Phone: 850-375-8207

Height: 5.00 ft 9.0 in 175.3 cm
 Weight: 147 lbs 0.0 oz 66.56 kg BSA: 1.811 m²

HIPAA Provider Taxonomy: KINDELAN, TAMARA JEAN

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: DOD ED Transfer
 Note Time: N/A
 Last Stored: 0829 11 Oct 2012
 Stored By: THRASHER, ROBIN S CIV 6843

Rev. 2012.08.31.1000

ED Transfer Report**MERWIN, DANIEL DENNIS**Patient Gender: **M**

From DOD ED Medical Record:

Disengaging **General Surgery**
Service:

History of Present Illness:

**STS FLU LIKE SYMP NOW HAVING ABD PAIN AND DRY HEEVES.STS PAIN TO
STERUM AND UPPER ABD AREA.**

Allergies

OTHEROther Allergies **OTHER**Dx 1: **Large bowel obstruction**

Latest Vital Signs:

BP: **106 / 64** HR: **63** RR: **14** TempF: **98.3** SpO2: **96** Pain Level: **5/10**

With the following:

X Belongings: **With Patient and/or Family**

X Authority for Admission completed @

X Labs/Radiology complete: **See Results in Essentris and CHCS I**

Recent Medications given:

Medications Due within 1-2 hours:

Report called by ED Nurse: **THRASHER, ROBIN S CIV 6843** Time/Date: **0829 11Oct2012**

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: Free Text H and P
 Note Time: N/A
 Last Stored: 0642 11 Oct 2012
 Stored By: O'DONNELL, MARY T CPT 1687

WARNING:

PLEASE COMPLETE THE MEDICATION RECONCILIATION NOTE BEFORE SAVING THIS H&P

WRNMMCB ADMISSION HISTORY & PHYSICAL EXAMINATION

DATE/TIME INITIATED: 0615 11Oct2012

Is this a readmission within the past 30 days? Yes No

Service: GENERAL SURGERY

Note By: O'DONNELL, MARY T CPT 1687

HISTORY:

HPI: 27 yo M with recent URI symptoms presents to ER last evening after sharp attack of epigastric abdominal pain after eating 3 slices of pizza. He reports feeling back pain early this afternoon, which he treated with a nap. Last evening, he ate 3 slices of pizza and took a shower when he experienced severe epigastric, sharp, throbbing abdominal pain that caused him to become nauseated. He drove himself to the ER describing that the position of sitting up made the pain worse. He did not vomit, reports passing flatus, last BM was just prior to this at 2100 last night, which was non-bloody and normal.

He reports intermittent abdominal pain throughout his life. The pain was as frequent as daily, when he exercised regularly, but has since tapered to twice a week vague abdominal pain that resolves. Family physicians have told him he has "IBS" without any other diagnosis. Most notably, he had an attack of abdominal pain with 1 bloody bowel movement during boot camp at Great Lakes for which he was admitted, CT scanned and underwent sigmoidoscopy to transverse colon, which could not be completed due to discomfort. Demonstrated normal findings with internal hemorrhoids. He has soft regular bowel movements once a day.

PMH: childhood asthma, internal hemorrhoids; intermittent sun-related rash

PSH: PRK, tonsillectomy

Allergy: cats

MEDs: non, aleve and Dayquil this weekends

Family: no history of colon cancer, IBS/IBD or Crohn's disease; DM and Heart dz

Social: no tobacco use, occasional alcohol use; runs 20-30 miles per day, this has decreased over the last month.

Tobacco Screening

Tobacco use in last 12 months? Yes/No No

ALLERGIES

IS THIS ADMISSION RELATED TO AN ADVERSE DRUG REACTION? No

DRUG: NONE

Please enter "NONE" or the "NAME OF THE DRUG"

#1 Type: NONE

Name:

Symptoms:

Onset

Severity:

Other Symptom:

Date:

SNAME

D

Code:

RxNor

Last Modification Date:

Inactive:

m

Code:

MEDICATION RECONCILIATION

Drug Name	Dose	Route	Frequency	Last Taken Date/Time	Medication Admission Plan
-----------	------	-------	-----------	----------------------	---------------------------

Medication Precautions

Is the patient pregnant? Yes No

Is the patient breastfeeding? Yes No

**** If any of the above answers are yes, please write an order to notify the Pharmacy that the patient is breastfeeding and a Pharmacy Consult for any potential medication contraindications.****

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3135

PHYSICAL EXAMINATION

AFVSS - 97.4, 82, 111/61, 15, 96% ra
 Gen A&Ox3, NAD now that received pain medication. Non toxic appearing.
 Heart: RRR no mrg
 Lungs: ctab
 Abd: soft, flat, tenderness in epigastrium, no tympany, no hernias, bowel sounds normal
 Ext: no rash, no edema
 Back: no CVA tenderness, no rash

LABORATORY DATA/DIAGNOSTIC IMAGING DATA/ECG DATA

10.1>14.2/40.9<246 143/4.3/105/32/14/0.88<106 9.8

Colitis at the level of the hepatic flexure with stool filled cecum and fecalization of small bowel.
 Findings are nonspecific and may be representative of an acute infection or inflammatory etiology
 such as Crohn's disease or ulcerative colitis. Clinical correlation is recommended.

Disease Management

Was the patient admitted with a new diagnosis or a suspicion of the following?

NO Acute MI/Coronary Syndrome
 No CHF Exacerbation
 NO Pneumonia

DVT Prophylaxis

Please assess the need for pharmacological and/or mechanical prophylaxis.

Does the patient need DVT prophylaxis? Yes X

Thrombosis Risk Factor Assessment Score See assessment scale:

Patient is low risk

DIAGNOSTIC ASSESSMENT & PLAN

A/P: 27 yo M with intermittent abdominal pain throughout his life with acute exacerbation last evening with no flatus and BM since yesterday evening. CT scan suggestive of inflammation in right colon. Needs colonoscopy and further lab work up to rule out malignancy.

- Admit to 5E, NPO, IVF
- Moviprep
- Colonoscopy later today
- CEA, pANCA, ANCA, ASCA

X RESIDENT

Resident: O'DONNELL, MARY T CPT 1687

DATE: 11Oct2012

X Electronic Signature

Name and date entered in this field counts as electronic signature.

Resident Comments:

Fellow:

Fellow:

Electronic Signature

Fellow Comments:

ATTENDING:

Staff Attending:

Electronic Signature

Attending Comments:

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: Medication Reconciliation
 Note Time: N/A
 Last Stored: 0615 11 Oct 2012
 Stored By: O'DONNELL, MARY T CPT 1687

MEDICATION RECONCILIATION COMPONENTS

Service: GENERAL SURGERY

Admission related to: ABDOMINAL PAIN

Date of Birth: 16Feb1985

Age: 32

Sex: M

Weight: 147 Lbs

0.0

oz

66.56 Kgs

Are you:

Pregnant

Lactating

ALLERGIES☒ Patient does not have any medication allergies.

#1 Type: NONE

Name:

Symptoms:

Onset

Severity:

Other Symptom:

Date:

SNOOME

D

Code:

RxNor

Last Modification Date:

Inactive:

m

Code:

H & P ELEMENTS**Current Medications**

Patient not taking any medications at time of admission to include: herbals, OTCs, dietary supplements, eye drops, inhalers, vitamins and illicit drugs.

Drug Name	Dose	Route	Frequency	Medication Admission Plan
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Medications Reconciled by Pharmacy

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: DOD ED Medical Record
 Note Time: N/A
 Last Stored: 0647 11 Oct 2012
 Stored By: LEE, AKINNOLA S SMITH-COLEMAN, DORETHEA 4534 KING, LYNIAIRE R CIV 6971
 PUTKO, ROBERT M LT 2636 HARDWARE, LESLIE W CIV 4699

LOINC 34108-1 Rev. 2012.08.17.1200

EMERGENCY DEPARTMENT MEDICAL RECORD

ED ARRIVAL DATE 10Oct2012 CHECK-IN 2112 Arrival By PRIVATELY OWNED VEHICLE Birthdate 16Feb1985
 TIME

Patient Info: Telephone, Work Phone, Address, City, State, Zip

HANOVER

MARYLAND

Sponsor Info: Name, Rank, Service, Duty Phone, PatCat, UIC

MERWIN, DANIEL DENNIS PETTY OFFICER NAVY
 SECOND CLA

Sponsor Address, City, State, Zip, Station

FORT GEORGE G MARYLAND 20755
 MEADE

Primary Care Manager UDE, ASSUMPTA O

Contact info for 48hrs:

1. TRIAGE

Triage Time 2130 Age Calculated Age 32

Chief Complaint ABDOMINAL BACK CHEST PAIN

Triage HPI STS FLU LIKE SYMP NOW HAVING ABD PAIN AND DRY HEEVES. STS
 PAIN TO STERUM AND UPPER ABD AREA.

BP 142 / 84 Source R HR 94 RR 16 SaO2% 98 RA Temp 98.8 F 37.1 C Oral

Weight 66.56 kg Tetanus Date Current

kg

PEDIATRIC IMMUNIZATIONS UTD?

Yes

Do you have any Pain? Yes

Location (select multiple)	Factors	Quality	Assessment	Score	Time/ Duration
ABD		SHARP/	Strong	9	INT

Gender M

Abuse/Neglect?

Have you ever been emotionally or physically abused or threatened by your partner or someone close to you?
 Have you ever been hit, slapped, kicked, pushed or otherwise physically hurt?

X No

Sexual Assault?

Has anyone ever forced you to engage in any type of sexual activity
 or touched you in a way that made you feel uncomfortable?

X No

Mental Health Issues?

X No

Primary Language English

Other Communication Needs None

Is the Patient High Risk for Falls or have a History of Falls? No

TRIAGE ACTION(S)

U/A

TRIAGE ACUITY 3

TRIAGED BY SMITH-COLEMAN, DORETHEA 4534

TRIAGED TO Waiting Room

X 2. BEDSIDE NURSING ASSESSMENT

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

X GENERAL APPEARANCE	Well nourished, Healthy in appearance		
X MENTAL STATUS	Awake, Alert, Oriented X3		
X NEUROLOGICAL	X Normal: PERL, Strength and Sensation all four extremities, Steady Gait, Speech Normal		
X HEENT	Detailed Assessment		
X CARDIOVASCULAR	Detailed Assessment		
	Comments: Report sternum pain/cp with inspiration. State " I never felt pain like this. Report increasing back pain onset yesterday. State had "flu like" sx (congestion and feverish feeling) onset 5days ago however state sx resolving.Denies n/v. Report "sternum pain causes me to take shallow breaths".		
X PULMONARY	Detailed Assessment		
	Comments: Report sternum pain/cp with inspiration. State " I never felt pain like this. Report increasing back pain onset yesterday. State had "flu like" sx (congestion and feverish feeling) onset 5days ago however state sx resolving.Denies n/v. Report "sternum pain causes me to take shallow breaths".		
X GASTROINTESTINAL	X Normal: Denies nausea vomiting diarrhea, Abdomen soft non-tender non-distended, Bowel sounds present in all four quadrants		
X GENITOURINARY	X Male		
	Genitals: No Complaints or Concerns	Urine: Clear yellow urine and urinates without difficulty	
X SKIN	X Appearance: Color normal for patient Warm, dry, and intact		
	Turgor: Good turgor <1-2 seconds		
X MUSCULOSKELETAL	#1 Location: back/sternum General: Pain Weight Bearing: Yes		
	Cap Refill: < 2 seconds	Edema: None	
	Range of motion: Full ROM	Sensation: Intact	
	Comments: Report sternum pain/cp with inspiration. State " I never felt pain like this. Report increasing back pain onset yesterday. State had "flu like" sx (congestion and feverish feeling) onset 5days ago however state sx resolving.Denies n/v. Report "sternum pain causes me to take shallow breaths".		
FALLS RISK PROTOCOL **Assessment is mandatory**			
No			
Patient meets: X None			
Patient is not considered a fall risk at this time.			
Patient placed on universal fall precautions			
X Bed In low position X Call bell within reach			
As Indicated Assessment Reviewed by RN: KING, LYNNAIRE R CIV 6971 Time/Date: 2157 10Oct2012			
3. MULTI-DISCIPLINARY PAST MEDICAL HISTORY			
OTHER			
OTHER			
Current Outpatient Medications List from CHCS			
Past Surgical History			
Social History			
Tobacco NO			
Alcohol YES Comment SOCIAL 24 HRS AGO			
Living Situation Lives alone			
4. PROVIDER HISTORY / ROS / PHYSICAL EXAM - Age >16			

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
USN ACTIVE DUTY ABAA
WRNMMC Bethesda 11Oct2012
PERSONAL/PRIV ACT 1974
Clinical Notes

RES	RP	Staff	H	Time Seen	2205	ChkIn Time	2112
X Triage Reviewed				X Medical Records Reviewed			
CC	ABDOMINAL BACK CHEST PAIN			STS FLU LIKE SYMP NOW HAVING ABD PAIN AND DRY HEEVES.STS PAIN TO STERUM AND UPPER ABD AREA.			
HPI	27yoM with thoracic back pain beginning today at 1400, followed by sternal/sub-xiphoid chest pain at 1630 and then 9/10 abdominal pain at 2000 this evening while in the shower. Pt states he felt feverish over weekend with cough and congestion but felt OK by Tuesday, and today the above symptoms began. Back/sternal pain worse with deep inspiration. Currently at 8/10. No recent heavy drinking, tolerating normal diet well with good fluid intake, pain unchanged with eating. No nausea/vomiting/diarrhea/constipation. No significant PMH, not on any meds.						
Review of Systems							
GEN	Felt feverish over weekend but no recorded fever			GU	Denies dysuria, hematuria		
DERM	Denies Rash						
HEENT	congestion						
CARD	chest pain as above						
PULM	Denies Dyspnea. Mild productive cough						
GI	abd pain as above. no nausea, vomiting, diarrhea, melena, bright red blood per rectum						
Physical Examination							
GEN	Well nourished, well developed and in no acute distress.						
*HEAD	Atraumatic (or No lacs, bruises, contusions.)						
*EYES	Anicteric, EOMI						
*NOSE	No active bleeding						
*MOUTH	Moist mucosa						
NECK	Supple, nontender, no adenopathy						
CHEST	No tenderness to palpation, No crepitus						
CV	RRR, no murmurs, rubs, gallops			PULM	X B CTA with good aeration; no retractions, no wheeze, rhonchi or rales		
ABD	Soft, TTP in upper quadrants b/l with maximal tenderness in epigastric/sub-xiphoid region. No guarding or rebound tenderness. NABS			BACK	No midline TTP, no CVAT. Pain not reproducible with palpation.		
				DERM	No rash, skin warm and dry		

5. ED COURSE / CONSULTS

Time/Date 2238 10Oct2012 pt evaluated. cbc/cmp/amylase/lipase with AAS ordered
Time/Date 0455 11Oct2012 Per Rad: CT c/o colonic obstruction. Transition point in transverse colon. fecalization of the small intestines present-fecal material in the cecum.

ED decision to Admit time: 0626

CONSULTATIONS

Consulting Service	Consultant	Reason for Consult	Order	Returned Call	Bedside
General Surgery				0454	

Key Consult Times

6. ANCILLARY TESTS / PROCEDURES

INTERVENTIONS:

X RAYS

X Radiology XAAS
Interpret:

Acute Abdominal Series was performed for the evaluation of abdominal pain. No masses, small bowel obstruction, large bowel obstruction, air-fluid levels, or free air was identified.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CAT Scans

X Abd/Pelv

Colitis at the level of the hepatic flexure with stool filled cecum and fecalization of small bowel. Findings are nonspecific and may be representative of an acute infection or inflammatory etiology such as Crohn's disease or ulcerative colitis. Clinical correlation is recommended

LABORATORY TESTS

NI/Unrem Labs -> X CBC X Chem

BNP

amylase, lipase normal

Placement (Initial)

7. MEDICAL DECISION MAKING / DIAGNOSIS

Medical Decision Making:

Time/Date

1 27yoM with no prior h/o LBO or abdominal surgery with LBO visualized on CT scan. SOD paged, awaiting eval. Vitals stable, labs WNL.

0503 11Oct2012

2 General Surgery will admit pt for further workup of obstruction.

0611 11Oct2012

Diagnosis

Diagnosis 1 Large bowel obstruction

8. DISPOSITION

Condition Stable

Disposition Admission

Admission Service General Surgery

9. ELECTRONIC SIGNATURES

Junior Resident/Intern Comments/Signature

#1 I have reviewed and discussed the patient with my Supervising Provider.

Provider PUTKO, ROBERT M LT 2636

#1 Pt reports onset of mid back pain-between the scapula-at 1400 hrs today. Went to sleep. Awoke 2 hrs later with epigastric/subxiphoid pain that is aggravated with deep breathig or sitting up. Has had antecedent chills few days ago but has had no cough, fever or SOB. Has had no vomiting but has hd some retching. No paresthesias or the extremities. No palpitations. Has no other complaints. PE: wd wn m in nad. Neck supple. Lungs; clear CVS: rsr ABD: soft, BS active. Some epigastric ttp w/o rebound. No ttp over the back/cva area. Other: TTP over the xiphoid and lower costochondral area. No step off.

Unless otherwise noted, all patient care documented in this note was performed under the direct care and supervision of the Attending Staff Emergency Physician.

Staff Provider

HARDWARE, LESLIE W CIV 4699

(Responsible for case)

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

USN ACTIVE DUTY ABAA

WRNMMC Bethesda 11Oct2012

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: DOD ED Medical Record
 Note Time: N/A
 Last Stored: 1637 19 Apr 2014
 Stored By: SALVADOR, JERLYN CTR 1376 THRASHER, NANCY L. CTR 7654 PIRRI, MICHAEL P CTR 0963
 MAURANO, ANDREW W USA 0040

LOINC 34108-1 Rev. 2014.03.12.1400

EMERGENCY DEPARTMENT MEDICAL RECORD

19Apr2014 ED ARRIVAL DATE ED ARRIVAL TIME 1510 ARRIVAL BY PRIVATELY OWNED VEHICLE
 Patient Info: Telephone, Work Phone, Address, City, State, Zip
 [REDACTED] [REDACTED] [REDACTED] HANOVER MARYLAND [REDACTED]
 Sponsor Info: Name, Rank, Service, Duty Phone, PatCat, UIC
 MERWIN, DANIEL DENNIS PETTY OFFICER NAVY [REDACTED]
 SECOND CLA
 Sponsor Address, City, State, Zip, Station
 FORT GEORGE G MARYLAND 20755
 MEADE
 Primary Care Manager UDE, ASSUMPTA O

1. TRIAGE

Triage Time 1531
 Allergies NKDA

X ID band placed

Birthdate 16Feb1985

Age Calculated Age 29

Gender M

Chief Complaint (L) FOOT SWOLLEN
 (From CHCS)

Triage HPI Pt. reports was playing softball and left foot
 (Subjective) went into a hole at 1415 today. C/o pain and
 swelling to left ankle region.

Triage Exam Ambulatory to triage with slight limp. Left ankle
 (Obj. Findings) swollen. Alert & oriented x3. Respirations even
 and unlabored. Distal neurovascular intact.

BP 132 / 74 Source R HR 92 RR 16 SaO2% 96 RA Temp 98.1 F Oral

Weight

Is there any sign of Pain? Yes

Location (select multiple)	Factors	Quality	Assessment	Score	Time/ Duration
Left ankle	W M	TB	Weak	3	CONT

Is the Patient High Risk for Falls or have a History of Falls? No

Abuse/Neglect?

Have you ever been emotionally or physically abused or threatened by your partner or someone close to you?
 Have you ever been hit, slapped, kicked, pushed or otherwise physically hurt?

X No

Sexual Assault?

Has anyone ever forced you to engage in any type of sexual activity
 or touched you in a way that made you feel uncomfortable?

X No

Mental Health Issues?

X No

Primary Language English

Other Communication Needs None

HIPAA Patient states, 'I DO AGREE to release information about my identity, condition, and location.'

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 19Apr2014

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Tetanus Date	Current	Immunizations verified up to date as of:	Verified UTD by patient only																				
TRIAGE ACTION(S) Triage Acuity 4T (ESI) TRIAGED BY THRASHER, NANCY L. CTR 7654 TRIAGED TO Waiting Room-FT/UCC Best contact info for next 48hrs: [REDACTED]																							
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Allergies Imported Allergies (via ICE/Melder) OTHER																							
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X 3. INITIAL/BEDSIDE NURSING ASSESSMENT																							
X GENERAL APPEARANCE Well nourished, Healthy in appearance X MENTAL STATUS Awake, Alert, Oriented X3 X MUSCULOSKELETAL Left ankle pain and swelling since stepping in a hole while playing softball this afternoon. Distal neurovascular intact. Able to bear weight with slight limp.																							
FALLS RISK PROTOCOL																							
No Patient meets: X None Patient is not considered a fall risk at this time. Patient placed on universal fall precautions X Bed In low position X Call bell within reach X Patient/family verbalizes understanding of risk for falls and measures taken to counter the risk. Assessment completed by: THRASHER, NANCY L. CTR 7654 Time/Date: 1546 19Apr2014																							
4. PROVIDER HISTORY / ROS / PHYSICAL EXAM																							
RES DM Staff MP Time Seen 1606 ChkIn Time 1510 X Triage Reviewed																							

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 19Apr2014
PERSONAL/PRIV ACT 1974
Clinical Notes

Triage HPI (Subjective)	Pt. reports was playing softball and left foot went into a hole at 1415 today. C/o pain and swelling to left ankle region.				
CC	(L) FOOT SWOLLEN				
History of Present Illness					
29 y/o male c/o left ankle pain and anterior/lateral edema after an inversion injury while playing softball this afternoon. No open lesions, numbness, weakness or decreased rom. No knee pain. No achille injury. Able to bear weight but with pain.					
X 2 systems reviewed					
Physical Exam					
GEN	Well nourished, well developed and in no acute distress.				
CHEST	No tenderness to palpation, No crepitus				
CV	RRR, no murmurs, rubs, gallops				
ABD	Soft, NTND without masses, no HSM				
EXTREM	left ankle - diffuse edema and anterior/lateral tenderness.	DERM	No rash, skin warm and dry		
NEURO	A&Ox3, CN II-XII intact, Full strength x 4				
Context					
Immunocompromised due to:					
Cancer					
Prenatal Care					
5. ED COURSE / CONSULTS					
Time/Date	1633 19Apr2014	negative foot and ankle x-ray			
6. TESTS / PROCEDURES / IMAGES / FILES					
7. MEDICAL DECISION MAKING / DIAGNOSIS					
Time Seen by Provider	1606				
Medical Decision Making:		Time/Date			
1					
Diagnosis					
Diagnosis 1	845.00 SPRAIN ANKLE				
8. DISPOSITION					
Condition	Stable				
Disposition	Discharge				
Discharge	Home w/o Activity Restriction				
Discharge Instructions					
Keep the ankle in the brace for the next week and use the crutches when walking until you can bear weight without pain. Ice to reduce swelling and elevate as much as possible. Follow up with PCM in 2 weeks.					
Exit Care Patient Aftercare/Discharge Instructions:					
DI 1:	Ankle Sprain				
Please follow-up as directed					
Contract for Safety					
Discharge Medications					
Name	Dose	Route	Frequency	#Amt	
ibuprofen (MOTRIN) ORAL Tab	1	Orally	Every 8 hours	14 days	
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DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 19Apr2014
PERSONAL/PRIV ACT 1974
Clinical Notes

Discharge Medication Reconciliation

Outpatient
MedicationNot
TakingCorrected SIG
(If needed)

Discharge Plan

Denies

Medication Review
CompletedActive PDTS
PrescriptionNot
TakingCorrected SIG
(If needed)

Discharge Plan

FLUZONE 2013-2014 VIAL

9. ELECTRONIC SIGNATURES

Junior Resident/Intern Comments/Signature

X NP/PA/IDC/IDMT Comments/Signature

#1 I have reviewed and discussed the patient with my Supervising Provider.

Sign Out

Final Extender Signature Maurano, Andrew PA-C

#1 1. I have discussed in detail and reviewed the treatment and management plan presented to me by the resident/junior provider and agree.

#2 2. I have evaluated the patient myself and discussed in detail the treatment and management plan presented to me by the resident/junior provider and agree.

#3 29yo M with left ankle sprain playing soft ball, no fracture on XR, will give splint for support and NSAIDs, will dc home neurovascular intact

Sign Out

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Staff Provider
(Responsible for case)

PIRRI, MICHAEL P CTR 0963

10. CODING ASSISTANCE SECTION (autopopulated by documentation above)

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 19Apr2014

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: DOD ED Medical Record
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LOINC 34108-1 Rev. 2014.03.12.1400

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 MERWIN, DANIEL DENNIS PETTY OFFICER NAVY 854-410-1041
 SECOND CLA
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 FORT GEORGE G MARYLAND 20755
 MEADE
 Primary Care Manager UDE, ASSUMPTA O

1. TRIAGE

Triage Time 1531
 Allergies NKDA

X ID band placed

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 and unlabored. Distal neurovascular intact.

BP 132 / 74 Source R HR 92 RR 16 SaO2% 96 RA Temp 98.1 F Oral

Weight

Is there any sign of Pain? Yes

Location (select multiple)	Factors	Quality	Assessment	Score	Time/ Duration
Left ankle	W M	TB	Weak	3	CONT

Is the Patient High Risk for Falls or have a History of Falls? No

Abuse/Neglect?

Have you ever been emotionally or physically abused or threatened by your partner or someone close to you?
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Mental Health Issues?

X No

Primary Language English

Other Communication Needs None

HIPAA Patient states, 'I DO AGREE to release information about my identity, condition, and location.'

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MERWIN, DANIEL DENNIS

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WRNMMC Bethesda 19Apr2014

PERSONAL/PRIV ACT 1974

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FMPL6SSN: [REDACTED]
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WRNMMC Bethesda 19Apr2014
PERSONAL/PRIV ACT 1974
Clinical Notes

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NEURO	A&Ox3, CN II-XII intact, Full strength x 4				
Context					
Immunocompromised due to:					
Cancer					
Prenatal Care					
5. ED COURSE / CONSULTS					
Time/Date	1633 19Apr2014	negative foot and ankle x-ray			
6. TESTS / PROCEDURES / IMAGES / FILES					
7. MEDICAL DECISION MAKING / DIAGNOSIS					
Time Seen by Provider	1606				
Medical Decision Making:		Time/Date			
1					
Diagnosis					
Diagnosis 1	845.00 SPRAIN ANKLE				
8. DISPOSITION					
Condition	Stable				
Disposition	Discharge				
Discharge	Home w/o Activity Restriction				
Discharge Instructions					
Keep the ankle in the brace for the next week and use the crutches when walking until you can bear weight without pain. Ice to reduce swelling and elevate as much as possible. Follow up with PCM in 2 weeks.					
Exit Care Patient Aftercare/Discharge Instructions:					
DI 1:	Ankle Sprain				
Please follow-up as directed					
Contract for Safety					
Discharge Medications					
Name	Dose	Route	Frequency	#Amt	
ibuprofen (MOTRIN) ORAL Tab	1	Orally	Every 8 hours	14 days	
800 MG ORAL					

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 19Apr2014
PERSONAL/PRIV ACT 1974
Clinical Notes

Discharge Medication Reconciliation

Outpatient
MedicationNot
TakingCorrected SIG
(If needed)

Discharge Plan

Denies

Medication Review
CompletedActive PDS
PrescriptionNot
TakingCorrected SIG
(If needed)

Discharge Plan

FLUZONE 2013-2014 VIAL

9. ELECTRONIC SIGNATURES

Junior Resident/Intern Comments/Signature

X NP/PA/IDC/IDMT Comments/Signature

#1 I have reviewed and discussed the patient with my Supervising Provider.

Sign Out

Final Extender Signature Maurano, Andrew PA-C

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Sign Out

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Staff Provider

PIRRI, MICHAEL P CTR 0963

(Responsible for case)

10. CODING ASSISTANCE SECTION (autopopulated by documentation above)

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 19Apr2014

PERSONAL/PRIV ACT 1974

Clinical Notes

Note Type: DOD ED Medical Record
 Note Time: N/A
 Last Stored: 1405 22 Jun 2016
 Stored By: Bitter, Jordan N CIV 8495 MOSS, THEA E LTJG 3982 WEATHERS, BRUCE K MD 5696

LOINC 34108-1 Rev. 2014.10.15.1335

EMERGENCY DEPARTMENT MEDICAL RECORD

ED ARRIVAL DATE 22Jun2016 CHECK-IN 1126 Arrival By PRIVATELY OWNED VEHICLE Birthdate 16Feb1985
 TIME

Contact info for 48hrs: [REDACTED]

1. TRIAGE

Triage Time 1130 Age Calculated Age 32

Chief Complaint Chest pain and light headed
(from CHCS)

Triage HPI Pt c/o constant left sided chest pain x 2 wks. Pt c/o increased sharpness with deep inspiration. Also lightheadedness started today.

Triage(con't.) Denies recent travel.

Recent travel Denies
outside of the
country in the
past 3 months

BP 158 / 102 Source R HR 83 RR 16 SaO2% 98 RA Temp 97.8 F Oral

Is there any sign of Pain? Yes

Location (select multiple)	Factors	Quality	Assessment	Score	Time/ Duration
CHEST				4	CONT

Gender M

Abuse/Neglect?

Have you ever been emotionally or physically abused or threatened by your partner or someone close to you?
Have you ever been hit, slapped, kicked, pushed or otherwise physically hurt?

X No

Sexual Assault?

Has anyone ever forced you to engage in any type of sexual activity
or touched you in a way that made you feel uncomfortable?

X No

Mental Health Issues?

X Yes

History: anxiety

Suicidal Ideations?

X No

Homicidal Ideations?

X No

Primary Language English

Other None
Communication Needs

HIPAA Patient states, 'I DO AGREE to release information about my identity, condition, and location.'

Tetanus Date Current

Is the Patient High Risk for Falls or have a History of Falls? No

TRIAGE ACTION(S) X ID band placed

TRIAGE ACUITY 3

TRIAGED BY Bitter, Jordan N CIV 8495

TRIAGED TO

X 2. BEDSIDE NURSING ASSESSMENT

X GENERAL Well nourished, Healthy in appearance
APPEARANCE

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 22Jun2016

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

X MENTAL STATUS *Awake, Alert, Oriented X3*

X NEUROLOGICAL

X Detailed Assessment

Respiratory Pattern: *N*Cough Reflex: *+*

X Glasgow Coma Scale

Eyes Open To: *4*Best Motor Response: *6*Best Verbal Response: *5*Glasgow Coma Score: *15*Level of Consciousness: *3*

X Opth

Right

Left

Pupil Size: *3mm**3mm*Pupil Shape: *R**R*Pupil Reaction: *B**B*Movement: *FR**FR*

X Speech

Appro

Motor/Sensory

Comments: *pt denies ha blurred or double vision. pt claims dizziness started this AM, none currently*

X CARDIOVASCULAR

X Detailed Assessment

Rate: *Regular Rate*Rhythm: *NSR*Heart sounds: *S1-S2 present*Ectopy: *None*

LUE

RUE

Circulation Perfusion: *Warm and dry**Warm and dry*Capillary Refill: *< 2 seconds**< 2 seconds*Pulses: *Equal Bilaterally**Equal Bilaterally*

LLE

RLE

Circulation Perfusion: *Warm and dry**Warm and dry*Capillary Refill: *< 2 seconds**< 2 seconds*Pulses: *Equal Bilaterally**Equal Bilaterally*Edema: *No*JVD: *No*Comments: *pt claims chest pain worsening with deep inspiration over past x2weeks. worse today. denies palpitations*

X PULMONARY

X Normal: *Breathing unlabored, Bilateral breath sounds clear to auscultation, Equal chest wall rise and fall*

Detailed Assessment

X GASTROINTESTINAL

Comments: *hx of IBS, BM daily, no changes. denies n/v/d*

X GENITOURINARY

X Male

Genitals: *No Complaints or Concerns*Urine: *Clear yellow urine and urinates without difficulty*FALLS RISK PROTOCOL ****Assessment is mandatory*****No*

Criteria:

Mental Status: *confusion, impaired, or inability to understand/follow directions.*Age: *Over 60 or infant/child.*Elimination: *incontinent or increased urgency/frequency.*

X Impaired physical status (e.g. dizzy, impaired balance/strength, hypotension, post-op within 24 hours, anemia, vision/hearing impairment, seizure disorder, assistive device, sedated.)

History or fear of falls.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 22Jun2016

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Equipment: any device that tethers the patient (e.g. cardiac monitor, infusion, catheter, chest tube).

Medications (e.g. diuretics, vasoactive drugs that alter thought processes, increase GI motility)

Patient meets: X 1

Level 1 Interventions:

- Provide a clear environment
- Maintain room illumination, adequate lighting.
- Ensure that side rails are up, carts, bed, table in locked position.
- Offer toileting assistance at least every two hours.

Patient placed on universal fall precautions

X Bed In low position

X Call bell within reach

Assessment completed by:

MOSS, THEA E LTJG 3982

Time/Date: 1213 22Jun2016

3. MULTI-DISCIPLINARY PAST MEDICAL HISTORY

Imported Allergies (via Melder)

OTHER

NKDA

Current Outpatient Medications List (Imported from CHCS)

Not Taking	Trade Name	Generic Name	Dose	Current SIG	Last Fill Date
	PODOFILOX--TOP 0.5% SOLN	PODOFILOX	APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS NEEDED	APPLY BID FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT	02/24/2016
	FLUOCINOLONE--TOP 0.01% SOLN	FLUOCINOLONE ACETONIDE	APPLY TO SCALP EVERY DAY AS NEEDED	APPLY TO SCALP DAILY AS NEEDED #1 RF3	09/29/2015
	FLUTICASONE---PO 220MCG/PUFF MDI	FLUTICASONE PROPIONATE	INHALE 2 PUFFS BY MOUTH TWICE A DAY THEN RINSE MOUTH WITH WATER	INH 2 PUFFS PO BID THEN RINSE MOUTH WITH WATER #1	09/28/2015

Additional Medications

Medication Review Completed

Past Medical History

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 22Jun2016

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Denies PMHx			
Past Surgical History			
Surgery	Year	Surgery	Year
Tonsillectomy (T&A);		Corneal Refractive Surgery (PRK/LASIK);	
Immunization History			
Social History			
4. PROVIDER HISTORY / ROS / PHYSICAL EXAM			
Staff	BW	Time Seen	1210 ChkIn Time 1126
X Triage Reviewed			
Pt c/o constant left sided chest pain x 2 wks. Pt c/o increased sharpness with deep inspiration. Also lightheadedness started today.			
CC	Chest pain and light headed		
Travel Screening History	Denies		
History of Present Illness			
31 yo AD USN m NSA analyst with h/o anxiety c/o 2 week h/o pain in L chest. Pt was seen two weeks ago and reports concern over blood pressure 138/82. Pt states he sneezed this am which cause severe pain in chest and he felt briefly lightheaded following his sneezing and pain. Pt denies any fevr, chills, NVD, SOB or other complaint.			
Review of Systems			
GEN	Denies fever, recent illness; see HPI	GU	Denies dysuria, hematuria
DERM	Denies Rash	MS	Denies focal swelling, Pain
HEENT	Denies URI symptoms, headache	NEURO	Denies vertigo, focal weakness; see HPI
CARD	see HPI	PSYCH	Denies suicidal or homicidal ideation, hallucinations; (+) anxiety
PULM	Denies Dyspnea, cough	ENDO	Denies Polyuria, polydipsia, temperature sensitivity
GI	Denies abdominal pain, nausea, vomiting, diarrhea, melena, bright red blood per rectum	HEME	Denies Easy Bruising, Easy Bleeding
Physical Exam			
GEN	Well nourished, well developed and in no acute distress.		
*HEAD	Atraumatic (or No lacs, bruises, contusions.)		
*EYES	Anicteric, BOMI, PERL		
*EARS	TM's normal bilaterally		
*NOSE	No active bleeding		
*MOUTH	Moist mucosa		
THROAT	Airway patent, pharynx clear and uvula midline		
NECK	Supple, nontender, no adenopathy		
CHEST	(+) tenderness to palpation B SCMs and L anterior chest wall; No crepitus; no swelling, no erythema		
CV	RRR, no murmurs, rubs, gallops	PULM	X B CTA with good aeration; no retractions, no wheeze, rhonchi or rales
ABD	Soft, NTND without masses, no HSM	BACK	No midline TTP, no CVAT
EXTREM	Full ROM, no calf tenderness, no edema	DERM	No rash, skin warm and dry
NEURO	A&Ox3, CN II-XII intact, Full strength x 4		
VASC	Symmetric pulses, capillary refill <2 seconds		
5. ED COURSE / CONSULTS			
Time/Date	1210 22JUNE2016 seen and examined		

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 22Jun2016
PERSONAL/PRIV ACT 1974
Clinical Notes

6. ANCILLARY TESTS / PROCEDURES

INTERVENTIONS: X Cardiac Monitoring X O2-see flowsheet X IV Access X IV Fluid during ED visit-see flowsheet

EKG: X Narrative interpretation Expanded interpretation

X Nonspecific STTW

EKG with nonspecific ST-T wave changes but no evidence of QT prolongation, ST elevations or depressions, or PR shortening.

X RAYS

X ED Interpret: XCXR

Other

Chest xray: no acute findings

X Radiology Interpret: XCXR

Chest xray: IMPRESSION:
Normal chest radiographs.Electronically signed by: Dr. MATTHEW LEO LUTYNSKI
Department of Radiology
Walter Reed National Military Medical CenterDate: 06/22/16
Time: 13:08APPROVED BY: LUTYNSKI, MATTHEW LEO
DATE/TIME: 20160622 130800**CAT Scans****LABORATORY TESTS**

NI/Unrem Labs -> X CBC X Chem X Trop X D-Dimer BNP

7. MEDICAL DECISION MAKING / DIAGNOSIS

Time Seen by Provider 1210

Medical Decision Making:

Time/Date

1 Hx and findings c/w costochondritis

Diagnosis

Diagnosis 1 COSTOCHONDRITIS (ICD9: 733.6)

8. DISPOSITIONCondition Improved
Disposition Discharge
Discharge Home w/o Activity Restriction**Discharge Instructions**Take your medication as needed for pain. Follow-up with your Primary Care provider or
sick-call as needed. Go to nearest ER for any emergency

Exit Care Patient Aftercare/Discharge Instructions:

DI 1: Costochondritis

Follow-up/Referral Clinic Kimbrough Ambulatory Care Center/Sick-Call-301-677-8800

Contract for Safety

Discharge Medications

Name	Dose	Route	Frequency	#Amt
ibuprofen (MOTRIN) ORAL Tab				
800 MG ORAL				

Discharge Medication Reconciliation

Active CHCS Prescription	Not Taking	Generic Name	Corrected SIG (If needed)	Discharge Plan
PODOFILOX--TOP 0.5% SOLN		PODOFILOX	APPLY TWICE A DAY FOR 3 DAYS THEN STOP FOR 4 DAYS, REPEAT WEEKLY AS	

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 22Jun2016

PERSONAL/PRIV ACT 1974

Clinical Notes

FLUOCINOLONE--TOP 0.01%
SOLN

FLUOCINOLONE
ACETONIDE

NEEDED

APPLY TO SCALP EVERY
DAY AS NEEDED

FLUTICASONE--PO
220MCG/PUFF MDI

FLUTICASONE
PROPIONATE

INHALE 2 PUFFS BY MOUTH
TWICE A DAY THEN RINSE
MOUTH WITH WATER

Additional Medications

Med Reconciliation
Completed

Additional Medications
(Medication Reconciliation)

Medication Review Completed

9. ELECTRONIC SIGNATURES

#1 2. I have evaluated the patient myself/

Unless otherwise noted, all patient care documented in this note was performed under the direct care and supervision of the Attending Staff Emergency Physician.

Staff Provider

WEATHERS, BRUCE K MD 5696

(Responsible for case)

10. CODING ASSISTANCE SECTION (autopopulated by documentation above)

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 22Jun2016

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: ED Medical Record *
 Note Time: N/A
 Last Stored: 1830 6 Jul 2017
 Stored By: FOTOPOULOS, JOHN P CIV 2450 JEZAK-DEMERY, TOBY CTR 2476 Owens, Susan W MD

LOINC 34108-1 Rev. 2016.06.17.1530 (R35)

Emergency Department Medical Record

06Jul2017 ED ARRIVAL DATE ED ARRIVAL TIME 1430 ARRIVAL MODE PRIVATELY OWNED VEHICLE

1. TRIAGE

Triage Time 1436

Allergies NKDA

X ID band placed

Birthdate 16Feb1985

Age 32 Calculated Age 32

Sex M

Chief Complaint PSYCH EVAL
 (From CHCS)

Triage HPI Pt c/o SI x days, pt has taken meds in past but is
 (Subjective) currently not on meds since april. Command rep with
 patient

BP 144 / 96 HR 93 RR 16 Pulse 97 RA Temp(F) 98.1 Oral
 O2(%)

Is there any sign of Pain? Yes

Score	Location (select multiple)	Quality	Time/ Duration	Modifying Factors
7	headache	DL	CONT	

Is the Patient High Risk for Falls or have a History of Falls? No

Abuse/Neglect?

Have you ever been emotionally or physically abused or threatened by your partner or someone close to you?
 Have you ever been hit, slapped, kicked, pushed or otherwise physically hurt?

X No

Sexual Assault?

Has anyone ever forced you to engage in any type of sexual activity
 or touched you in a way that made you feel uncomfortable?

X No

Mental Health Issues?

X Yes

History: depression

Suicidal Ideations?

X Yes

Security Contacted: ?

1:1 watch stationed: MTF or Command ?

1:1 Watch verbalizes understanding of role?

Plan: ?

Homicidal Ideations?

X No

Primary Language English

Other Communication Needs None

HIPAA Patient states, 'I DO AGREE to release information about my identity, condition, and location.'

Tetanus Date Current

Immunizations verified Verified UTD by patient only
 up to date as of

Triage Action(s)

Triage Acuity 3
 (ESI)

Triage By

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 06Jul2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

FOTOPOULOS, JOHN P CIV 2450
 Triaged To Waiting Room-Main
 Best contact info for next 48hrs:
 [REDACTED]

2. MULTI-DISCIPLINARY PAST MEDICAL HISTORY

Allergies

NKDA

Imported Allergies (via ICE/Melder)

NKDA

NKA

Current Outpatient Medications List

Not Taking	Medication	Last Fill Date	Not Taking	CHCS PDS Drug Name	Last Fill Date
	OMEGA-3/DHA/EPA/FISH OIL--PO 1,000MG CAP	06/06/2017		XIFAXAN/550 MG/TABLET	06/06/2017
	PROBIOTIC (VSL#3 DS)--PO PACK	06/06/2017		FISH OIL/300-1000MG/CAPSULE DR	06/06/2017
	SIMETHICONE--PO 80MG TBCH	05/18/2017		VSL#3 DS/900B CELL/PACKET	06/06/2017
	IBUPROFEN--PO 100MG/5ML SUSP	04/28/2017		FISH OIL/300-1000MG/CAPSULE DR	05/23/2017
	PSEUDOEPHEDRINE--PO 30MG/5ML SOLN	04/28/2017		MYTAB GAS/80 MG/TAB CHEW	05/17/2017
	PSYLLIUM/SUCROSE--PO 3.4GM/SCOOP POWD	05/10/2017		PROAIR HFA/90 MCG/HFA AER AD	05/17/2017
	HYOSCYAMINE IR--PO 0.125MG TBSL	05/10/2017		CETIRIZINE HCL/10 MG/TABLET	05/17/2017
				PAROEX/0.12 %/MOUTHWASH	05/10/2017
				HYOSCYAMINE SULFATE/0.125 MG/T	05/10/2017
				OXYCODONE-ACETAMINOPHE/5 MG-32	05/03/2017
				OXYCODONE-ACETAMINOPHE/5 MG-32	05/03/2017
				AMOXICILLIN-CLAVULANATE/400-57M	04/27/2017
				NASAL DECON (PSEUDOEPH/30 MG/5	04/27/2017
				AMOXICILLIN-CLAVULANATE/400-57M	04/27/2017
				IBUPROFEN/100 MG/5ML/ORAL SUSP	04/27/2017
				OXYCODONE HCL/5 MG/5 ML/SOLUTI	04/27/2017
				NASAL DECONGESTANT/0.05 %/SPRA	04/26/2017
				WHITE PETROLATUM/OINT. (GM)	04/26/2017
				PAROEX/0.12 %/MOUTHWASH	04/26/2017
				ONDANSETRON ODT/4 MG/TAB RAPDI	04/26/2017

Past Medical History

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 06Jul2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Irritable Bowel Syndrome;

Past Surgical History

Surgery	Date	Surgery	Date
wisdom teeth extraction	?	Corneal Refractive Surgery (PRK/LASIK);	?
Tonsillectomy:	2003	expose and bond #11	?
Maxillo facial	2015		

Other Surgical History SEE H&P

Family History

X 3. INITIAL/BEDSIDE NURSING ASSESSMENT

X GENERAL APPEARANCE Well nourished, Healthy in appearance

X MENTAL STATUS Awake, Alert, Oriented X3

X PULMONARY Breathing unlabored, Bilateral breath sounds clear to auscultation, Equal chest wall rise and fall

X GASTROINTESTINAL Denies nausea vomiting diarrhea, Abdomen soft non-tender non-distended, Bowel sounds present in all four quadrants

X PSYCHOSOCIAL

Behavior/Emotional State: Expression relaxed, manner alert, affect appropriate

Affect: pleasant Eye Contact: Yes

Escort with Patient: Yes Command representative

Contracts for Safety: Yes

Comments: PT PRESENTS WITH SI IDEATION X1 WEEK. PT DOES NOT HAVE A PLAN. NO HI NOTED. PT HAS A HISTORY OF DEPRESSION BUT NO PRIOR SI ATTEMPTS.

FALLS RISK PROTOCOL

Patient placed on universal fall precautions

X Call bell within reach

Assessment completed by: JEZAK-DEMERY, TOBY CTR 2476 Time/Date: 1818 06Jul2017

4. PROVIDER HISTORY / ROS / PHYSICAL EXAM

RES - Staff so Time Seen 1607 ChkIn Time 1430

X Triage Reviewed

Triage HPI (Subjective) Pt c/o SI x days, pt has taken meds in past but is currently not on meds since april. Command rep with patient

CC PSYCH EVAL

History of Present Illness

32 yo male Navy AD sent from Ft Meade for SI. Has had increasing SI for past 3 weeks, job problems, lonely..family in SC, lives with roommate. Sees Dr. Paul here and called her to tell her he was here. Disc SI with command at Meade. researching on computer painless and assured way to commit suicide...guns/ CO...but has no plan. Attempted x 2 while in HS, ASA/ETOH and ETOH. On lexapro and stopped in April, told psychiatrist and OK. Hx mj depression/anxiety/schizoaffective traits. No pmh other than allergies.

X All other ROS/systems reviewed and are negative

Physical Exam

alert and cooperative, VSS

GEN Well nourished, well developed and in no acute distress.

*HEAD Atraumatic (or No lacs, bruises, contusions.)

*EYES Anicteric, EOMI, PERL

*NOSE No active bleeding

*MOUTH Moist mucosa

NECK Supple, nontender, no adenopathy

CHEST No tenderness to palpation, No crepitus

CV RRR, no murmurs, rubs, gallops PULM X B CTA with good aeration; no retractions, no wheeze, rhonchi or rales

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 06Jul2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

ABD	Soft, NTND without masses, no HSM	BACK	No midline TTP, no CVAT
EXTREM	Full ROM, no calf tenderness, no edema	DERM	No rash, skin warm and dry
NEURO	A&Ox3, CN II-XII intact, Full strength x 4		

5. ED COURSE / CONSULTS

ED COURSE
Time/Date 1612 06Jul2017 d/w POD...coming to see

CONSULTATIONS		Key Consult Times		
Consulting Service	Consultant	Reason for Consult	Order	Returned Call Bedside
Psychiatry				

6. TESTS / PROCEDURES / IMAGES / FILES

7. MEDICAL DECISION MAKING / DIAGNOSIS

Time Seen by Provider: 1607
Medical Decision Making:

1 Has been seen by Psychiatry...may be discharged, to follow up with his psych on Monday on scheduled appt. SI and safety discussed with Psych.	Time/Date 1829 06Jul2017
2 Pt feels better after being seen	

Diagnosis

Diagnosis 1 Depression

8. DISPOSITION

Condition Stable
Disposition Discharge
Discharge Home w/o Activity Restriction

Discharge Instructions
Follow up with your psychiatrist at Ft. Meade on Monday.

Contract for Safety
Discharge Medications
Discharge Medication Reconciliation

Medication	Not Taking	Corrected SIG (If needed)	Discharge Plan
OMEGA-3/DHA/EPA/FISH OIL--PO 1,000MG CAP		TAKE 2 BY MOUTH EVERY DAY	
PROBIOTIC (VSL#3 DS)--PO PACK		TAKE ONE PACKET BY MOUTH EVERY DAY	
SIMETHICONE--PO 80MG TBCH		CHEW 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR GAS	
IBUPROFEN--PO 100MG/5ML SUSP		DRINK 20ML (400MG) EVERY-FOUR HOURS FOR BASELINE-PAIN CONTROL	
PSEUDOEPHEDRINE--PO 30MG/5ML SOLN		DRINK 10ML EVERY 6 HOURS-FOR CONGESTION ~	
PSYLLIUM/SUCROSE--PO 3.4GM/SCOOP POWD		TAKE ONE SCOOP EVERY DAY MIXED IN LIQUID. AFTER TWO WEEKS INCREASE TO TWICE EVERY DAY	
HYOSCYAMINE IR--PO 0.125MG TBSL		DISSOLVE 1 TABLET UNDER TONGUE EVERY EIGHT HOURS AS NEEDED FOR ABDOMINAL PAIN	

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 06Jul2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

CHCS PDTs Drug Name	Not Taking	Corrected SIG (If needed)	Discharge Plan
XIFAXAN/550 MG/TABLET			
FISH			
OIL/300-1000MG/CAPSULE DR			
VSL#3 DS/900B CELL/PACKET			
FISH			
OIL/300-1000MG/CAPSULE DR			
MYTAB GAS/80 MG/TAB CHEW			
PROAIR HFA/90 MCG/HFA AER AD			
CETIRIZINE HCL/10 MG/TABLET			
PAROEX/0.12 %/MOUTHWASH			
HYOSCYAMINE SULFATE/0.125 MG/T			
OXYCODONE-ACETAMINOPHE/5 MG-32			
OXYCODONE-ACETAMINOPHE/5 MG-32			
AMOXICILLIN-CLAVULANAT/40 0-57M			
NASAL DECON (PSEUDOEPH/30 MG/5			
AMOXICILLIN-CLAVULANAT/40 0-57M			
IBUPROFEN/100 MG/5ML/ORAL SUSP			
OXYCODONE HCL/5 MG/5 ML/SOLUTI			
NASAL DECONGESTANT/0.05 %/SPRA			
WHITE			
PETROLATUM//OINT. (GM)			
PAROEX/0.12 %/MOUTHWASH			
ONDANSETRON ODT/4 MG/TAB			
RAPDI			
9. ELECTRONIC SIGNATURES			
Junior Resident/Intern Comments/Signature			
#1 4. I have seen this patient primarily.			
Unless otherwise noted, all patient care documented in this note was performed under the direct care and supervision of the Attending Staff Emergency Physician.			
Staff Provider Owens, Susan W MD (Responsible for case)			
10. CODING ASSISTANCE SECTION (autopopulated by documentation above)			

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 06Jul2017
PERSONAL/PRIV ACT 1974
Clinical Notes

Note Type: ANES PreAnesthesia Eval *
 Note Time: N/A
 Last Stored: 0858 27 Apr 2017
 Stored By: Bundoc, Elisio G JR 0762 HARKINS, CHARLES K MIL 4731

LOINC 34876-3 2015.04.08.1515 (R.2.0)

PreAnesthesia Evaluation

Patient Pre-Op Information

DoD ID (EDI-PI): 1286180538 **DEERS ID/Electronic Data Interchange Person Identifier**
 ASA: 2
 Age: 32 Gender: M
 Combat Casualty Patient? X No

Allergy Information

** NOTE: Previously unidentified medication allergies must be entered into CHCS/AHLTA (per local policy) to allow drug-allergy checking.

If a Drug is not on the formulary list please change Type of allergy to MISC. This will allow entry of the unlisted drug name. **

#1 Type: MISC. Name: Feathers Symptoms: UserSpecifiedSymptom
 Onset Date: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:
 #2 Type: MISC. Name: Cat dander Symptoms: UserSpecifiedSymptom
 Onset Date: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:

Procedure Information

Pediatric Patient ***Less than 18 yrs***
 Parent/Legal Guardian:
 Phone:
 Relationship:
 Planned Date of Procedure: 27Apr2017 Patient Status: Outpatient/APV;
 Clinical Service: OMS Surgeon/Provider: Jensen
 Planned Procedure: Lefort Osteotomy, Possibly Segmental, Possible Maxillo-Mandibular Fixation And Any Other Indicated Procedures.

Past Medical History / Review of Systems (ROS)

HPI

Pt in ortho tx. Teeth do not come together on left side when pt bites.
 Feels like midline is off. Pt does not snore.

The Following Checked ROS are Remarkable:

Airway/EENT:

X Cardiovascular: denies CP/SOB
 X Exercise Tolerance: 4-10 METS (i.e. climb 1 flight stairs, brisk walk on level ground, play golf)

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Newborn SF 535 (Revised)

CliniComp, Intl.

ADLs:

X ADL, Independent
 X GI/Hepatic: IBS
 X Neuro/Psych: anxiety

Past Surgical and Anesthetic History

Procedure	Date	Anesthesia	Comments
wisdom teeth extraction	?	Unknown.	No anesthetic-related problems.
Corneal Refractive Surgery (PRK/LASIK);	?	Unknown.	No anesthetic-related problems.
Tonsillectomy:	2003	Unknown.	No anesthetic-related problems.
expose and bond #11	?	Unknown.	No anesthetic-related problems.
Maxillo facial	2015	Unknown.	No anesthetic-related problems.
Other Surgical History:	SEE H&P		

Family History

X No Family History of Anesthetic Problems

Social History

X Select Box for Expanded History

Special Duty Status: None.

Tobacco:	Tobacco Use: Never	Type: N/A
Alcohol:	Alcohol Use: Active	Type: Social: 3-4/week
	Drinks/Day: SEE TYPE	Last Drink: 1 week ago
Drug Use:	Recreational Drug Use: N/A	Type: N/A

Medications

X Admission Medications

CHCS Drug Name	SIG	Corrected SIG	Comments
Additional medications not listed above			
Drug Name	Taking	Corrected SIG	Comment
multivitamin (DAILY VITE) ORAL Tab	X		

Physical Examination**Vital Signs:**

HR: 72 BP: 125 / 86 mmHg
 Temp (F): 98.5
 RR: 16 Pulse O₂(%): 98 O₂ Source: Room Air

175.3 cm =
 Admission Weight: 76.80 Kg =
 BMI: 24.97

Pain Score: 0

Airway:

General: Normal appearing airway.
 Mallampati Class: 2
 Thyro-Mental(TM) Distance: 3 fingerbreadths or greater
 Mouth Opening: 3 fingerbreadths or greater
 Dentition: Normal/intact. orthodontics in place
 Neck: Unremarkable.
 Pulmonary: Normal to auscultation.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Newborn SF 535 (Revised)

Cardiovascular: Normal heart sounds.
 X Indwelling Lines/Monitors:
 Peripheral IV Line: 18G LH

Laboratory and Clinical Studies

Lab Results:

CBC: 14.4 / BMP: 140 / 99 / 16.0 /
 6.0 (at 1147 12 Apr 2017) >-----< 262 (at 1147 12 Apr 2017) -----+-----+-----< 112 (at 1147 12 Apr 2017)
 / 42.3 \ 4.9 / 28 / 0.88 \
 Ca: 9.9

Consults and Additional Evaluation

X Patient is suitable for proposed scheduled surgery.

X Anesthetic Assessment/Plan

NPO Since Date: 27Apr2017 Time: 0000

ASA Physical Status Classification: 2

Anesthesia Specific Concerns: None noted.

Is the patient currently on beta-blocker therapy? X No

Anesthetic Plan

X General Anesthesia

Signatures

X Trainee Signature:

Name of Staff Anesthesia Provider: HARKINS, CHARLES K MIL 4731

NOT an elect. signature

Trainee: Bundoc, Elisio G JR 0762

Time/Date: 0701 27Apr2017

Staff Anesthesia Provider Signature:

X Check if supervising a trainee

Does Staff Anesthesia concur with trainee assessment? X Yes

Provider Signature: HARKINS, CHARLES K MIL 4731

Time/Date: 0725 27Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Newborn SF 535 (Revised)

CliniComp, Intl.

Note Type: PERIOP Nurse Preop Eval-Tch * (T-CON)
 Note Time: N/A
 Last Stored: 1452 24 Apr 2017
 Stored By: HIGHSMITH, JOANN

Preop Evaluation and Teaching Note

Allergy Information

If a Drug is not on the formulary list please change Type of allergy to MISC. This will allow entry of the unlisted drug name. **

#1 Type: MISC. Name: Feathers Symptoms: UserSpecifiedSymptom
 Onset Date: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:
 #2 Type: MISC. Name: Cat dander Symptoms: UserSpecifiedSymptom
 Onset Date: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:
 Food Allergies: X No
 Latex Allergies: X No

MDRO/Isolation

CHCS MDRO Status:
 Isolation Precautions: ** Isolation Status Descriptions **
 For:

Procedure Information

Planned Date of Procedure: 27Apr2017 Patient Status: Outpatient/APV;
 Clinical Service: OMS Surgeon/Provider: Jensen
 Planned Procedure: Left Osteotomy, Possibly Segmental, Possible Maxillo-Mandibular Fixation And Any Other Indicated Procedures.

Consent Verification

Informed Consent verified and completed IAW local policy: X No
 Comment: Signatures, date and time needed.

Pre-Op Vital Signs

HR: BP: / mmHg
 Temp (C): Temp (F): Temp Source: T-CON
 RR: Pulse Ox(%): O2 Source: @ lpm
 Admission Height: 175.3 in Ht: 175.26 cm = 69 in
 Admission Weight: 76.80 kg = lbs Wt: 76.80 kg = 168.96 lbs
 BMI: 24.97 BMI: 24.9483

Past Surgical and Anesthetic History

Procedure	Date	Anesthesia	Comments
wisdom teeth extraction	?	Unknown.	No anesthetic-related problems.
Corneal Refractive Surgery (PRK/LASIK);	?	Unknown.	No anesthetic-related problems.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

Tonsillectomy:	2003	Unknown.	No anesthetic-related problems.
expose and bond #11	?	Unknown.	No anesthetic-related problems.
Maxillo facial	2015	Unknown.	No anesthetic-related problems.
Other Surgical History: SEE H&P			
Pre-existing Implanted Devices:		X Yes	
Type/Location:	Tooth eleven	Additional Implants	
Family History			
X No Family History of Anesthetic Problems			
Social History			
Special Duty Status: None.			
Tobacco:	Tobacco Use: Never	Type: N/A	
	Tobacco use within the past 30 days prior to the day of hospital admission? (i.e., cigarettes, smokeless tobacco, cigars, pipes)		X No
Alcohol:	Alcohol Use: Active	Type: Social: 3-4/week	
	Drinks/Day: SEE TYPE	Last Drink: 1 week ago	
Drug Use:	Recreational Drug Use: N/A	Type: N/A	
Employment History: USN			
Living Situation: Lives with roommate			
Do you have any questions or concerns about this hospitalization or illness?			X No
Do you have any concerns regarding your sexual health?			X No
Do you have concerns about violence, abuse or neglect for yourself or your family?			X No
Review of Systems **Select to Expand, Review, Edit**			
Genito-Urinary:			
Comment: SEE H&P			
Preadmission Assessment/Teaching			
Knowledge Assessment			
	Language(s) Spoken:	English	
	Language Preference for discussing Healthcare:	English	
	Learning Methods:	Hands on; Video;	
	Barriers to Learning:	None	
Mobility Assessment Independent (I)			
All surgical/procedure patients classified as HIGH RISK for falls. Institute fall risk policy.			
Advance Directives			
Does the patient have an Advance Directive/ Living Will/Medical Power of Attorney?			X No
Does the patient want assistance, information or referral for an Advance Directive/Living Will/Medical Power of Attorney?			X No
Assessment/Teaching Comment: Patient denies.			
Emergency Contact/Next of Kin			
X Emergency Contact/Next of Kin.			
	Next of Kin:	X No	
	Relationship:	Friend	
	Name:	Jessica Rupp	
	Phone: 443-991-2459	Cell	Addtl Phone number
Instructions given to patient: (Verbal and Written)			

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 27Apr2017
PERSONAL/PRIV ACT 1974
Clinical Notes

- X Preop Instructions provided to patient.
Patient/(guardian) verbalized understanding and willingness to comply.
- X Patient verbalized and understands that patient must have Escort on ****Day of Surgery****
- Comment: *See the APU pre-procedure teaching sheet.*

PRE-OP ALERT**Signatures**

RN Signature: HIGHSMITH, JOANN CTR 7559

Time/Date: 1447 24Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

Note Type: SURG Master Note *
 Note Time: N/A
 Last Stored: 0643 28 Apr 2017
 Stored By: Jensen, Damon T 2878 CERVENKA, PETER D 0736

SURG Master Note

- PATIENT DATA AND INFORMATION -

Age: 32 Gender: M Information Source(s): Patient;
 Clinical Service: Oral-Maxillofacial Surg/ABAA Surgeon/Provider: Jensen, Damon T 2878

Signature:

Time/Date:

X ATTACH IMAGE OR EXTERNAL FILE

X Add Image 1

Add Image 2

①

①

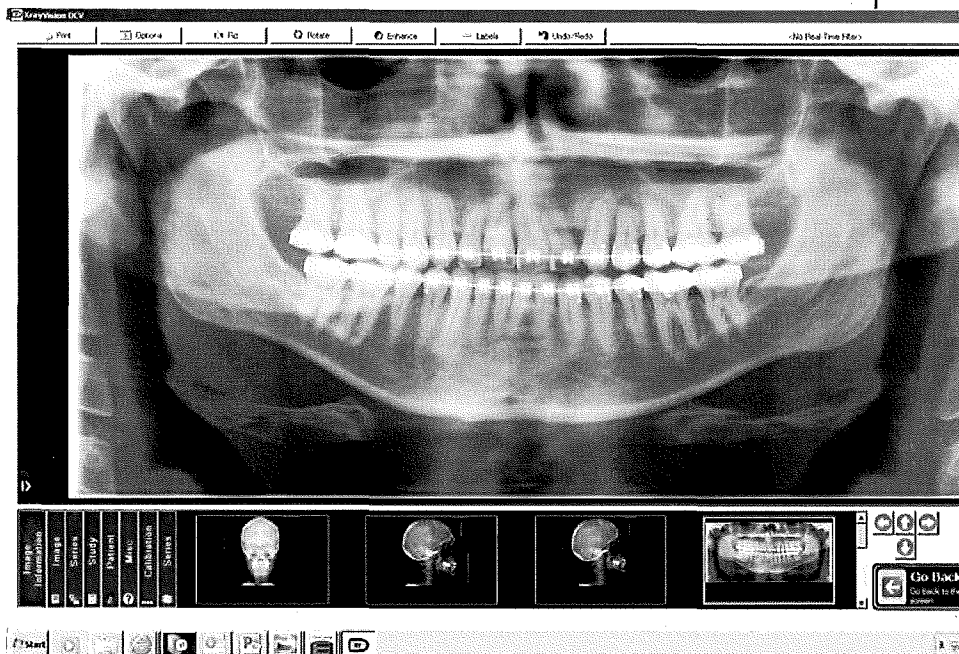


Image 1 Comment: Questionable periapical region over #12

X TEMPLATE HISTORY **Select to build History: CC, HPI, PMHx, PSHx, etc**

Chief Complaint

"Teeth don't come together"

History of Present Illness

Pt in ortho tx. Teeth do not come together on left side when pt bites. Feels like midline is off. Pt does not snore.

Past Medical History

Irritable Bowel Syndrome;

Past Surgical History

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3167

wisdom teeth extraction	?	
Corneal Refractive Surgery (PRK/LASIK);	?	
Tonsillectomy:	2003	
expose and bond #11	?	
Maxillo facial	2015	
Other Surgical History: SEE H&P		
Social History		
Special Duty Status: None.		
Tobacco Use: Never	Type: N/A	
Alcohol Use: Active	Type: Social: 3-4/week	
Drinks/Day: SEE TYPE	Last Drink: 1 week ago	
Recreational Drug Use: N/A	Type: N/A	
Employment History: USN		
Living Situation: Lives with roommate		
Other Social History:		
Family History		
cancer		
HTN		
diabetes		
heart disease		
X REVIEW OF SYSTEMS (ROS) **AHLTA copy/paste, Expanded ROS, etc**		
X Review of Systems negative and within normal limits		
Airway/EENT:		
Cardiovascular:		
Musculoskeletal:		
ALLERGY INFORMATION		
#1 Type: MISC.	Name: Feathers	Symptoms: UserSpecifiedSymptom
Onset 04/24/2017	Severity: SEVERE	Other Symptom: Dyspnea
Date:		
SNOME		
D		
Code:		
RxNor	Last Modification Date: 04/24/2017	Inactive:
m		
Code:		
#2 Type: MISC.	Name: Cat dander	Symptoms: UserSpecifiedSymptom
Onset 04/24/2017	Severity: SEVERE	Other Symptom: Dyspnea
Date:		
SNOME		
D		
Code:		
RxNor	Last Modification Date: 04/24/2017	Inactive:
m		
Code:		
MEDICATIONS ON ADMISSION		
X Admission Medications: to include home, non prescription, herbals, medications taken in another care facility and illicit drugs.		
Active CHCS Medication:	Dosing Instructions (No abbreviations)	
Additional Medications:	Dosing Instructions (No abbreviations)	
multivitamin (DAILY VITE) ORAL Tab	X	

DODID:
MERWIN, DANIEL DENNIS
FMPL6SSN: [REDACTED]
??? ???
WRNMMC Bethesda 27Apr2017
PERSONAL/PRIV ACT 1974
Clinical Notes

PAIN

Pain Score: 0

PHYSICAL EXAMINATION **Ht/Wt, VS, Focused/Expanded Exam, if applicable**

Admission Height: 175.3 cm = in
 Admission Weight: 76.80 kg = lbs
 BMI: 24.97 BSA: 1.925

Latest Vital Signs:

HR: 80 BP: 120 / 79 mmHg
 Temp(F): 97.7 Temp Source: forehead
 Pulse Ox(%): 96 O2 Source: Room Air

X Focused Exam Facial 3rds: 51mm/58mm/68mm
 tooth show repose: 2mm animation: 10mm
 Midline max:MSP 1mm to right man:max 1mm to left

DODID:**MERWIN, DANIEL DENNIS****FMPL6SSN:** [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

Angle class canine: Class III right and left
 Angle class molar: Class III right and left
 Overjet: 0mm
 Overbite: 0mm
 Transverse: adequate (no crossbite)
 Cant: None
 Alar: 30mm
 Upper lip: 21mm
 Lower lip: 42mm

#12 clinically tests delayed sensitivity no mobility no percussion pain 4 mm pockets

RADS: Maxillary hypoplasia radiolucency around 12

HEART: RRR

LUNG :CTAB

Airway: MP II

Left (Small)

MULTI-DRUG RESISTANT ORGANISM (MDRO) **Current Status and Precautions**

X VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT **Required if 18yrs and older**

Select VTE Risk Stratification: VTE Low Risk
 VTE Prophylaxis to Order: Early and Frequent Ambulation
 Contraindications to consider with Pharmacologic VTE Prophylaxis
 NONE.
 VTE Prophylaxis Planned
 SCD in MOR early ambulation

X ACTIVE CODE STATUS/RESUSCITATION PLAN **Required for ALL patients**

Initial Resuscitation Status: Full
 X I have personally discussed and reviewed this patient's admission circumstances and Code Status with the patient. The patient has medical decision making capacity at this time and has chosen to be "Full Code" status and understands they may change this care decision at any time. An advance directive document, if available, was a part of this discussion.

X ASSESSMENT AND PLAN **Pre-Op Diagnosis/Planned Procedure**

Assessment: maxillary AP hypoplasia
 Pre-Op Diagnosis: maxillary AP hypoplasia
 X Check box for additional Diagnosis
 Pre-Op Diagnosis 2: possible necrosis 12
 Planned Procedure: Maxillary Lefort I advancement

X PRE-OPERATIVE INSTRUCTIONS/COUNSELING

Patient was given verbal and written instructions.
 X Provider Specific Instructions:
 given by resident
 Provider Name: Jensen, Damon T 2878 Date: 12Apr2017
 Scheduled Procedure Time/Date: 27APR2017@0800 With => Jensen, Damon T 2878
 Phone Number(s): 307-203-9044

X REVIEWED (H&P) PRIOR TO SURGERY/PROCEDURE **Required for ALL patients**

Patient assessed/re-examined and history and physical reviewed prior to surgery/procedure requiring anesthesia services. The changes found in patient's condition since history and physical exam were completed are listed below: PT had root canal started on #12 which currently has IRM in it. Pre op pt reports 5/10 pain after RCT started. Pt to have RCT completed after surgery. Comfortable proceeding with surgery as no s/s of infection feel pain is post extirpation tenderness. Ortho set up ran by COL Terp discussed right posterior opening (right posterior molars are not in contact as per set up.

Reviewed By: Jensen, Damon T 2878

Time/Date: 0825 27Apr2017

Intern Addendum:

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Resident

Resident Addendum:

Staff Attending

Signature:

Time/Date:

OPERATIVE REPORT **To include the Brief Operative Report required before the next level of care...USE 'standalone' SURG Operative Report* Note!**

X POST PROCEDURE RELEASE/DISCHARGE SUMMARY **Required for ALL patients**

Staff Provider: Jensen, Damon T 2878

Clinical Service: Oral-Maxillofacial Surg/ABAA

Admission Diagnosis: Maxillary AP hypoplasia

Discharge Diagnosis: Maxillary AP hypoplasia

Admission Date: 27Apr2017

Discharge Date:

Procedure Performed 1: Lefort I osteotomy

Date: 27Apr2017

Check box for Additional Procedures

Clinical Course: Unremarkable

Disposition: Discharged Home

Condition on Discharge: Stable

Convalescent Day(s): 14

X POST-OP DISCHARGE MEDICATION RECONCILIATION **Required for ALL patients**

New Home Medications

Medication Name: Ibuprofen 100mg/5ml SUSP

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 40ml (800mg) every eight hours for baseline pain control.

Special Instructions:

Medication Name: Oxycodone 5mg/5ml SOLN

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 5-10ml every 4 hours as needed for breakthrough post surgical pain.

Special Instructions:

Medication Name: SODIUM CHL (SEA MIST) 0.65% NASAL SPRAY

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): 2 puffs each nostril 4 x daily to keep nose moist

Special Instructions:

Medication Name: Pseudoephedrine 30mg/5ml

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 10ml every 6 hours for congestion

Special Instructions:

Medication Name: ONDANSETRON (ZOFTRAN-ODT)--4MG TAB

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): dissolve 1 tab under tongue every 12 hours as needed for nausea

Special Instructions:

Medication Name: Augmentin 400mg/5ml SUSP

Patient Friendly Discharge Dose, Route, Freq (REQUIRED): Drink 10ml, twice a day, until finished, (5 days).

Special Instructions:

Medication Name: WHITE PETROLATUM 30GM TUBE

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Patient Friendly Discharge apply to lips as needed to keep moist
Dose, Route, Freq (REQUIRED):

Medication Name: OXYMETAZOLINE (AFRIN EQ)--NAS 0.05% SPRA
Patient Friendly Discharge 2 puffs each nostril 2 x daily for 3 days
Dose, Route, Freq (REQUIRED):

Medication Name: CHLORHEXIDINE (PERDIEX) 15ML UNIT DOSE
Patient Friendly Discharge Swish 15ml and spit, twice daily
Dose, Route, Freq (REQUIRED):

Pre-Admission Home Medications

X Medication Name: multivitamin (DAILY VITE) ORAL Tab
Patient Friendly Discharge
Dose, Route, Freq (REQUIRED):
Special Instructions: Continue taking this medication as previously prescribed.

PHARMACY **Completed by PHARMACY, if required per facility policy**

X PATIENT DISCHARGE INSTRUCTIONS

X Discharge Instructions:

The patient was admitted to the APU and taken to the operating room for a lefort osteotomy of the maxilla. They tolerated the procedure well. There were no complications during surgery. The patient was extubated in the OR and transported to the PACU in stable condition where they made an uneventful recovery overnight and obtained radiographic imaging. The following morning the patient was transferred to the APU for routine post operative care. Before discharge the patient's pain was well controlled with oral pain medications, they were voiding spontaneously without issue, tolerating oral intake, and ambulating safely. The patient remained afebrile with stable, normal vital signs and was discharged home with appropriate follow up.

MEDICATIONS: Continue all home medications. New medications listed below. Be sure to eat soft nutritious food prior to taking any medications (see DIET below). This will decrease the chances of post surgical nausea.

Discharge Meds:
-As listed above

SINUS PRECAUTIONS: Due to the nature of the surgical procedure in relation to your maxillary sinus cavity it is essential you follow the guidelines below to maximize your chances for a successful and uneventful healing process:
-Take the medications your surgeon prescribed, as prescribed.
-Do not blow your nose for two-weeks. It is best to wipe away nasal secretions carefully. After 2 weeks, if you must blow your nose, blow gently through both sides at the same time. Do not pinch your nose; do not blow just one side at a time.
-Do not pinch your nose and forcefully clear ears.
-If you must sneeze, keep your mouth open while doing so without pinching your nose.
-Avoid sucking. Do not drink through a straw. Do not smoke.
-Avoid blowing. Do not play a wind instrument. Do not blow up balloons. No forceful or projectile spitting.
-Do not lift or push objects weighing more than 20 pounds.
-No bending over - Keep your head above the level of your heart. Sleep with your head slightly elevated with two pillows.

WHAT TO EXPECT: The first 2-3 days after surgery, are generally the most uncomfortable and there is usually significant swelling. After the first week, you should be more comfortable. For the first 14 days it is normal to experience a little amount of everything. This includes swelling, bleeding, soreness, tightness, bruising/yellowing and a little pain or discomfort. Your nose may feel stiff, congested and mildly ooze with blood, use gauze to gently dab this away. With taking your prescribed medications and strictly following recommendations, this should all be tolerable. It is not uncommon for the anesthesia team to nasally intubate (place a tube through your nose and into your trachea) for oral surgical procedures. This can cause your nose to be sore and even bleed a little after the surgery for the first few days. Dark red-brown blood may come out of nose after 1 week, this is normal. If bleeding is bright red and heavy, this is abnormal, notify your surgical team. Saline nasal rinses (over the counter) can be used to help with nasal congestion as needed. The remainder of your postoperative course should consist of gradual, steady improvement.

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

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WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3172

ACTIVITY RESTRICTIONS: Please do not drive for 24 hours after your surgery. Until that time, you will still be affected by the anesthesia medications you were given during your surgery, and it is not safe for you to drive. Starting 24 hours after surgery you may drive limited amounts. Avoid heavy lifting and mildly strenuous activity/exercises that will significantly elevate blood pressure and heart rate for at least three days. You should limit yourself to light activity for one week following the surgery. However, spending as much time as comfortably possible out of bed sitting up and moving around the house helps speed recovery to daily activities.

SLEEPING: Please keep your head elevated while sleeping. This will minimize swelling and discomfort and reduce pain while allowing you to breathe more easily. One or two pillows may be placed beneath your mattress at the head of the bed to prop the bed into a more vertical position.

SWELLING: Swelling is common after surgery for two weeks. For the first 48 hours place an ice pack (or frozen peas/corn) on your face near the surgical site for 10-20 minutes every 2-3 hours. (Do not put ice in direct contact with the skin). 48 hours after surgery, we suggest switching to warm moist heat to decrease swelling (use a clean facecloth and tap water).

DIET: In the past, but very unusual at the present time, teeth were wired together after jaw surgery. This allows the bones to heal while they are being held still. In the majority of cases today, we use small bone plates and screws to hold the bones still to assist in healing. Support is also given by the splint and elastic traction (elastic bands placed onto your teeth.) This allows the jaw to move and function during the healing period of 8-12 weeks. It must be remembered, however, that the bones are not completely healed and are being stabilized only by the screws and plates. Therefore, we encourage a gradual progression of movement and use of the jaws, keeping in mind that adequate healing does not take place until approximately 6-8 weeks. **REMEMBER:** Your jaws are weakest at 10 days after your surgery. No alcoholic beverages should be consumed for at least twenty-four hours following general anesthesia or as long as you are taking narcotic pain medications.

Initially, it will be difficult to eat adequate amounts of food in only three meals per day. Try to eat five or six times a day, eating smaller portions each time. The following guidelines may be of help to you:

DIET: IMMEDIATELY FOLLOWING SURGERY UNTIL OTHERWISE INSTRUCTED (USUALLY 6 WEEKS)

During this period the diet should be essentially non-chewing. This will minimize the stress on the plates and screws. This may consist of either blenderized food or fluids that don't require chewing. This can include soups, milkshakes, baby food, or any blenderized food just avoid hot food/liquids that could injure/irritate your surgical sites. Some sort of diet supplement such as Ensure, Boost, protein shakes, smoothies or similar liquid meal replacements may be used once or twice a day to increase calorie intake. Plenty of clear fluids, water, etc. will help clean the thicker fluids from your mouth and throat. **REMEMBER:** It is very important to eat as much as possible to help your wounds heal properly. No straws!!

DIET: 6 - 8 WEEKS AFTER SURGERY

Chewing can start during this period of time. Initially begin with soft foods that require minimal chewing. This can consist of mashed potatoes, scrambled eggs, soft pasta that is cut into small pieces, soft rice dishes, or soft sandwiches that are cut into small pieces. One can also eat the foods that were eaten during the initial period. **SLOWLY** advance your diet, progressing into softer meats such as hamburger and soft chicken. The portions should be small so as not to place too much force on the healing bones. Soft fish dishes are also excellent. You will find that your jaw will tire easily. This will continue for the first 2-3 months until your jaw muscles have accommodated for your new jaw position. Avoid eating food which requires chewing for prolonged periods of time.

INTRAORAL SUTURES/STITCHES: Your sutures dissolve on their own. You may notice that they are loose after the swelling of your gum tissue decreases. This is completely normal. They commonly dissolve within the first month following surgery.

WOUND CARE FOR EXTRA-ORAL SURGICAL SITE: You may shower beginning 24 hours after the surgery.

SURGICAL SITES WITH GLUE/TAPE: The extraoral incision site has a dressing affixed in place with glue that will eventually come off on its own. If the edges peel up simply trim them with scissors. You may remove the dressing once it has loosened but do not attempt to remove early. The dressing will be removed at one of your scheduled follow up appointments.

SURGICAL SITES WITH SUTURES ONLY: The extraoral incision site was closed with sutures or "stitches." These will stay in place until the surgeon removes them, do not attempt to remove them on your own. It is important to keep the incision site clean. Wash your hands thoroughly with antibacterial soap, or use hand sanitizer, before cleaning the site. To clean, dilute a 1:1 solution of hydrogen peroxide and water, using a Q-tip gently clean the surgical site. Using a soft clean cloth, gently pad the area dry and apply a thick amount of Vaseline or the prescribed ointment.

Report to an emergency room or OMFS clinic immediately if you have any of the following:

1) Temperature greater than 101.5 F

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

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WRNMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

AR 3173

- 2) Swelling that makes it difficult to breath, speak, or swallow
- 3) Pain not controlled by prescribed meds
- 4) Nausea and vomiting not controlled by prescribed meds
- 5) Excess bleeding or oozing from wounds

Contact the OMS clinic during normal working hours for any questions or concerns, (301) 295-4340. The Duty section at the OMS clinic is available 24 hours a day for emergencies, call or report to the WRNMMC emergency department (301) 295-4810.

For non-emergent after hours concerns call the Walter Reed National Military Medical Center quarterdeck at (301)295-4611 and ask for the oral surgeon on call.

You have a scheduled follow up appointment as below. Please call (301)295-4340 if you need to reschedule. Follow up is at Bldg 1 deck 2 oral surgery. call 307-203-9044 if you need to reschedule

Follow-up appointment will be Time/Date: 01MAY2017@0900 with Jensen, Damon T 2878

follow up is at building 1 deck 2 oral surgery cell contact 307-203-9044

Follow-up appointment will be Time/Date: 10MAY2017@1300 with Jensen, Damon T 2878

6 week follow up at Building 9 deck 2 (arrowhead) for pano, pa cep, lat cep. Please note your third/june follow up is at a different location than your 01MAY and 10 MAY follow ups

Follow-up appointment will be Time/Date: 07JUN2017@1100 with Jensen, Damon T 2878

Report any of the following to your Surgeon/Provider
OR

NEAREST Emergency Room IMMEDIATELY

- Fever over 101 degrees by mouth
- Nausea or vomiting for more than 24 hours
- Pain unrelieved by medication.
- Separation of wound edges.
- Increasing bleeding or drainage from wound
- Swelling that does not subside after 7 days.
- Redness around the surgical site that is warm to the touch or is accompanied by drainage or foul odor.
- For General Surgery; if you experience Nausea and Worsening Abdominal Pain.

X DISCHARGE CONVALESCENCE INFORMATION **Use for ANY patient, if applicable**

***Convalescence information entered below will populate to the Discharge Convalescence Memo *. ***

Admitted to the hospital from 27Apr2017 to

Recommend a period of 14 days of convalescence after the date of discharge from the hospital.

Additional Restrictions/Comments:

See Discharge Instructions

Please feel free to call our facility with questions at the number(s) listed below.

See Discharge Instructions

- FINAL SIGNATURES -

Intern

Name of Supervising Resident:

Name of Supervising Staff/Attending: Jensen, Damon T 2878

Signature: Cvelich, Michael K LT 6793

Time/Date: 1047 12Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

X Resident

I have discussed the patient with my supervising Staff/Attending. The supervising Attending for this patient care encounter is:

Name of Supervising Staff/Attending: Jensen, Damon T 2878

Resident Addendum:

Signature: CERVENKA, PETER D 0736

Time/Date: 0643 28Apr2017

Fellow/Consultant Addendum:

Nurse Practitioner Addendum:

other Provider Addendum:

Staff Attending (Signature Required)

I have reviewed the documentation, examined the patient, discussed the case with the multidisciplinary team and agree with findings and plan of care. Agree with above pt referred to endo for eval of 12. Scheduled 20APR for endo eval.

Signature: Jensen, Damon T 2878

Time/Date: 1059 12Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

CliniComp, Intl.

Note Type: Medication Reconciliation *
 Note Time: N/A
 Last Stored: 0512 27 Apr 2017
 Stored By: Jensen, Damon T 2878 LONGO, ANTONIO CIV. 0901

LOINC 56445-0 Rev. 2015.10.09.1255 (R2.1)

Medication Reconciliation Worksheet

Date of Birth: 16Feb1985 Age: 32 Sex: M

Height: 175.3 cm = in
 Weight: 76.80 kg
 BMI: 24.97
 BSA(m²): 1.925

Pregnant? N Lactating: N

Source(s) of Information:

Patient;

Allergy Information

#1 Type: MISC. Name: Feathers Symptoms: UserSpecifiedSymptom
 Onset: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 Date:
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:
 #2 Type: MISC. Name: Cat dander Symptoms: UserSpecifiedSymptom
 Onset: 04/24/2017 Severity: SEVERE Other Symptom: Dyspnea
 Date:
 SNAME
 D
 Code:
 RxNor Last Modification Date: 04/24/2017 Inactive:
 m
 Code:

CHCS Identified Allergies

Medication Listing

Admission Medications: to include home, non prescription, herbals, medications taken in another care facility and illicit drugs.

Active CHCS Medication List

Drug Name	Last Refill Date	Patient Currently Taking	Dosing Instructions (NO abbreviations)	Inpatient Plan (Provider Only)
OXYMETAZOLINE--NAS 0.05% SPRA	04/27/2017		2 PUFFS EACH NOSTRIL 2-TIMES A DAY EVERY DAY FOR 3-DAYS	
PSEUDOEPHEDRINE--PO 30MG/5ML SOLN	04/27/2017		5 ML BY MOUTH EVERY SIX-HOURS ~	
oxyCODONE/APAP--PO 5/325MG TAB	04/27/2017		TAKE 1 TO 2 TABLETS EVERY 6-HOURS AS NEEDED	

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

PETROLATUM NF--TOP OINT	04/27/2017	FOR POST-SURGICAL PAIN ~ APPLY TO LIPS AS NEEDED TO~KEEP MOIST ~
AMOXICILLIN/CLAVULANATE--PO 875MG TAB	04/27/2017	TAKE 1 TABLET TWICE A DAY UNTIL GONE
ONDANSETRON--PO 4MG TAB	04/27/2017	DISSOLVE 1 TABLET UNDER-TONGUE EVERY 12 HOURS AS-NEEDED FOR NAUSEA ~
CHLORHEXIDINE (AF)--MTH 0.12% SOLN	04/27/2017	RINSE (50% PERIDEX/50%-WATER) 2 TIMES A DAY EVERY-DAY STARTING ON THE DAY-AFTER SURGERY ~
IBUPROFEN--PO 800MG TAB	04/27/2017	TAKE ONE TABLET THREE TIMES~EVERY DAY ~
ESCITALOPRAM--PO 20MG TAB	03/01/2017	TAKE ONE TABLET BY MOUTH EVERY DAY
NALTREXONE--PO 50MG TAB	03/01/2017	TAKE 1/2 TABLET BY MOUTH EVERY DAY X 1 WEEK, THEN INCREASE TO ONE TABLET BY MOUTH EVERY DAY IF TOLER

Additional Medications:

Drug Name	Patient Currently Taking	Dosing Instructions (NO abbreviations)	Inpatient Plan (Provider Only)
multivitamin (DAILY VITE) ORAL Tab	X		

Provider

#1 Signature: Jensen, Damon T 2878
HT: 69" WT: 165

Time/Date: 1029 12Apr2017

DODID:

MERWIN, DANIEL DENNIS

FMPL6SSN: [REDACTED]

??? ???

WRNMMC Bethesda 27Apr2017

PERSONAL/PRIV ACT 1974

Clinical Notes

Medical Record	WRNMMC Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	
1. OPERATION or PROCEDURE (Describe)	A. IDENTIFICATION	SIDE (MARK ONE)
EXCISION <i>Scrotum</i>		<input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Not Applicable

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):

Under local anesthesia, the lesion(s) will be surgically removed and sent to pathology. The site will be closed with sutures and bandaged. Risks include: bleeding, scarring, infection, nerve damage, poor cosmetic result, and lesion recurrence.

which is to be performed by or under the direction of DR. *Dr. Blazs*

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any, are (if "none", so state): **NONE**

6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and the observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.
(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in parts A & B must be completed before signing.)

9. COUNSELING Provider: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

Provider's Signature:

Provider's Printed Name:

10. PATIENT/Guardian: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Patient/Guardian's Signature:

Witness' Signature:

Date (MM/DD/YYYY)

Time (HH:MM)

D. UNIVERSAL PROTOCOL / TIME OUT

"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:

- | | |
|--|---|
| 1. CORRECT PATIENT (Full Name / Birth Date)..... | <input checked="" type="checkbox"/> YES |
| 2. CORRECT PROCEDURE | <input checked="" type="checkbox"/> YES |
| 3. CORRECT SITE** | <input checked="" type="checkbox"/> YES |
| 4. REQUIRED EQUIPMENT AVAILABLE..... | <input checked="" type="checkbox"/> YES |
| 5. IMAGES / LABS AVAILABLE, PROPERLY LABELED | <input checked="" type="checkbox"/> YES |

N/A ☐

N/A ☒

** The site must be marked and verified for procedures involving right/left distinction, multiple structures (e.g. digits), or multiple levels (as in spinal procedures) per WRNMMC policies.

Signature below indicates the procedure may be started. If any element is not completed as required, procedure may NOT be started.

Timeout Verified by:

Printed Last Name

Signature

Date (MM/DD/YYYY)

Time (HH:MM)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - Last, First Middle; ID no. (SSN or other); Hospital or Medical Facility)

Register #

Ward #

MERWIN, DANIEL D.
20/12/1985 DOB: 1985

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES

Medical Record

LOCAL FORM 522 (Rev. 2/2012) AR 3178
Prescribed by GSA/ICMR FMR (41 CFR) 102-193.30(i)
DoD Exception to OF 522 approved by GSA

Clear Form

WALTER REED-BETHESDA BEHAVIORAL HEALTH CLINIC

LIMITS OF CONFIDENTIALITY

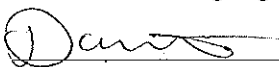
Authority: DoD 6025.18-R, "Health Information Privacy Regulation"

Limitations of Confidentiality: As part of your healthcare team, our goal is to provide you with quality care as well as protect the privacy of your personal information. The care we provide you may include, but is not limited to, assessment, referral, individual therapy, couples therapy, family therapy, group therapy, and psychiatric evaluation and medications. As your providers, we will document information about your visits in your military health record (written and electronic) to ensure continuity of care. Your health record is maintained as the property of the U.S. Government. In the majority of cases, we will not disclose any of your personal information nor confirm/deny that we have met with you unless you provide us with written authorization to disclose your personal information. There are exceptions, however, under which we may be required to release your personal information without obtaining your prior authorization. For example:

1. **Safety:** If you threaten to harm yourself, we may seek hospitalization and/or contact others to ensure your safety. If you threaten serious bodily harm to another, we are required to take protective actions, such as contacting the victim, police, chain of command, or seeking your hospitalization.
2. **Abuse:** If we believe that a child or vulnerable adult is being abused, we are required to file a report with the appropriate protective agency. We may also be required to Report spousal abuse under certain circumstances.
3. **Court Orders and Subpoenas:** If you are involved in legal actions/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), we have a limited "privileged communication" that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving some violations of the UCMJ, civil, or criminal law where we may be required to divulge that information to your Commanding Officer (CO) and/or other authorities. If you have any concerns related to this, please contact an attorney.
4. **Command Consultations:** For service members, your Commanding Officer or Command Element (CO) is entitled to limited information, as pertinent to any duty limitation or restriction, security clearance, or treatment that might affect duty performance or jeopardize the safety of yourself, co-workers, or the unit's mission. Your CO or chain of command is not authorized to view your medical record through informal means. Information that impacts your duty status may be provided to your CO in writing, such as through service-specific documentation. We do not practice routine disclosure to commands. When we must disclose information, it is the minimum necessary and will only be to your CO unless you give written permission otherwise. This applies even if you are command-referred here. For information on command referred evaluations, see Department of Defense Instruction 6490.4.
5. **Care Coordination:** Because we operate as a team with other healthcare staff to provide you the best possible services, we may disclose your information to other providers or care managers to facilitate your continued care. These members of the health care team are permitted access to your records in their treatment of you. In most cases, your information will not be discussed outside the clinic or hospital setting without your written permission.
6. **Legal:** Medical care providers may be required to report information disclosed about the intent to violate a military regulation or a law.
7. **Quality Care Reviews:** Quality assurance personnel may review your record to ensure that care standards are being met. If this occurs, the reviewer is required to keep your identity confidential.
8. **Third-Party Insurance:** If you have health insurance besides TRICARE, limited information may be released to your insurance company.
9. **Email and Other Electronic Contact:** As per The Health Information Technology for Economic and Clinical Health Act (HITECH Act) that is part of the American Recovery and Reinvestment Act of 2009 (ARRA), we can only communicate with you electronically through encrypted technologies. Because of these restrictions, our ability to contact you electronically is limited to an encrypted method that you and your provider might establish.

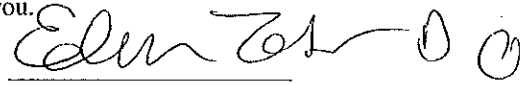
If you have any questions or concerns, please feel free to discuss them with us. Our intent is to discuss our limitations with you now and throughout your treatment as they may arise. We shall approach your care in the spirit of advocacy for you and in accordance with our hospital's vision of providing patient and family-centered care.

Acknowledgment of Privacy Act Rights and Limitations: Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.



Patient Signature

Witness Signature



Provider Signature

DANIEL M. M...

Printed Name/Date

Printed Name/Date

Edm... 06 SEP 16

Printed Name/Date

6 SEP 16



Walter Reed
National Military
Medical Center

Bithiah R. Reed

Ph.D., ABPP, MSCP, CDR, USPHS

Service Chief

Adult Outpatient Behavioral Health Clinic

Walter Reed National Military Medical Center

8901 Wisconsin Ave., Bethesda, MD 20889-5600

(301)400-1931

Bithiah.r.reed.mil@mail.mil

07 AUG 2015

Dear Valued Beneficiary,

Thank you for choosing this clinic for your mental health care. We strive to provide patient-centered care, and that includes continual efforts to improve access to care by minimizing missed appointments.

Missed appointments: These are documented as "no show" in the electronic medical record and you may receive a "wellness check" call from the clinic. Greater than one missed "new" appointment will not be rescheduled except through a discussion with the Clinic Manager or Service Chief. A pattern of missing follow-up appointments (greater than two) will trigger similar intervention by clinic leadership, as these negatively impact providers' ability to deliver care safely and accessibly. A pattern of missed appointments may also warrant contacting the patient's Commanding Officer (for active duty), or making referrals elsewhere and closing an episode of care here.

Same day appointment cancellation: These often go unused because they are almost impossible to re-book with other patients on such short notice. They negatively impact our clinic's access to care. These late cancellations are also documented as "no-show," and if this becomes a pattern (greater than two), clinic leadership may intervene as noted above.

Please try to attend the appointments you schedule with us, or change the appointment in advance. If you need to cancel, please do so during business hours prior to the day your appointment occurs. You can expect our providers and the clinic leadership to look for ways to help our patients problem-solve appointment attendance issues, and actively intervene if missing appointments becomes a pattern.

Questions or concerns may be discussed with your provider, the Clinic Manager, or Service Chief.

Bithiah R. Reed

I acknowledge receipt of the above letter and understand that I am responsible for adhering to this policy.

Beneficiary's Signature

Beneficiary's printed name

Date

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 31y M

Priority: Exam#: 0067-16227558

Procedure: CHEST PA/LAT Exam date: 6/22/2016 12:38:00 PM

Reason for exam: r/o abnormality

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

HISTORY: r/o abnormality

TECHNIQUE: Upright, PA and lateral chest radiographs. Two views.

COMPARISON: None.

FINDINGS:

Lungs: Lungs are clear.

Pleura: No pleural effusion or visible pneumothorax.

Heart / Mediastinum: Within normal limits.

Upper Abdomen: Within normal limits.

Bones and Soft Tissues: No acute osseous abnormality.

IMPRESSION:

Normal chest radiographs.

Electronically signed by: Dr. MATTHEW LEO LUTYNSKI
Department of Radiology
Walter Reed National Military Medical Center

Date: 06/22/16

Time: 13:08

Interpreting Radiologist: LUTYNSKI, MATTHEW

Approved by: LUTYNSKI, MATTHEW

Supervised by: LUTYNSKI, MATTHEW

Transcription date: Jun 22 2016 01:08PM

Transcriptionist: LUTYNSKI, MATTHEW

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 31y M

Priority: Exam#: 0067-16131283

Procedure: MRI, BRAIN W W/O CON Exam date: 4/15/2016 4:48:00 AM

Reason for exam: SM with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad

Order comment: Please use gad

Result code: SEE RADIOLOGIST'S REPORT

Finding:

Brain MRI without and with gadolinium: 04/15/16 04:48:00.

History: 31 y/o M with acute onset distortion taste, Please evaluate olfactory nerves for pathology, and brain for possible pathology, please use gad.

Technique: Sagittal T1, axial and coronal T2, axial T2 FLAIR, axial DWI, axial GRE, axial T1, axial post T1 FS, coronal post 3D SPGR of the brain. A total of 16 mL of ProHance was given intravenously as part of the study.

FINDINGS: No focal mass lesion or abnormal enhancement along the expected course of either olfactory bulb or groove is seen. There is normal appearance of both olfactory bulb and nerves.

Acute: No hemorrhage, herniation, or hydrocephalus. No evidence of acute ischemia.

Brain: Brain parenchyma is within normal limits in signal and volume for age.

Vessels: No abnormal intravascular signal to suggest thrombosis. There is note of a tubular enhancing structure posteriorly in the left cerebellar hemisphere compatible with an incidental developmental venous anomaly

Bones: No suspicious lesion in the calvarium or skull base.

Other: Extracranial soft tissues are unremarkable.

IMPRESSION:

1. No enhancing mass lesions along the expected course of either olfactory bulb or groove is seen. Both olfactory bulbs and nerves appear to be normally developed.

2. No intracranial pathology. No abnormal enhancement.

Electronically signed by: Demarco
Department of Radiology
Walter Reed National Military Medical Center

Date: 04/15/16
Time: 08:18

Interpreting Radiologist: DEMARCO, JAMES

Approved by: DEMARCO, JAMES

Supervised by: DEMARCO, JAMES

Transcription date: Apr 15 2016 08:18AM

Transcriptionist: DEMARCO, JAMES

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 31y M

Priority: Exam#: 0067-16054521

Procedure: ANKLE, LT 3 VIEWS Exam date: 2/16/2016 2:10:00 PM

Reason for exam: H/o anterior talofibular ligament sprain, conservative management. Recurrence of pain. Concern for arthritis.

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

Comparison: MRI October 5, 2014 and prior radiographs May 6, 2014

Findings: Routine radiographs of the ankle were obtained. Normal alignment is present without evidence for acute fracture or dislocation. There is mild lateral soft tissue swelling present. The ankle mortise and talar dome are intact. The joint spaces are preserved without significant degenerative changes.

Impression: Lateral soft tissue swelling without evidence for acute bony abnormality

Electronically signed by: Dr. ZACHARY ETHAN FISHER
Department of Radiology
Walter Reed National Military Medical Center

Date: 02/16/16
Time: 14:54

Interpreting Radiologist: FISHER, ZACHARY

Approved by: FISHER, ZACHARY

Supervised by: FISHER, ZACHARY

Transcription date: Feb 16 2016 02:54PM

Transcriptionist: FISHER, ZACHARY

Medical Record

WRNMMC Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

1. OPERATION or PROCEDURE (Describe)

A. IDENTIFICATION

SIDE (MARK ONE)

PUNCH BIOPSY: 2mm 3mm 4mm 5mm 6mm 8mm

☐ Right☐ Bilateral☐ Left☐ Not Applicable

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):

Under local anesthesia, the lesion(s) will be removed with a round "cookie cutter" device and sent to pathology. The site will be closed with stitches and bandaged. Risks include: bleeding, scarring, infection, nerve damage, poor cosmetic result, and lesion recurrence.

which is to be performed by or under the direction of

DR. TAYLOR

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any, are (if "none", so state):

None

6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and the observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.
(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in parts A & B must be completed before signing.)

9. COUNSELING Provider: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

Provider's Signature:

Taylor

Provider's Printed Name:

TAYLOR

10. PATIENT/Guardian: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Patient/Guardian's Signature:

D. Taylor

06/22/2025 1530

Date (MM/DD/YYYY)

Time (HH:MM)

Witness' Signature:

M. Taylor

D. UNIVERSAL PROTOCOL / TIME OUT

"Time-Out" - Performed immediately before starting the procedure. Entire team confirms the following:

- | | | |
|--|------------------------------|------------------------------|
| 1. CORRECT PATIENT (Full Name / Birth Date)..... | <input type="checkbox"/> YES | |
| 2. CORRECT PROCEDURE | <input type="checkbox"/> YES | |
| 3. CORRECT SITE** | <input type="checkbox"/> YES | |
| 4. REQUIRED EQUIPMENT AVAILABLE..... | <input type="checkbox"/> YES | N/A <input type="checkbox"/> |
| 5. IMAGES / LABS AVAILABLE, PROPERLY LABELED | <input type="checkbox"/> YES | N/A <input type="checkbox"/> |

** The site must be marked and verified for procedures involving right/left distinction, multiple structures (e.g. digits), or multiple levels (as in spinal procedures) per WRNMMC policies.

Signature below indicates the procedure may be started. If any element is not completed as required, procedure may NOT be started.

Timeout Verified by:

N. Taylor

Printed Last Name

Signature

06/22/2025 1530

Date (MM/DD/YYYY)

Time (HH:MM)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - Last, First Middle; ID no. (SSN or other); Hospital or Medical Facility)

MERWIN, DANIEL D.
20 / [REDACTED] DOB: [REDACTED] 1985

Register #

Ward #

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES

Medical Record

LOCAL FORM 522 (Rev. 2/2012)

Prescribed by GSA/ICMR FMR (41 CFR) 102-193.30(i)

DoD Exception to OF 522 approved by GSA

Clear Form

Note Type: BH Narrative Summ/Disposition
 Note Time: N/A
 Last Stored: 0921 22 Apr 2015
 Stored By: Brockington, Rhonda J, NP

THREE COPIES MUST BE PRINTED OUT MANUALLY:
 - PATIENT SIGNED COPY FOR INPATIENT RECORD.
 - ONE COPY FOR PATIENT
 - ONE FOR OUTPATIENT RECORD

FBCH BH Narrative Summary/Disposition

ADMISSION DATE: 25Mar2015

DISCHARGE DATE: 22APR2015

PRIMARY CARE MANAGER:

ADMITTING DIAGNOSIS: ALCOHOL ABUSE

ADMISSION DATA

HISTORY:

HPI: 30 y.o. male admitted to 4 North for "drinking a lot." Pt began drinking at age 12 with his older, high school age friends for fun. He drank every other weekend for the next few years until he turned 18, at which point he began drinking 4-6 mixed drinks 3-4 days each week until 2012. During that period, he drank when he was sad, and when he was out at parties. In 2012, he had a major break-up from a 2-yr relationship, and began consuming 4-6 vodka or rum mixed drinks daily. Pt states that he drinks when he is sad, has relationship problems, or needs to fall asleep. He has very few friends, so he drinks alone. He attributes his lack of friends to his poor relationship with his father growing up. Pt states that he does not drink as much as he does at home when he goes out because he does not want others to see him like that. Says that alcohol makes him forget what is bothering him, but believes that it is not actually fixing his problems. Pt attempted to stop drinking on 18-19 March 2015, but was not able to maintain abstinence and started drinking again on 20 March. He had his last drink on 24 March. Pt denies visual, auditory, olfactory hallucinations, but states that his thoughts seem to race and he speeds through everything that he does feels like he is always moving fast.

Suicidal Ideation: Pt admits to SI three days ago. He thought of a plan to use a helium hood because it is less painful and no one would know if he died. Pt did not have the means to complete this action, and said he doesn't think he would have done it. Says he often thinks of committing suicide. The thought comes and goes, and is due to a mixture of sadness and alcohol. In the past, he has never thought through a plan in that much detail.

He has attempted suicide twice in the past. He does not possess of firearms.

Grief, Abandonment, Abuse: Pt states that as a child his father would punish him and his sisters by spanking them with his hands hard enough to leave marks. States that his father seemed to take out his anger on them as he spanked them, and that his father yelled a lot. For a few weeks pt was placed in foster care while his father was investigated for child abuse, but he was soon returned to his father. Father spanked pt and his siblings until they were late teens, and once punched pt in face. Pt states that when he was 17, his father forcefully grabbed and shaved off his hair one day. Father drank alcohol every day, but pt does not know if he had a substance abuse problem. Pt believes that his problems maintaining friendships stems from his lack of relationship with his father. Says there was no real relationship between the two and that he had to work for everything he wanted. No sexual abuse history.

Medications: Multivitamin

Allergies: Cats; pt's throat closes and he itches

Pain: 2/10 today because he recently got his braces tightened

Social Hx: Pt states he doesn't really have any friends, and if not at work programming, he spends most of his time alone. No smoker, no illicit drugs, no supplements, drinks up to 16oz coffee per day, single.

Past psychiatric Hx: Pt has no psychiatric diagnoses. Pt has anxiety that keeps him up at night. He anxiously thinks about a lot of things at night, which results in his inability to fall asleep for a while. When he cannot fall asleep, he uses alcohol to help. When he eventually does fall asleep, he wakes up a few times to use the restroom in the night. He usually gets 5-7 hr of sleep a night, but says he does not sleep well, and does not feel rested in the morning. He naturally wakes up between 0700-0800 every day, no matter how late he goes to bed. He says that he often cannot stay awake during the day and has to take naps.

Prior Suicide attempts: Pt attempted to commit suicide twice in high school. First attempt he swallowed a whole bottle of aspirin. Said he just got sick, but was not hospitalized and told very few people. Second attempt was also in high school, and he tried to drink a lot of alcohol, but that also was to no avail.

Hx of Violent behavior: Pt got into a few fights in high school, and got into two fights when he was deployed on a Navy ship from 2006-2009. One fight was in 2006 and the other was in 2007.

Hx of firearms in home: Pt does not possess any firearms. Were at house when he lived with a significant other in the past, but none of his own.

Hx of pending legal issues: Pt does not have any legal issues.

716436

MERWIN, DANIEL DENNIS

20- 985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Financial: Pt says finances cause him much stress and worry. He is in debt, and is getting closer to paying off his debt, but it still worries him quite a lot.

Education: Pt states he did not do well in high school; graduated with 2.2 GPA. Worked as much as possible during the week, he said legal max was 20hr and worked 40hr during summer. Currently pt has 60 credit hours towards his Computer Science degree, but says he hates school. In the future, he does not know exactly what he wants to do, but has always wanted to be a chef and open his own restaurant.

PMX: Inflammatory colon; has been tested for Crohns and other GI conditions, but none found yet. Since age 15, has had stabbing pain and inflammation (as seen on imaging) caused by eating spicy and fiber-rich foods. Has been hospitalized for this.

Family Hx: Pt has a younger sister with depression. His other sister, maternal grandmother and possibly his mother have bipolar disorder. Pt does not know much about his father's side of the family.

Military hx: Pt is in a Navy cryptologic tech.

Deployment hx: Pt did tour on Navy ship from 2006-2009.

TBI hx: Denies.

PTSD hx: Denies.

SIGECAPS:

Sleep: 5-7 hrs of poor quality sleep, uses alcohol to fall asleep

Interest: No change; never really had much interest in anything, recently purchased snow-board gear to try this hobby

Guilt: No change, says maybe sometimes he feels guilty about lying so much as a child

Energy: No change

Connections: Does not enjoy the fact that he has no friends

Appetite: No change, eating normally recommended portions

Psychomotor: agitated +

Suicide/Homicide: SI three days ago (See above); denies homicidal ideation

Sex: No change in libido, usually high

PERTINENT PHYSICAL EXAM FINDINGS ON ADMISSION:

Exam Date: 0025 25 Mar 2015

Vital Signs: SBP: 131 DBP: 80 HR: 80 RR: 16 TEMP: 98.3

Comments: alert and cooperative and agreeable to exam

Head/Neck: Normocephalic. Supple without masses

Eyes: PERLA

Ears: Clear TMS, normal canals

Nose/Sinuses: No nasal/tender discharge, no tender Sinuses, patent nares

Throat/Mouth/Teeth: Normal

Female Breast: N/A

Chest/Lungs: Equal BS, no rales, rhonchi, wheezes or rubs

Heart: No gallops, rubs or murmurs

Abdomen: Soft, nontender, normal BS, no organomegaly

Male Genitalia: Not observed

Rectal/Prostate: offered and pt declined

Genitalia/Rectal (F): Not observed

Pelvic: Not observed

Back: Standing: Cervical exam:
Sidebending: 30 degrees b/l
Rotation: 60 degrees b/l
Flexion: 30 degrees
Extension: 10 degrees

Lumbar exam:
Flexion: 120 degrees
Extension: 20 degrees

Pulses: Posterior Tibial and Dorsalis Pedis 2

Extremities: No clubbing, cyanosis or edema

Skin: Lesions noted on back of head, three hairless spots with dry, flaky skin

Lymphatics: No palpable or enlarged nodes

Neurologic:

716436

MERWIN, DANIEL DENNIS

20- 985

USN ACTIVE DUTY AFPA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Cranial Nerves: **Intact**
 Motor: **5/5 upper and lower extremities**
 Sensory: **normal to light touch**
 Coordination: **romberg negative**
 Reflexes: **patella 2/4 b/l and achilles 2/4 b/l**

Mental Status:

General Appearance: **Well nourished, well developed**
 Psychomotor State: **no agitation tics or abnormal movements**
 Relation to Interviewer: **pleasant**
 Mood: **(observed) friendly and open, mildly anxious**
 Affect: **open and friendly, lively but consistent throughout encounter, congruent with mood**
 Speech: **Normal rate, appropriate volume for size of room, appropriate inflection and articulation**
 Thought Processes: **Linear, logical, coherent**
 Thought Content:
 Suicidal Ideation: **Suicidal ideation 3 days ago. He thought of a plan to use a helium hood bc it is less painful and no one would know if he died. Did not have means to complete action, and said he doesn't think he would have done it. Often thinks of committing suicide; the thought comes and goes, and is due to a mixture of sadness and alcohol. In the past, he has never thought through a plan in that much detail.**
 Homicidal Ideation: **denies past to present**
 Delusions: **denies past to present**
 Hallucinations: **denies past to present**
 Higher Cognitive Functions: **intact**
 Judgement/Impulse Control: **poor**
 Insight: **self-referred, aware that he has a problem and willing to take steps to fix it**
 Estimated Intelligence: **above average**
 Risk Assessment: **A complete History and Physical Evaluation as well as a comprehensive nursing evaluation performed on admission. Risk evaluation was completed on the day of admission and the patient was appropriate in risk for admission to the RTC.**

LABORATORY DATA/DIAGNOSTIC IMAGING DATA/ECG DATA:

Drug Abuse Screen Site/Specimen 30 Mar 2015 0805
 Amphetamines URINE Not detected <i>
 Barbiturates URINE Not detected <i>
 Benzodiazepines URINE Not detected <i>
 Cocaine URINE Not detected <i>
 Opiates URINE Not detected <i>
 Phencyclidine, UA URINE Not detected <i>
 Cannabinoids URINE Not detected <i>
 Methadone URINE Not detected <i>
 Oxycodone URINE Not detected <i>
 Coagulation Panel 1 (PT+APTT) Site/Specimen 27 Mar 2015 1600
 Protine PLASMA 12.5
 INR PLASMA 1.0 <i>
 APTT PLASMA 32.9 <i>
 Urinalysis Panel Site/Specimen 27 Mar 2015 2159
 Color URINE Straw
 Ketones URINE neg
 Hemoglobin URINE neg
 Nitrite URINE neg
 pH URINE 7.0
 Protein URINE neg
 Appearance URINE Clear
 Leukocyte Esterase URINE neg
 Specific Gravity URINE 1.006
 Urobilinogen URINE normal
 Glucose URINE neg
 Bilirubin URINE neg

716436

MERWIN, DANIEL DENNIS

20- 985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

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Drug Abuse Screen Site/Specimen 27 Mar 2015 1630
Amphetamines URINE Not detected <i>
Barbiturates URINE Not detected <i>
Benzodiazepines URINE Not detected <i>
Cocaine URINE Not detected <i>
Opiates URINE Not detected <i>
Phencyclidine, UA URINE Not detected <i>
Cannabinoids URINE Not detected <i>
Methadone URINE Not detected <i>
Oxycodone URINE Not detected <i>

Urinalysis Panel Site/Specimen 27 Mar 2015 1630
Color URINE Straw
Ketones URINE neg
Hemoglobin URINE neg
Nitrite URINE neg
pH URINE 7.0
RBC URINE < 1
Protein URINE neg
Appearance URINE Clear
Leukocyte Esterase URINE MOD (H)
Specific Gravity URINE 1.008
Urobilinogen URINE normal
WBC URINE 3 (H)
Glucose URINE neg
Bilirubin URINE neg

Comprehensive Metabolic Panel Site/Specimen 27 Mar 2015 1600
Albumin SERUM 4.9
Alkaline Phosphatase SERUM 71
Alanine Aminotransferase SERUM 29 <i>
Bilirubin SERUM 0.3
Urea Nitrogen SERUM 14
Calcium SERUM 10.0
Carbon Dioxide SERUM 29
Chloride SERUM 98
Creatinine SERUM 0.9
Glucose SERUM 82
Potassium SERUM 4.7
Protein SERUM 7.9
Sodium SERUM 139
Anion Gap SERUM 13
GFR Calculated Non-Black SERUM 114.7
GFR Calculated Black SERUM 132.6 <i>
Aspartate Aminotransferase SERUM <5

Thyroid Stimulating Hormone Site/Specimen 27 Mar 2015 1600
Thyrotropin SERUM 0.757 <i>

Gamma Glutamyl Transferase Site/Specimen 27 Mar 2015 1600
Gamma-Glutamyl Transferase SERUM 40

Magnesium Site/Specimen 27 Mar 2015 1600
Magnesium SERUM 2.2

CBC W/Diff Site/Specimen 27 Mar 2015 1600
WBC BLOOD 6.8
RBC BLOOD 4.65
Hemoglobin BLOOD 14.5
Hematocrit BLOOD 43.1
MCV BLOOD 92.6
MCH BLOOD 31.1
MCHC BLOOD 33.6
RDW CV BLOOD 12.0
Platelets BLOOD 296
MPV BLOOD 8.5
Neutrophils BLOOD 67.0
Lymphocytes BLOOD 25.1
Monocytes BLOOD 6.7
Eosinophils BLOOD 0.9
Basophils BLOOD 0.3
ABS Neutrophils BLOOD 4.5
ABS Lymphocytes BLOOD 1.7
ABS Monocytes BLOOD 0.5
ABS Eosinophils BLOOD 0.1
ABS Basophils BLOOD 0.0
Differential Review BLOOD MANUAL DIFF NOT PERFORMED

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716436

MERWIN, DANIEL DENNIS

20- [REDACTED] 1985

USN ACTIVE DUTY AFPA

PBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Drug Abuse Screen Site/Specimen 20 Apr 2015 0012 <o> Units Ref Rng
 Amphetamines URINE Not detected <i> (Not-detected)
 Barbiturates URINE Not detected <i> (Not-detected)
 Benzodiazepines URINE Not detected <i> (Not-detected)
 Cocaine URINE Not detected <i> (Not-detected)
 Opiates URINE Not detected <i> (Not-detected)
 Phencyclidine, UA URINE Not detected <i> (Not-detected)
 Cannabinoids URINE Not detected <i> (Not-detected)
 Methadone URINE Not detected <i> (Not-detected)
 Oxycodone URINE Not detected <i> (Not-detected)

ETG/ETS, UA (500 Cut-Off) Site/Specimen 13 Apr 2015 0548 Units Ref Rng
 Ethyl Glucuronide URINE Negative ng/mL Cutoff=500

Drug Abuse Screen Site/Specimen 13 Apr 2015 0548 Units Ref Rng
 Amphetamines URINE Not detected <i> (Not-detected)
 Barbiturates URINE Not detected <i> (Not-detected)
 Benzodiazepines URINE Not detected <i> (Not-detected)
 Cocaine URINE Not detected <i> (Not-detected)
 Opiates URINE Not detected <i> (Not-detected)
 Phencyclidine, UA URINE Not detected <i> (Not-detected)
 Cannabinoids URINE Not detected <i> (Not-detected)
 Methadone URINE Not detected <i> (Not-detected)
 Oxycodone URINE Not detected <i> (Not-detected)

ETG/ETS, UA (500 Cut-Off) Site/Specimen 06 Apr 2015 0722 Units Ref Rng
 Ethyl Glucuronide URINE Negative ng/mL Cutoff=500

Drug Abuse Screen Site/Specimen 06 Apr 2015 0722 Units Ref Rng
 Amphetamines URINE Not detected <i> (Not-detected)
 Barbiturates URINE Not detected <i> (Not-detected)
 Benzodiazepines URINE Not detected <i> (Not-detected)
 Cocaine URINE Not detected <i> (Not-detected)
 Opiates URINE Not detected <i> (Not-detected)
 Phencyclidine, UA URINE Not detected <i> (Not-detected)
 Cannabinoids URINE Not detected <i> (Not-detected)
 Methadone URINE Not detected <i> (Not-detected)
 Oxycodone URINE Not detected <i> (Not-detected)

Chlamydia+Gonococcus DNA Panel NAAT Site/Specimen 30 Mar 2015 2236 Units Ref Rng
 Neisseria gonorrhoeae DNA URINE NEGATIVE FOR N.GONORRHOEAE <i>
 Chlamydia trachomatis DNA URINE NEGATIVE FOR C.TRACHOMATIS <i> (Negative)

ETG/ETS, UA (500 Cut-Off) Site/Specimen 30 Mar 2015 0805 Units Ref Rng
 Ethyl Glucuronide URINE Negative ng/mL Cutoff=500

Drug Abuse Screen Site/Specimen 30 Mar 2015 0805 Units Ref Rng
 Amphetamines URINE Not detected <i> (Not-detected)
 Barbiturates URINE Not detected <i> (Not-detected)
 Benzodiazepines URINE Not detected <i> (Not-detected)
 Cocaine URINE Not detected <i> (Not-detected)
 Opiates URINE Not detected <i> (Not-detected)
 Phencyclidine, UA URINE Not detected <i> (Not-detected)
 Cannabinoids URINE Not detected <i> (Not-detected)
 Methadone URINE Not detected <i> (Not-detected)
 Oxycodone URINE Not detected <i> (Not-detected)

Urinalysis Panel Site/Specimen 27 Mar 2015 2159 Units Ref Rng
 Color URINE Straw (Yellow)
 Ketones URINE neg mg/dL (neg)
 Hemoglobin URINE neg (neg)
 Nitrite URINE neg (neg)
 pH URINE 7.0 (5.0-9.0)
 Protein URINE neg mg/dL (neg)
 Appearance URINE Clear (Clear)
 Leukocyte Esterase URINE neg (neg)
 Specific Gravity URINE 1.006 (1.000-1.035)
 Urobilinogen URINE normal mg/dL (norm 0.2-1)
 Glucose URINE neg mg/dL (neg)
 Bilirubin URINE neg (neg)

Mephedrone, MDPV, Methylone Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Mephedrone URINE Negative NEGATIVE
 Methylenedioxypyrovalerone URINE Negative NEGATIVE
 Methylone URINE Negative <r> NEGATIVE

Cannabinoids (THC), Synthetic Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Cannabinoids, Synthetic URINE Negative <r>

716436

MERWIN, DANIEL DENNIS

20- 985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Chlamydia-Gonococcus DNA Panel NAAT Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Neisseria gonorrhoeae DNA URINE NEGATIVE FOR N.GONORRHOEAE <i>
 Chlamydia trachomatis DNA URINE NEGATIVE FOR C.TRACHOMATIS <i> (Negative)
 ETG/ETS, UA (250 Cut-Off) Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Ethyl Glucuronide URINE Negative ng/mL Cutoff=250
 Drug Abuse Screen Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Amphetamines URINE Not detected <i> (Not-detected)
 Barbiturates URINE Not detected <i> (Not-detected)
 Benzodiazepines URINE Not detected <i> (Not-detected)
 Cocaine URINE Not detected <i> (Not-detected)
 Opiates URINE Not detected <i> (Not-detected)
 Phencyclidine, UA URINE Not detected <i> (Not-detected)
 Cannabinoids URINE Not detected <i> (Not-detected)
 Methadone URINE Not detected <i> (Not-detected)
 Oxycodone URINE Not detected <i> (Not-detected)
 Urinalysis Panel Site/Specimen 27 Mar 2015 1630 Units Ref Rng
 Color URINE Straw (Yellow)
 Ketones URINE neg mg/dL (neg)
 Hemoglobin URINE neg (neg)
 Nitrite URINE neg (neg)
 pH URINE 7.0 (5.0-9.0)
 RBC URINE < 1 /HPF (0-3)
 Protein URINE neg mg/dL (neg)
 Appearance URINE Clear (Clear)
 Leukocyte Esterase URINE MOD (H) (neg)
 Specific Gravity URINE 1.008 (1.000-1.035)
 Urobilinogen URINE normal mg/dL (norm 0.2-1)
 WBC URINE 3 (H) /HPF (0-2)
 Glucose URINE neg mg/dL (neg)
 Bilirubin URINE neg (neg)
 Vitamin D, 1,25-Dihydroxy (Calcitriol) Panel Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Vitamin D, 1,25-Dihydroxy SERUM 78 <r> pg/mL
 Vitamin D2, 1,25-Dihydroxy SERUM <10 pg/mL
 Vitamin D3, 1,25-Dihydroxy SERUM 76 pg/mL
 Vitamin B1 (Thiamine) Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Vitamin B1 (Thiamine) BLOOD 193.4 nmol/L 66.5-200.0
 HIV-1/0/2 Ab Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 HIV-1/0/2 Ab SERUM *****
 Rapid Plasma Reagin Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Reagin Ab SERUM NONREACTIVE <i> (Non-Reactive)
 Homocysteine Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Homocysteine SERUM 9.1 <r> <i> mmol/L (4.0-15.4)
 Vitamin B12 (Cyanocobalamin)+Folate Panel Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Vitamin B12 (Cobalamins) SERUM 329 <i> pg/mL (211-946)
 Folate SERUM >20.00 <i> ng/mL (4.6-34.8)
 Magnesium Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Magnesium SERUM 2.2 mg/dL (1.7-2.6)
 Thyroid Stimulating Hormone Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Thyrotropin SERUM 0.757 <i> mIU/mL (0.27-4.20)
 Gamma Glutamyl Transferase Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Gamma-Glutamyl Transferase SERUM 40 U/L (10-71)
 Comprehensive Metabolic Panel Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Albumin SERUM 4.9 g/dL (3.5-5.2)
 Alkaline Phosphatase SERUM 71 U/L (40-130)
 Alanine Aminotransferase SERUM 29 <i> U/L (0-41)
 Bilirubin SERUM 0.3 mg/dL (0-1.0)
 Urea Nitrogen SERUM 14 mg/dL (6-20)
 Calcium SERUM 10.0 mg/dL (8.6-10.2)
 Carbon Dioxide SERUM 29 mmol/L (22-31)
 Chloride SERUM 98 mmol/L (98-107)
 Creatinine SERUM 0.9 mg/dL (0.7-1.4)
 Glucose SERUM 82 mg/dL (74-106)
 Potassium SERUM 4.7 mmol/L (3.5-5.1)
 Protein SERUM 7.9 g/dL (6.4-8.3)
 Sodium SERUM 139 mmol/L (135-145)
 Anion Gap SERUM 13 mmol/L (8-16)

716436

MERWIN, DANIEL DENNIS

20- 1985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

GFR Calculated Non-Black SERUM 114.7 mL/min (>=90)
 GFR Calculated Black SERUM 132.6 <1> mL/min (>=90)
 Aspartate Aminotransferase SERUM <5 U/L (0-40)
 CBC W/Diff Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 WBC BLOOD 6.8 x10(3)/mcL (3.6-10.6)
 RBC BLOOD 4.65 x10(6)/mcL (4.21-5.92)
 Hemoglobin BLOOD 14.5 g/dL (12.8-17.7)
 Hematocrit BLOOD 43.1 % (37.5-50.9)
 MCV BLOOD 92.6 fL (79.5-96.8)
 MCH BLOOD 31.1 pg (26.2-33.1)
 MCHC BLOOD 33.6 g/dL (32.6-35.0)
 RDW CV BLOOD 12.0 % (12.0-16.2)
 Platelets BLOOD 296 x10(3)/mcL (162-427)
 MPV BLOOD 8.5 fL (7.0-10.9)
 Neutrophils BLOOD 67.0 % (40.7-76.4)
 Lymphocytes BLOOD 25.1 % (15.9-47.8)
 Monocytes BLOOD 6.7 % (4.5-11.8)
 Eosinophils BLOOD 0.9 % (0.3-7.1)
 Basophils BLOOD 0.3 % (0.2-1.2)
 ABS Neutrophils BLOOD 4.5 x10(3)/mcL (1.8-7.5)
 ABS Lymphocytes BLOOD 1.7 x10(3)/mcL (1.0-3.1)
 ABS Monocytes BLOOD 0.5 x10(3)/mcL (0.2-0.8)
 ABS Eosinophils BLOOD 0.1 x10(3)/mcL (0.0-0.5)
 ABS Basophils BLOOD 0.0 x10(3)/mcL (0.0-0.4)
 Differential Review BLOOD MANUAL DIFF NOT PERFORMED
 Coagulation Panel 1 (PT+APTT) Site/Specimen 27 Mar 2015 1600 Units Ref Rng
 Prottime PLASMA 12.5 Sec (12.4-14.4)
 INR PLASMA 1.0 <1>
 APTT PLASMA 32.9 <1> Sec (23.4-36.2)

TREATMENT/PROCEDURES.

#1

DATE:

RESULTS:

The patient was treated with yoga, Qi-Gong, Reiki therapy and meditation for ongoing alcohol use disorder and behavioral health issues. Therapeutic benefit was achieved.

PROSTHESIS:

#1 NONE

DATE:

Did Any of the Following Complications Occur During Hospitalization?

#1 NONE

DATE:

HOSPITAL COURSE

HOSPITAL COURSE:

Fort Belvoir Community Hospital
 Rehabilitation Treatment Center
 Discharge Narrative Summary

Patient: Merwin, Daniel

Admission Date: 25th March 2015

Discharge Date: 22nd April 2015

Treatment Progress Summary:

Reason for Admission: Alcohol Use disorder

Reason for Discharge: Patient has successfully completed 28 days of inpatient addiction treatment.

Physical Condition: Patient has been medically cleared for discharge by his treating physician.

Educational Progress: Patient has gained a basic understanding of the educational topics covered during the course of treatment, including the following: addiction as a disease; stages of change as they apply to substance use; defense mechanisms in substance use; anger and stress management; relaxation techniques; the association of depression and anxiety with substance use; identification and modification of maladaptive beliefs; effective communication skills; utilization of social support; identification of substance use triggers; crisis management; and, relapse prevention. The

716436

MERWIN, DANIEL DENNIS

20- 1985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

patient participated in group and individual therapy, art therapy, creative writing, and recreational activities, and participated in individual goal-setting and completed individual homework assignments.

Community Adjustment: Patient adjusted well to the community environment. He was self-motivated and accepted responsibility for his treatment by actively engaging in the treatment modalities offered and completing individual assignments. He was an active contributor to the group process as well.

Art therapist input ~ (quoted): "Patient participated in group art therapy sessions 3-4 times weekly during his inpatient treatment. Art therapy sessions integrate both creative and traditional psychotherapeutic interventions to increase insight, provide an outlet for challenging emotions, manage resistance, and address treatment goals holistically."

This patient was an active and engaged participant in art therapy. His identified art therapy specific goals included expressing, understanding, and managing emotions; improving insight through creative exploration; and building social/relational skills through shared experiences and giving/receiving feedback. Patient responded particularly well to interventions focusing on group cohesion and social support, and took on an active leadership role within art therapy sessions during his time in treatment. . Patient responded particularly well to insight- and product-oriented art therapy interventions, and was able to effectively utilize the creative process as a way of expressing himself and connecting with others. Patient was a willing and engaged participant in art therapy and effectively developed a foundational process for containing and managing difficult emotions related to family of origin issues and self-concept. It is recommended that ongoing outpatient treatment for this patient incorporate opportunities for creative work to continue building positive self-concept as well as insight into behavioral patterns related to his substance abuse, and this writer has provided the patient with area resources for veteran- and military-led therapeutic art and writing opportunities, as well as available art therapy services".

E.A. McKee, LCPAT, ATR-BC.

Licensed, Registered and Board-Certified Art Therapist.

Peer (12-Step) counselor input ~ (quoted) "The patient acquired the foundation of Steps of 1-3, evidenced by daily reconnection to spirituality. Patient acknowledged being powerless over their substance abuse and the humility to ask for help when life gets unmanageable. Patient was open-minded of the need of lifestyle changes. Patient expressed a leap of faith in self, evidence by shared humiliations in group(s) of and the willingness to explore positive lifestyles outcome changes needed to live without substance abuse. This patient came to writers' group appalled that he was confronted on his very first day. While in group this patient disclosed emotions of anger that increase entitlement issues that sustain affixed to the past and now used for insight by realizing that was holding on to the past for the use of sympathy to manipulated others. This was evidenced by patient expressing in group the need to forgive others, also the need to be accepted by others, while bonding with peers to better understand shortcomings or character flaws they could do harm in the end. It is the writers' position that this patient has a very good sobriety outlook toward recovery. It was my honor to have served this Service Member".

Eugene Allen

Peer Counselor

Recreational therapist input ~ (quoted) "Patient participated in recreation therapy group 3-4x per week during inpatient stay at RTC. Recreation therapy focuses on improving patient's affect, reducing depression, enhance self-sufficiency, and identify new positive leisure opportunities and interest, as well as recreation participation by using different recreational modalities such as archery, bowling and nutrition cooking class. Patient did a great job in recreation therapy. Patient was able to stay on task without encouragement from staff. Patient was open-minded in trying new unfamiliar activities. Patient learned new positive coping skills through recreation participation. Patient is now able to identify 3 positive leisure activities to use as coping skills. Patient will be giving a list of volunteer community resources to continue to build positive leisure skills."

Jeremy Johnson CTRS

Recreation Therapist

Understanding for Disease Process: Patient demonstrated an understanding of substance addiction as a disease and verbalized the need for abstinence to maintain improvements to his physical health and emotional health, as well as to improve interpersonal relationships and overall quality of life.

Commitment to Treatment Needs: Patient attended Alcoholics Anonymous (AA) and sought information on self-help groups available within his community. Patient understands the need to find and maintain a permanent sponsor when he returns home. The patient appears to be committed to participating in self-help groups after discharge. He has agreed to follow through with all outpatient treatment recommendations.

Command/Family Involvement: Patient's command team appeared fully engaged with treatment. Patient and family members communicated via phone.

716436

MERWIN, DANIEL DENNIS

20- 1985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Patient's Assessment of Progress: Patient reported that he has benefited from treatment, has developed insight into his problematic substance use, and has gained an understanding of effective methods of maintaining sobriety and coping with life stressors in an adaptive fashion.

Discharge Assessment of Functioning:

Treatment Program Assessment of Continuing Treatment Needs: On a daily basis, the patient needs to continue employing behaviors and strategies that support total abstinence from all mood- and mind-altering substances. It recommended that patient follow up with Washington Navy Yard for outpatient aftercare for treatment and also attends AA/NA meetings or Smart Recovery (12-Step groups; minimum of weekly communication with a sponsor with several years of sobriety; weekly individual and group substance abuse counseling; ongoing mental health therapy/medication management, as needed.

Patient Assessment of Continuing Needs: Patient acknowledges that he needs continued treatment to address his substance use disorder and mental health. It is recommended that patient follow-up with Washington NY to manage substance use disorder and WRNMMC for behavioral health. Patient will follow-up with Washington NY on the 22 of April 2015 at 1000. Patient was referred to behavioral health at WRNMMC for continuum of care and appointment is with Major Zembrzuska on the 23rd of April, 2015 at 0900.

Family Assessment of Continuing Needs: Patient's family was not directly involved in treatment.

Goals Completed During Treatment:

- 1). List and discuss negative consequences resulting from or exacerbated by alcohol use.
Therapeutic Intervention- Pt. will make a list of the ways chemical use has negatively impacted his life; substance abuse negative impact versus sobriety positive impact. Pt. will acknowledge how he has used denial to minimize the severity and negative consequences of alcohol use. Pt. will also acknowledge the need to stay in treatment. (Completed)
- 2). Patient will verbalize recognition that mood altering chemicals were used as the primary coping mechanism to escape from stress.
Therapeutic Intervention- Explore how addiction was used to escape from stress. Pt. will learn and develop alternatives to drinking that will help him manage his anxiety. (Completed)
- 3). Pt. will meet with an AA member who has been working the 12-Step program for several years and find out specifically how the program has helped him/her stay sober afterward.
Therapeutic Intervention- Pt. will attain a temporary sponsor while in treatment. (Completed)
- 4). Identify triggers and cues for alcohol use and also learn basic coping skills and healthy alternatives to keep his mind of drinking.
Therapeutic Intervention- Patient will identify projects, and recreational activities free from substance/alcohol use. (Completed)
- 5). Pt. will utilize cognitive methods to control trigger thoughts and reduce impulsive reactions to those thoughts.
Therapeutic Intervention- Pt. will identify dysfunctional thoughts that lead to impulsivity; then replace each thought with a thought that is accurate, positive, self-enhancing, and adaptive. (Completed)

Goals to be completed after Treatment:

Continued treatment/ assessment to stabilize condition medically, behaviorally, emotionally, cognitively and return to functioning within normal parameters.

Discharge Mental Status Exam:

Patient was well-groomed and appropriately dressed in the uniform of the day. He was alert and oriented to person, place, time, and circumstance, with no evidence of disorder of perception or thought process or content during the interview. Speech was of normal rate, tone, and rhythm. Expressive and receptive communication skills were intact. Memory appeared intact. Affect was full-range and mood was euthymic. He denied current suicidal or homicidal ideation, plan, or intent. Insight (e.g., the ability to identify and understand how psychological symptoms are affecting functioning) and judgment (e.g., the ability to determine right from wrong) appeared intact. Intelligence was clinically estimated as within the average range based on use of vocabulary, syntax, and semantics. He neither demonstrated nor reported difficulties with self-care.

Discharge Risk Assessment:

RISK ASSESSMENT

Suicide Risk

Suicide Risk

After considering variables that influence suicide risk, including prior suicide attempts, psychiatric diagnoses that alleviate risk, age, gender, family background, interpersonal relationships, physical health, suicide risk variables regarding lethality/access/planning, affective control, degree of hope, family history of completed suicide, degree of willingness to seek help, connection with therapist, and degree of psychosocial support for dealing with current

716436

MERWIN, DANIEL DENNIS

20- [REDACTED] 985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

life stressors, current suicide risk is judged to be: Low.

Homicide Risk (using TIPM, Rosenberg, 1997)

Is patient having homicidal Thoughts (T)? Patient denied.

Is patient Intending (I) to attempt homicide? Patient denied.

Does patient have a homicide Plan (P)? Patient denied.

Does patient have the Means (M)? Patient denied.

Summary of risk assessment: Patient denies any current thoughts or ideation about suicide, and denies any history or current homicidal ideation, plan, or intent. He has displayed future orientation. Patient appears to be at low risk for self-harm or harm to others at present. Protective factors include future orientation, and a desire to continue his military career.

DIAGNOSES

1. Alcohol Use Disorder, Severe (in a controlled environment)
2. Generalized Anxiety Disorder

Final Recommendations:

1. Abstinence from alcohol (including non-alcoholic beer & cold medications) and all mood-altering substances.
2. Follow-up with Washington NY on the 22nd of April at 1000.
3. Appointment with Behavioral Health, Major Zembruuska on the 23rd of April, 2015 at 0900.
4. Participate in 12-Step meetings and/or Smart Recovery for 90 days and maintain a minimum of weekly contact with sponsor (if possible).
5. Continue medications as prescribed (see discharge medication list).

Olusola Edwards, LPC, LMFT, LCDC
21st April 2015

DID AN ADVERSE DRUG REACTION OCCUR DURING THIS PATIENT STAY? No

Was the patient physically restrained during this admission? No

DISCHARGE DIAGNOSIS:

1. Alcohol Use Disorder X
2. Intermittent headaches since childhood-Required P/u by PCN, PC instructed to f/u with PCN X
3. Anxiety-on Zoloft 50mg qhs

Discharge Mental Status Exam Completed: Yes

Excess medications secured/disposed: N/A

Firearms secured: N/A

Risk Assessment completed: Yes

TBI referral made: No

Substance Abuse referral made: Yes

FAP referral made: N/A

SARC referral made: N/A

Support Systems and/or chain of command involved in discharge planning: Yes

Pending UCMJ/legal concerns addressed: N/A

Narrative Summary provided to gaining provider(s)? No

DISCHARGE INSTRUCTIONS

PHYSICAL LIMITATIONS:

#1 Unrestricted

PHYSICAL THERAPY: NO

Has the required outpatient physical therapy consult, to include precautions and limitations, been entered into CHCS/AHLTA? NO

PRESCRIBED DIET: Regular INSTRUCTED ON DIET: X YES NO

INSTRUCTED ON POTENTIAL DRUG/NUTRIENT INTERACTIONS OF DISCHARGE MEDS: X YES NO

MEDICATION RECONCILIATION:

X I have reconciled the patient's medications in the discharge summary and in CHCS/AHLTA.

X I have given the patient a list of medications on the Discharge Summary and asked that they review this with their primary care manager.

MEDICATIONS FOR DISCHARGE:

Drug Name	Dose	Route	Frequency	Discharge Plan for Medication
multivitamin (DAILY VITE) ORAL Tab	1 tab	By Mouth	DAILY	Continue as previously prescribed

716436

MERWIN, DANIEL DENNIS

20- 985

USN ACTIVE DUTY AFBA

FBCH 25Mar2015

PERSONAL DATA/PRIV ACT 1974

SF-509

CliniComp, Intl.

Indication: Nutritional supplement	Dispensed: 30	Special Instructions: Continue taking this medication as previously prescribed.	
User: TRALINE (ZOLOFT) 12/2 BY Mouth AT BEDTIME Continue as previously prescribed ORAL Tab 100 MG ORAL			
Indication: Anxiety	Dispensed: 30	Special Instructions: Continue taking this medication as previously prescribed.	

Is more than one antipsychotic medication prescribed? NO

MEDICATIONS REVIEWED:
 with Patient Patient/Caregiver verbalized basic understanding including precautions about mixing prescribed medications with alcohol, illicit drugs, and OTC medications and follow up required

Is patient being discharged on anticoagulant(s)?

ACTIVITY RESTRICTIONS - WOUND CARE - INSTRUCTIONS

Activity Restrictions: See profile/LINDU form. Recommend no access to firearms, classified information or government vehicles. Recommend no night shifts or overnight duty to maintain sleep hygiene. Until further evaluation at next level of treatment.

SPECIAL INSTRUCTIONS: Please take all prescribed medications at prescribed doses. Please attend all appointments. If suicidal or homicidal feeling occur or return, please call your provider, call your commander, go to nearest ER, or call 911.

Influenza vaccine given this Hospitalization? Yes No X
 IF "No" GIVE REASON: Previously received

Pneumovax Given this Hospitalization? Yes No X
 IF "No" GIVE REASON: Not indicated

TD or DTaP given? No X
 Reason for Not Giving:

Tobacco use within last 12 months? NO

Diabetes: NO

CLINIC FOLLOW UP

CLINIC NAME/PHONE #	LOCATION	APPT. (DATE/TIME)	Clinic Physician
#1			

COMMENTS: **Final Recommendations:**
 1. Abstinence from alcohol (including non-alcoholic beer & cold medications) and all mood-altering substances.
 2. Follow-up with Washington NY on the 22nd of April at 1000.
 3. Appointment with Behavioral Health, Major Zembrzuska on the 23rd of April, 2015 at 0900.
 4. Participate in 12-Step meetings and/or Smart Recovery for 90 days and maintain a minimum of weekly contact with sponsor (If possible).
 5. Continue medications as prescribed (see discharge medication list).

Olusola Edwards, LPC, LMFT, LCDC
 21st April 2015

Patient is responsible for calling the clinic directly to schedule and confirm each of these appointments. You may also schedule/confirm appointments through the Appointment Call Center at (1-855-227-6331).

DISPOSITION/RECEIVING ACTIVITY (ACTIVE DUTY ONLY)

SIGNATURES: Sign Name and Date below as appropriate role and check box as electronically signed

ATTENDING:	DATE:	Electronically Signed
RESIDENT:	DATE:	Electronically Signed
INTERN:	DATE:	Electronically Signed
PA/NP: MAJ Brockington, FNP	DATE: 04/21/2015	X Electronically Signed
SUB INTERN:	DATE:	Electronically Signed

RN REVIEWING DISCHARGE INSTRUCTIONS WITH PATIENT:
 COMMENTS

716436

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20-1985

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SF-509

I HAVE BEEN INSTRUCTED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS ON SELF-CARE		DATE: <u>4/22/15</u>
PATIENT/GUARDIAN'S SIGNATURE: <u>Danwin</u>		
ACTIVE DUTY: <input checked="" type="checkbox"/> YES	COMMENT: <u>N/A</u>	
MEDICAL BOARD: <input type="checkbox"/> NO	DUTY CHOICES <u>N/A</u>	
MED BOARD DICTATED: <input type="checkbox"/> YES	NO DATE DICTATED: <input type="checkbox"/>	DATE MUST BE ENTERED.
RECEIVING ACTIVITY: <u>N/A</u>	ESTIMATED DATE FOR DICTATION:	
COMMENT: <u>N/A</u>		PLEASE REEVALUATE WHERE YOU ARE SENDING PATIENT.

716436
 MERWIN, DANIEL DENNIS
 20- [REDACTED] 985
 USN ACTIVE DUTY AFBA
 FBCH 25Mar2015
 PERSONAL DATA/PRIV ACT 1974
 SF-509

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 29y M

Priority: Exam#: 0067-14327819

Procedure: MRI, FOOT LT W OR W/O CON Exam date: 10/5/2014 2:43:00 PM

Reason for exam: Pt had and ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

HISTORY: Continuous pain following injury

COMPARISONS: Left foot and ankle radiographs dated 5/6/14

TECHNIQUE: WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:

ANKLE:

A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

Plantar aponeurosis: within normal limits.

Tendons

Achilles' tendon: within normal limits.

Peroneal tendons: within normal limits.

Flexor tendons: Apart from minimal fluid accumulation at the knot of Henry, the flexor tendons about the ankle are otherwise within normal limits.

Extensor tendons: within normal limits.

Ligaments:

Syndesmotic ankle ligaments: within normal limits.

Low lateral ankle ligaments: The anterior talofibular ligament appears thickened. Calcaneofibular and posterior talofibular ligaments are within normal limits.

Deltoid ligamentous complex: within normal limits.

Spring ligamentous complex: within normal limits.

Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: within normal limits.

Chondral surfaces: within normal limits.

FOREFOOT:

Tendons:

Distal peroneal tendons: within normal limits.

Distal flexor tendons: within normal limits.

Distal extensor tendons: within normal limits.

Ligaments:

Intermetatarsal ligaments: within normal limits.

Lisfranc ligament: within normal limits.

The plantar plate and capsular ligamentous structures about the metatarsal phalangeal and interphalangeal joints of the forefoot are within normal limits.

Recesses and Bursae: No evidence of Morton's neuroma or intermetatarsal bursitis.

Muscle morphology and signal intensity: within normal limits.

Bone morphology and signal intensity: Mild degenerative changes are seen at the 1st metatarsophalangeal joint.

IMPRESSION:

Findings suggestive of prior lateral ankle sprain.

Electronically signed by resident: Dr. MATTHEW LEO LUTYNSKI

Date: 10/06/14

Time:14:23

Electronically signed by:FRANK EDWARD MULLENS

Department of Radiology

Walter Reed National Military Medical Center

Date: 10/06/14

Time:15:52

Interpreting Radiologist: MULLENS, FRANK

Approved by: LUTYNSKI, MATTHEW

Supervised by: MULLENS, FRANK

Transcription date: Oct 06 2014 03:52PM

Transcriptionist: LUTYNSKI, MATTHEW

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 29y M

Priority: Exam#: 0067-14327823

Procedure: MRI, ANKLE LT W OR W/O CON Exam date: 10/5/2014 2:43:00 PM

Reason for exam: Pt had a L ankle sprain in april and continues to have pain, discomfort and swelling despite conservative treatment. r/o stress fx

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

HISTORY: Continuous pain following injury

COMPARISONS: Left foot and ankle radiographs dated 5/6/14

TECHNIQUE: WRNMMC MRI of the left ankle was performed utilizing standard imaging sequences (3 plane localizer, axial T1, axial PD fat-sat, coronal T1, coronal PD fat-sat, sagittal T1, sagittal PD fat-sat). No intravenous or intra-articular contrast was administered. Subsequently, MRI of the forefoot was obtained to include 3 plane localizer, coronal T1, coronal PD fat-sat, axial T1, sagittal T1, axial PD fat-sat, sagittal PD fat-sat.

FINDINGS:

ANKLE:

A skin marker was placed along the anterolateral aspect of the lower leg at the site of symptoms.

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Tendons

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Deltoid ligamentous complex: within normal limits.

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Lisfranc ligament: within normal limits.

Sinus tarsi and tarsal tunnel: within normal limits.

Muscle morphology and signal intensity: within normal limits.

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Department of Radiology

Walter Reed National Military Medical Center

Date: 10/06/14

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Transcription date: Oct 06 2014 03:52PM

Transcriptionist: LUTYNSKI, MATTHEW

WRNMMC BEHAVIORAL HEALTH CLINIC
LIMITS OF CONFIDENTIALITY

Authority: DoD 6025.18-R, "Health Information Privacy Regulation"

Limitations of Confidentiality: As part of your healthcare team, our goal is to provide you with quality care as well as protect the privacy of your personal information. The care we provide you may include, but is not limited to, assessment, referral, individual therapy, couples therapy, family therapy, group therapy, and psychiatric evaluation and medications. As your providers, we will document information about your visit in your military health record (written and electronic) to ensure continuity of care. Your health record is maintained as the property of the U.S. Government. In the majority of cases, we will not disclose any of your personal information nor confirm/deny that we have met with you unless you provide us with written authorization to disclose your personal information. There are exceptions, however, under which we may be required to release your personal information without obtaining your prior authorization. For example:

1. **Safety:** If you threaten to harm yourself, we may seek hospitalization and/or contact others to ensure your safety. If you threaten serious bodily harm to another, we are required to take protective actions, such as contacting the victim, police, chain of command, or seeking your hospitalization.
2. **Abuse:** If we believe that a child or vulnerable adult is being abused, we are required to file a report with the appropriate protective agency. We may also be required to report spousal abuse under certain circumstances.
3. **Court Orders and Subpoenas:** If you are involved in legal actions/proceedings, your record may be subject subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), we have a limited "privileged communication" that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving some violations of the UCMJ, civil, or criminal law where we may be required to divulge that information to your Commanding Officer (Co) and/or other authorities. If you have any concerns related to this, please contact an attorney.
4. **Command Consultations:** For service members, your Commanding Officer or Command Element (CO) is entitled to limited information, as pertinent to any duty limitations or restriction, security clearance, or treatment that might affect duty performance or jeopardize the safety of yourself, co-workers, or the unit's mission. Your CO or chain of command is not authorized to view your medical records through informal means. Information that impacts your duty status may be provided to your CO in writing, such as through service-specific documentation. We do not practice routine disclosure to commands. When we must disclose information, it is the minimum necessary and will only be to your CO unless you give written permission otherwise. This applies even if you are command-referred here. For information on command referred evaluations, see Department of Defense Instruction 6490.4.
5. **Care Coordination:** Because we operate as a team with other healthcare staff to provide you the best possible services, we may disclose your information to other providers or care managers to facilitate your continued care. These members of the health care team are permitted access to your records in their treatment of you. In most cases, your information will not be discussed outside the clinic or hospital setting without your written permission.
6. **Legal:** Medical care providers may be required to report information disclosed about the intent to violate a military regulation or law.
7. **Quality Care Reviews:** Quality assurance personnel may review your record to ensure that care standards are being met. If this occurs, the reviewer is required to keep your identity confidential.
8. **Third-Party Insurance:** If you have health insurance besides TRICARE, limited information may be released to your insurance company.
9. As per the Health Information Technology for Economic and Clinical Health Act (HITECH act) that is part of the American Recovery and Reinvestment Act of 2009 (ARRA), we can only communicate with you electronically through encrypted technologies. Because of these restrictions, our ability to contact you electronically is limited to an encrypted method that you and your provider might establish.

If you have any questions or concerns, please feel free to discuss them with us. Our intent is to discuss our limitations with you now and throughout your treatment as they may arise. We shall approach your care in the spirit of advocacy for you and in accordance with our hospital's vision of providing patient and family-centered care.

Acknowledgement of Privacy Act Rights and Limitations: Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

[Signature]
Patient Signature

Witness Signature

[Signature] LCGW-C
Provider Signature

Daniel Mawin
Printed Name/Date

Printed Name/Date

L. Nilsen 8-4-14
Printed Name/Date

08 AUG 14



**Walter Reed
National Military
Medical Center**

Russell B. Carr, M.D.
Commander, Medical Corps, United States Navy
Service Chief
Adult Behavioral Health Clinic
Walter Reed National Military Medical Center
8901 Wisconsin Ave., Bethesda, MD 20889-5600

2 January 2013

From: CDR Russell B. Carr, MC, USN, Service Chief, Adult Behavioral Health Clinic
To: All Patients of Adult Behavioral Health Clinic

SUBJECT: CHANGE IN CLINIC'S POLICY ON FAILURE TO KEEP APPOINTMENTS

1. I want to thank all of you for choosing our clinic for your mental health care. We take pride in providing Patient and Family-Centered Care. So our patients can have better access to our providers, I am implementing policies to help make sure that Wounded Warriors and others who need and want to be seen in our clinic can get the care they need.

2. One aspect of these changes involves our "No-Show" policy. These are instances when patients have appointments scheduled but do not come for them. Here is how our new policies will affect you:

a. Any appointment you cancel on the same day as the appointment will be documented as a "No-Show." This helps us and our patients by having time to open the appointment for other patients to use it.

b. The missed appointment will be documented in your electronic medical record (AHLTA). Your provider may call you. This is typically done to ensure the patient is safe.


c. Initial Appointments: Patients will be allowed one rescheduling for a missed appointment for a new referral. After missing two appointments for the initial evaluation, the patient will need to discuss the situation with either the Clinic Manager or Service Chief to reschedule a third new appointment. Otherwise, the referral for this episode of care will be closed. For active duty patients, we will consider if the missing of these two appointments warrants contact with the service member's Commanding Officer.

d. Follow-Up Appointments: Nothing will change if you miss one follow-up appointment with a provider. You will also be allowed to reschedule after two in a row missed follow-up appointments. But after two in a row missed follow-up appointments, any appointments regularly reserved for you at a set time with a provider will be opened for other patients. After three in a row follow-up appointments are missed, you will need to discuss the situation with either the Clinic Manager or Service Chief to schedule another appointment. Otherwise, care with that particular provider will be considered closed, and the situation will be discussed with any other providers you have in the clinic. For active duty patients, we will consider if the missing of three appointments in a row warrants contact with the service member's Commanding Officer.


e. If a provider feels that missed appointments are directly due to the patient's mental health issues, then the patient's current care may not be closed. However, the provider will address with the patient the reasons for the missed appointments and problem-solve with him or her ways to address any problems.

f. Patients will not be refused care due to this policy. Non-active duty patients will be offered care through the TRICARE network. Active duty patients can get care after either talking to CDR Carr or other clinic personnel. Clinic leadership may discuss the situation with the service member's Commanding Officer.

g. If you have questions or concerns, please contact me, CDR Carr. My office phone number is 301-319-4376. You may also contact the hospital's Patient Advocate Office at 301-295-0156.


R. B. CARR
CDR MC USN

I have read this policy, discussed it with a clinic staff member, and understand it.

 Date 24 AUG 14

Name: DANIEL MERWIN Age: 29 SSN (Sponsor): [REDACTED] Date: 04 AUG 14
 Home Phone: [REDACTED] Cell Phone: Home (message OK?) Email: [REDACTED] @gmail.com
 Mailing address: [REDACTED] HANOVER MD [REDACTED] com
 Gender: ☒ Male ☐ Female Ethnicity: COLOMBIAN Martial Status: SINGLE Branch of Service: NAVY
 Rank: E6 MOS/Description: SIN - CRYPTOLOGIST Current Job: ANALYST ETS Date: _____
 Time in Service: 9 Y Time in Unit: 2 Y Unit: NJOC MD Phone: 301 3724637
 Commanding Officer: CAPT ELAM Sr. Enlisted Leader: MASTER CHIEF BARNES Primary Care Provider: _____
 Is this visit deployment related? ☐ yes ☒ no WTU? ☐ yes ☐ no Case Manager: _____ Phone: _____
 Are you PRP/SCI Authorized/PSP/Special Duty (i.e. Active Flying Status or SMOD)? ☐ no yes: _____
 Previous Deployments (list): USS ESSEX 442 - 3 YEARS OVERSEAS TOUR
 Who referred you here? ☒ Self ☐ Unit ☐ Chaplain ☐ Emergency Room ☐ Substance Abuse Program
☐ Inpatient Psychiatry Other: _____

Do you consider this evaluation to be voluntary or involuntary?

a.) ☒ Voluntary. I agree to be seen by Mental Health.

b.) ☐ In voluntary. I do not agree to this evaluation. (Provider must ensure patient has been adequately informed of his/her rights LAW Pub. Law 102-48)

Any previous use of behavioral health services (military or civilian)? No ☐ Yes: _____

Any history of abuse? ☐ yes ☒ no Traumatic experiences? ☒ yes ☐ no Life threatening events? ☐ yes ☒ no

Please describe the concern(s) that brought you here today: NOT SURE FAMILY ANXIETY

Please circle the symptoms you have been experiencing in the past month:

Depressed or sad mood	<u>Difficulty concentrating</u>	Problems with eating	Have you ever experienced:
<u>Anxiety or worries</u>	<u>Nightmares</u>	Thoughts of death	Alcohol or drug problems:
Loneliness	Family problems	Tearfulness	Learning problems
Recent loss or grief	Problems sleeping	Distrustful	Work problems
Financial problems	Sexual problems	Angry outbursts	Suicidal thoughts
Feel picked on	Gambling problems	Restless or on edge	Homicidal thoughts
Fear of being harmed	Fatigue / low energy	Excessive spending	Physical altercations <u>→ FIGHTS</u>

Suicide attempts in the past (ever): IN HIGH SCHOOL BUT NO ONE EVER KNEW are there weapons in your home? ☐ yes ☐ no

Do you feel safe at home? ☒ yes ☐ no Any current or past domestic violence? ☐ yes ☒ no

Current medical problems (explain): _____

Have you ever had a head injury? ☒ no ☐ yes details and date: _____

Current medications and doses (include over the counter and supplements): _____

Medication allergies and reactions: NONE

What provides you with strength and hope: UNSURE... ESCAPING INTO MY HEAD AND

Do you have unmet spiritual needs? SOLICITING PRAYER

What have you been doing to help yourself so far? BREATHE EXERCISE

☐ I have an illness or condition that made me change the kind or amount of food I eat, or make it hard for me to eat.

☐ I eat fewer than 2 meals per day. ☐ Without wanting to, I have lost or gained 10 or more pounds in the last 6 months.

What are the top 3 goals you would like to address?

1. ANXIETY
2. PAST ISSUE - FAMILY ABUSE (VERBAL - PARTIALLY PHYSICAL)
3. NEW WAY OF HANDLING ISSUES RATHER THAN IGNORE

Thank you for completing this questionnaire. You may add extra information you'd like us to know on the reverse side.

AUDIT-C Questionnaire

Patient Name: DANIEL MERWIN

Date of Visit: 04 AUG 11

1. How often do you have a drink containing alcohol?

- ☐ a.) Never
- ☐ b.) Monthly or less
- ☒ c.) 2-4 times a month
- ☒ d.) 2-3 times a week
- ☐ e.) 4 or more

VARIES - IF I KEEP BUSY 2-4 TIMES A MONTH

2. How many standard drinks containing alcohol do you have on a typical day?

- ☒ a.) 1 or 2
- ☒ b.) 3 or 4 *VARIES*
- ☐ c.) 5 or 6
- ☐ d.) 7 to 9
- ☐ e.) 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a.) Never
- ☒ b.) Less than monthly
- ☐ c.) Monthly
- ☐ d.) Weekly
- ☐ e.) Daily or almost daily

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day			
1. Feeling nervous, anxious, or on edge	0	1	2	③			
2. Not being able to stop or control worrying	0	①	2	3			
3. Worrying too much about different things	0	1	②	3			
4. Trouble relaxing	0	1	②	3			
5. Being so restless that it's hard to sit still	0	①	2	3			
6. Becoming easily annoyed or irritable	0	1	2	③			
7. Feeling afraid as if something awful might happen	①	1	2	3			
Add the score for each column							
	0	+	2	+	4	+	6
Total Score (add your column scores) =					12		

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult X _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the *CURRENT* (i.e. *LAST 2 WEEKS*) *SEVERITY* of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	(2)	3	4
2. Difficulty staying asleep	0	(1)	2	3	4
3. Problems waking up too early	(0)	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
 0 1 (2) 3 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all A Little Somewhat Much Very Much Noticeable
 Noticeable (1) 2 3 4
 0

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all A Little Somewhat Much Very Much Worried
 Worried (1) 2 3 4
 0

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all A Little Somewhat Much Very Much Interfering
 Interfering (1) 2 3 4
 0

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = 9 your total score

Total score categories:

0-7 = No clinically significant insomnia

8-14 = Subthreshold insomnia

15-21 = Clinical insomnia (moderate severity)

22-28 = Clinical insomnia (severe)

hard to get to sleep
 wakes up when something
 is on his mind
 a rain/storm helps.

PTSD CheckList – Military Version (PCL-M)

Patient's Name: DANIEL MCBROWN

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful military experience from the past?	X				
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience from the past?	X				
3.	Suddenly <i>acting or feeling</i> as if a stressful military experience were <i>happening</i> again (as if you were reliving it)?	X				
4.	Feeling <i>very upset</i> when <i>something</i> reminded you of a stressful military experience from the past?	X				
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something</i> reminded you of a stressful military experience from the past?	X				
6.	Avoid <i>thinking about or talking about</i> a stressful military experience from the past or avoid <i>having feelings</i> related to it?	X				
7.	Avoid <i>activities or situations</i> because they remind you of a stressful military experience from the past?	X				
8.	Trouble <i>remembering important parts</i> of a stressful military experience from the past?	X				
9.	Loss of <i>interest in things that you used to enjoy</i> ?	X				
10.	Feeling <i>distant or cut off</i> from other people?	X				
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	X				
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	X				
13.	Trouble <i>falling or staying asleep</i> ?	X				
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	X				
15.	Having <i>difficulty concentrating</i> ?	X				
16.	Being " <i>super alert</i> " or watchful on guard?	X				
17.	Feeling <i>jumpy</i> or easily startled?	X				

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 3 + 4 + 0
=Total Score: 7/27

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input checked="" type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
--	---	--	---

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 29y M

Priority: Exam#: 0067-14130311

Procedure: FOOT, LT 3 VIEWS Exam date: 4/19/2014 3:42:00 PM

Reason for exam: Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

History: Running and stepped in hole c/o left ankle/foot pain and swelling.
R/o fx

Technique: Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident: Dr. NATHAN S NIELSEN

Date: 04/19/14

Time:19:41

Electronically signed by:Dr. Kenric T Aban

Date: 04/20/14

Time:19:40

Interpreting Radiologist: ABAN, KENRIC

Approved by: ABAN, KENRIC

Supervised by: ABAN, KENRIC

Transcription date: Apr 20 2014 07:40PM

Transcriptionist: NIELSEN, NATHAN

Patient Radiology Report

MERWIN, DANIEL 20[REDACTED] 29y M

Priority: Exam#: 0067-14130312

Procedure: ANKLE, LT 3 VIEWS Exam date: 4/19/2014 3:42:00 PM

Reason for exam: Running and stepped in hole c/o left ankle/foot pain and swelling. R/o fx

Order comment:

Result code: SEE RADIOLOGIST'S REPORT

Finding:

History: Running and stepped in hole c/o left ankle/foot pain and swelling.
R/o fx

Technique: Frontal, oblique, and lateral radiographs of the left foot and ankle

Comparison: None available

Findings:

No acute fracture or dislocation. Osseous alignment and mineralization is normal. Joint spaces are preserved. The ankle mortise and talar dome are intact. A small developing plantar calcaneal spur is identified. No significant degenerative or erosive changes are seen. There is mild soft tissue edema overlying the lateral malleolus.

Impression:

Mild soft tissue edema overlying the lateral malleolus without evidence of acute osseous abnormality.

Electronically signed by resident: Dr. NATHAN S NIELSEN

Date: 04/19/14

Time:19:41

Electronically signed by:Dr. Kenric T Aban

Date: 04/20/14

Time:19:40

Interpreting Radiologist: ABAN, KENRIC

Approved by: ABAN, KENRIC

Supervised by: ABAN, KENRIC

Transcription date: Apr 20 2014 07:40PM

Transcriptionist: NIELSEN, NATHAN

PNAVINST 5100.19

05 October 2000

B6-D-3 Appendix B

Enclosure (1)

n. Any other symptoms that you think may be related to lung problems:

Yes/No

5. Have you ever any of the following cardiovascular or heart problems?

a. Heart attack:

b. Stroke: Yes/No

c. Angina: Yes/No

d. Heart failure:

e. Swelling in your arms or feet (not caused by walking): Yes/No

f. Heart arrhythmia (heart beating irregularly): Yes/No

g. High blood pressure: Yes/No

h. Any other heart problem that you've been told about: Yes/No

6. Have you ever had any of the following cardiovascular or heart symptoms?

a. Frequent pain or soreness in your chest: Yes/No

b. Pain or tightness in your chest during physical activity:

Yes/No

c. Pain or tightness in your chest that interferes with your job:

Yes/No

d. In the past 2 years have you noticed your heart skipping or missing a beat: Yes/No

e. Heartburn or indigestion that is not related to eating: Yes/No

f. Any other symptom that you think may be related to heart or circulation problems: Yes/No

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

b. Heart trouble: Yes/No

c. Blood pressure: Yes/No

d. Seizures (fits): Yes/No

8. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No

b. Skin allergies or rash: Yes/No

c. Anxiety: Yes/No

d. General weakness or fatigue: Yes/No

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
27 JAN 07	MEDICAL DEPARTMENT; USS ESSEX (LHD 2) FPO AP 96643-1661	
TIME IN: 1315	HM NAME: HM3 JACKSON MO OR IDC NAME:	
TIME OUT:	CC: FACIAL CELLULITIS F/U	
	SI: 21 Y/O ♂ INFD MEDICAL FOR F/U ON FACIAL	
T - 9716	ABCESS X 5 DAYS - PT IS REPORTING A THROBBING	
P - 72	3/ID NECK PX C MILD STIFFNESS STIFFNESS. PT ALSO	
RR		
HR - 18	REPORTS TAKING DICLOXACILLIN + TYLENOL #3	
B/P - 111/63		
MEDS: 41/03	DI AGN - ABSCESS, INFLAMM	
	DICLOXACILLIN (C) SIDE OF NECK - (+) DRAINAGE, CERVICITIS, INFLAMMATION	
	TYLENOL #3 C MILD SURROUNDING ERYTHEMA, GLETTA.	
ALLERGY:	Improved, (D) Swelling minor under LAD	
NKA	Minor - minor discharge	
LMP: Ø	N/A Abscess (improving) Facial	
SMOKE: Ø	(D) Cont antibiotics Dicrox + Tylenol #3 ASAP,	
	warm compresses.	
DRINK:	(D) RTC in am or sooner if symptoms worsen	
YES	(D) Monitor PRN	
	(D) (MD) Intra Abscess	
29 Jan 07	PN BMO	
0830 am	Here for F/U improving & F/U/MN	
	Ext. Area - (D) Swelling improving	
	(D) Neck - - - (D) discharge - - Cont. w/ same antibiotics	

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

USS ESSEX (LHD 2)

PATIENT'S NAME (Last, First, Middle Initial)

MORWIN DANIEL

RELATIONSHIP TO SPONSOR

SELF

STATUS

ACDU

SEX

RANK/GRADE

ABFAN

SPONSOR'S NAME

N/A

ORGANIZATION

DEPT: AIR, DIV: V-3

DEPART./SERVICE
DOD/USN

SSN/IDENTIFICATION NO.

20

DATE OF BIRTH

1985

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

AR 3215

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
26 JAN 07	MEDICAL DEPARTMENT; USS ESSEX (LHD 2) FPO AP 96643-1661		
TIME IN: 26 0930	HM NAME: <u>MR RONDE / DE SANTANA</u> MO OR IDC NAME:		
TIME OUT:	<u>C: ABCESS</u> Day 2 of Diclox.		
T - 96.6	<u>S: 21 x 6 8" C/O edema to abcess. ABSCESS</u>		
R - 16	<u>drained 25 JAN 07. Pt states drained abscess</u>		
HR - 96	<u>"12" times & warm compress. til drained. Pt</u>		
B/P - 112/73	<u>states 6/10 PAIN. No further draining.</u>		
MEDS: T3	<u>O: RA PT A+C X3 - Lung CTA</u>		
	<u>Dicloxacillin - Pt & redness / edema @ side JAW TO UPPER</u>		
	<u>@ side neck. - unchanged in diameter (2cm)</u>		
ALLERGY:	<u>- Swelling site warm to touch BVS</u>		
	<u>- AN Penicillin</u>		
LMP:	<u>AIR: Abcess</u> (20)		
SMOKE: 0	<u>- Cont ABX + NSAID & compresses.</u>		
	<u>- RTC in am. If no improvement, consider ABX change to Dory.</u>		
DRINK:	<u>- Return sooner if needed.</u>		
<u>social</u>	<u>Sortor</u>		
	SORTOR, BRETT V.		
	CDR MC USN		
PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)		RECORDS MAINTAINED AT: USS ESSEX (LHD 2)	
PATIENT'S NAME (Last, First, Middle Initial)		SEX	
<u>MERWIN, DANIEL</u>		<u>MALE</u>	
RELATIONSHIP TO SPONSOR		STATUS	
<u>SELF</u>		<u>ACDU</u>	
SPONSOR'S NAME		ORGANIZATION	
<u>N/A</u>		<u>DEPT: AIE DIV: V-3</u>	
DEPART./SERVICE		SSN/IDENTIFICATION NO.	
<u>DOD/USN</u>		<u>20 [REDACTED]</u>	
		DATE OF BIRTH	
		<u>25 [REDACTED]</u>	

NSN 7540-00-834-4176

800-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
25 JAN 07	MEDICAL DEPARTMENT; USS ESSEX (LHD 2) FPO AP 96643-1661	
TIME IN: 0805	HM NAME: <i>Harzhen</i>	MO OR IDC NAME:
TIME OUT: 0801	CC: <i>FLU ABSCESS</i>	
T - 98.2	S: <i>21y/o FLU ABSCESS FROM YESTERDAY WOK-UP THIS AM</i>	
R - 16	HAD PAINABLE, SLIGHTLY BLISTER, 7/10 P. STATES HE	
HR - 89	HE USED WARM COMPRESS THIS AM.	
B/P - 128/69	- painful today. <i>Harzhen</i>	
MEDS:	O: <i>Is reviewed</i>	
DICLOXACILLIN	Gen. NAD	
MOTRIN	Face - draining abscess on @ angle of mandible	
ALLERGY:	Exposed wound + ~5cc purulent material removed.	
N/A	Wound was dressed.	
LMP:	AIP: Abscess (20)	
SMOKE: <input checked="" type="checkbox"/>	- Cont. Diet.	
	- T3 #10	
DRINK: <input checked="" type="checkbox"/>	- Cont. warm compresses.	
	- RTC - 2.3 d, sooner pm.	
	<i>Sutor</i>	
	SORTOR, BRETT V.	
	CDR MC USN	

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	USS ESSEX (LHD 2)		
PATIENT'S NAME (Last, First, Middle Initial)	MENWILL, DAVID L		SEX
RELATIONSHIP TO SPONSOR	SELF	STATUS	ACDU
SPONSOR'S NAME	N/A	ORGANIZATION	DEPT: <i>AN</i> DIV: <i>V3</i>
DEPART./SERVICE DOD/USN	SSN/IDENTIFICATION NO.	DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

AR 3217

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

24 JAN 07

HM3 SVACHA

IN: 0715

CC: NODULE AT @ SIDE OF JAWLINE

Pm/PSH

OUT:

S: 21 y/o ♂ PRESENTING T 1-ZIN NODULE
ON @ SIDE OF FACE (JAW LINE) SINCE- similar nodule
last wk.
@ 4/6 area

T 98.6

MONDAY. PT STATES YELLOW DRAINAGE

P 94

AND BLEEDING FROM SITE. PT % 3/10

R 18

PAIN CURRENTLY AND 7/10 PAIN WHEN

BP 113/65

NODULE IS TOUCHED. @ FICIA/V/D. @ NAUSEA.

PT PRESENTED T SAME S/S ON 22 JAN 07.

ROS: @ fever, drainage

NKDA

O: VITALS NOTED: AFEBRILE. GEN- WNL/W/D. AOX3
NAD. NODULE SITE: TIP, @ ERYTHEMIA.

MEDS

SMD

IBP 800mg

O: VS reviewed

Gen - NAD

Heart - ~ 2cm enlargement, tense but non-fluctuant

abscess on @ angle of mandible

Neck - supple & quiet

Lymph - @ axillary or clavicular nodes.

A/P: Abscess

20

- Warm compresses frequently
- Dilox 500mg qid food.

RTC i 2-3 days, sooner per.

Sorter

SORTOR, BRETT V.
CDR MC USN

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

PATIENT'S NAME (Last, First, Middle Initial)

MERWIN, DANIEL

SEX

M

RELATIONSHIP TO SPONSOR

STATUS

AD

RANK/GRADE

ABHAN

SPONSOR'S NAME

ORGANIZATION

AIR/V3

DEPART./SERVICE

DOD/USN

SSN/IDENTIFICATION NO.

261

DATE OF BIRTH

85

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505


AR 3218

NSN 7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
22 JAN 07	CO: INGROWN NAIL. NODULE TO (R) SIDE OF HEAD S: 21 Y/O OF INTD MEDICAL PROBLEMING INGROWN		
@ 0943	NAIL AND NODULE TO THE SIDE OF THE HEAD X 1 1/2 WEEKS. PT IS REPORTING A SHARP S/P/O		
112/09	TOB PX TO ACTIVITY. PT DENIES ANY DRAINAGE. 76 FEVER + CHILLS. PT IS ALSO REPORTING A 2-3 CM		
97.4	NODULE TO THE (R) SIDE OF THE HEAD (COMPLE) MILD		
18	DRAINAGE.		
	O: VITALS NOTED. AFEBRILE		
	REN-DOX3, WD IWN, NAO		
	(L) ROST GROT TOB (-) DRAINAGE, ERYTHOMA, OR TENDERNESS.		
	Ext: (1) minor erythema along d. discharge wound		
	(2) Neurovascularly intact		
	A/P Inguinal her had mild		
	(1) Warm soaky QD-BID		
	(2) F/U PRN waiting for worsening symptoms: F/U PRN		
	(3) Mohm going to 760 needed for pain		
	(4) A surgical excision needed @ this time		
	Javier LT 2 / MC / 6937 Agaz Jr.		

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT: 			
PATIENT'S NAME (Last, First, Middle Initial) MERVIN, DALE			SEX M
RELATIONSHIP TO SPONSOR		STATUS	RANK/GRADE ABHAN
SPONSOR'S NAME			ORGANIZATION
DEPART/SERVICE AIR/V-3	SSN/IDENTIFICATION NO. 20/ [REDACTED]		DATE OF BIRTH [REDACTED] 85

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

AR 3219

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
HN BARBER Today's Date: <u>1 OCT 2006</u> Time: <u>0935</u> Temp: <u>97.8</u> Pulse: <u>89</u> Resp: <u>12</u> B/P: <u>122/57</u> S _p O ₂ : Allergies: <u>NKDA</u> Meds/Supps: <u>STD tx.</u>	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) <u>C/O: ISSUE TO PENIS</u> <u>21 y/o C/O OF BURNING, PINCHING SENSATION IN PENIS SINCE 3 days</u> <u>AGO. PT NOTICED SWELLING STARTED 2 days ago. PT UNABLE TO RECALL ANY</u> <u>TRAUMA / LAST SEXUAL ENCOUNTER 1 MONTH EARLIER. PT STATES IT FEELS LIKE</u> <u>ONE OF THE BLOOD VESSELS MAY HAVE RUPTURED. PT DENIES S/S OF</u> <u>STD INFECTION, DISCHARGE, SORES. & ELEVATION & discharge</u> <u>@ testis @ inguinal region.</u> <u>General: NAD pleasant.</u> <u>HENT: & LAD & oral lesions</u> <u>HEENT: (R) BS (S) guarding (S) rebound hepatosplenomegaly</u> <u>Ext: (R) site swollen & swelling (L) (D) (ingual)</u> <u>& swelling discharge & sign of inguinal hernia</u> <u>2 y/o CM w/ inflammatory response to head</u> <u>of penis. skin most likely irritation</u> <u>(1) history STD tx</u> <u>(2) PE on STD education</u> <u>(3) & sexual activity for 2-3 mo</u> <u>(4) Return for HIV</u> <u>(5) Will monitor</u> <div style="text-align: right;"> Javier LT 2 / MC / 6937 Agrez Jr. </div>

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:		USS ESSEX (LHD 2)	
PATIENT'S NAME (Last, First, Middle Initial)		SEX	
MERWIN, DANIEL D		MALE / FEMALE	
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	
N/A	Active Duty	ABHAN	
SPONSOR'S NAME		ACTIVITY/DIVISION	
N/A		LHD 2 / V-3	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH	
DOD/	20/	1985	

CHRONOLOGICAL RECORD OF MEDICAL CARE

AR 3220

HEALTH RECORD

CHRONOLOGICAL RECORD

MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

Today's Date:

19 JUNE 2006

Time: 0755

Temp: 98.0

Pulse: 67

Resp: 14

B/P: 99/58

SpO₂: 99

Allergies:

NKDA

Meds/Supps:

21 y/o ♂ c/c INGROWN TOENAIL ON LEFT GREAT TOE FOR THE
LAST 2 WEEKS. PT HAD A PARTIAL TOENAIL REMOVAL IN DEC 2005.

4) pain & dnd pain, m.i. & m.b.l.a. & purulent discharge
Gr: A:0, MAD

Skin: ① great toe - mild redness; tip medial aspect. Mild edema.
- & purulent discharge

AMP: Ingrown toenail, mild

1) Warm soaks QD-BID

2) flx PBN worsening of pain, redness, & discharge of pus.

Verbrugge, Abel K
LT/MC/USNA
2/AA/ 9060

18 JUL 06

CC F/U FOR INGROWN TOENAIL, ① BIG TOE
PT STATES "MY TOE HAS BEEN PUSSING AND
SWELLING FOR THE PASS 10 days. THE PAIN HAS
GOTTEN WORSE." - Recurrent, mild tenderness, no improvement.

①/① PERYTHIONE, ① SWELLING

YELLOWISH TINT TO NAIL.

AMP: IGT

Consent signed & placed on chart.

Procedure - Toe pruned & draped in usual fashion.

(over)

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

USS ESSEX (LHD 2)

PATIENT'S NAME (Last, First, Middle Initial)

MERWIN, DANIEL D

SEX

MALE / FEMALE

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ACTIVITY/DIVISION

DEPART./SERVICE

SSN/IDENTIFICATION NO

DATE OF BIRTH

DOD/ AIR

20/

LHD 2/ V-3

1/85

CHRONOLOGICAL RECORD OF MEDICAL CARE

AR 3221

Digital block obtained using 5cc 1% lidocaine 3 epi on both sides.

Medial 1/2 nail elevated then split and removed from toe.

Hygentropin tissue trimmed.

Wound was cleaned & dressed.

Keep wound dry today then shower normally.

Wear wide, - enough shoes.

Demonstrated proper trimming technique.

RTC: per.

~~H.W. Kende~~

Sortor
SORTOR, BRETT V.
LCDR MC USNR

2

ZATION (Sign each entry)

OSIS, TREATMENT, TREATING

SYMPTOM

DATE

AR 3222

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

INGROWN TOENAIL REMOVAL

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be REMOVAL OF HALF OF
(Description of operation or procedure in layman's language)

LEFT BIG TOE NAIL. Removal after proper anesthesia

Risks: bleeding, infection, recurrence.

which is to be performed by or under the direction of Dr. Sutton

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

- The name of the patient and his/her family is not used to identify said pictures.
- Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Patient)

18 JUNE 2006 10:10

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

MERWIN, DANIEL D



REGISTER NO.

WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRM (41 CFR) 201-45.505
522-110

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE/TIME

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

18 APR '06

USS ESSEX LHD-2

USS ESSEX (LHD-2) UIC:21533

Hearing Conservation Program

HEARING CAN BE PERMANENTLY LOST BY PHYSICAL DAMAGE, ILLNESS, AGE, TOXIC REACTION TO DRUGS OR CHEMICALS, AND LONG EXPOSURE TO HIGH NOISE LEVELS. NOISE LEVELS WHICH ARE HAZARDOUS TO HEARING MAY BE ENCOUNTERED ABOARD NAVAL VESSELS. LONG EXPOSURE TIMES TO HIGH NOISE LEVELS PRODUCE DAMAGE TO NERVE CELLS IN THE INNER EAR. HEARING IMPAIRMENT FROM NOISE (NO MATTER HOW INTENSE THE SOUND LEVEL) DOES NOT HAVE TO OCCUR IF PROPER HEARING PROTECTION IS UTILIZED.

A HEARING CONSERVATION PROGRAM IS IN EFFECT AT THIS COMMAND. THE PROGRAM INCLUDES MONITORING AND LABELING OF NOISE HAZARD AREAS, HEARING TESTING, THE USE OF PROTECTIVE DEVICES, AND TRAINING AS REQUIRED BY OPNAVINST 5100.19 SERIES. YOU ARE AN IMPORTANT PART OF THIS PROGRAM AS IT IS DESIGNED TO SAVE YOUR HEARING. NOISE HAZARDOUS AREAS MUST BE OBSERVED AND HEARING PROTECTION MUST BE WORN IN THESE AREAS. ANNUAL AUDIOGRAMS ARE REQUIRED TO MONITOR PERSONNEL IN THE HEARING CONSERVATION PROGRAM.

84 DB OR GREATER OF CONTINUOUS NOISE= (SINGLE HEARING PROTECTION)

104 DB OR GREATER OF IMPACT NOISE= (DOUBLE HEARING PROTECTION)

GOOD EAR CARE INCLUDES NOT PLACING FOREIGN OBJECTS INTO EARS TO CLEAN THEM (IT USUALLY RESULTS IN PACKING OF EAR WAX), AND EARLY MEDICAL EVALUATION IF DRAINAGE, PAIN OR HEARING DIFFICULTY DEVELOP. THE EAR PLUGS SHOULD BE WASHED FREQUENTLY WITH SOAP AND WATER, AIR DRIED AND STOWED IN PLASTIC EAR PLUG CASES. REPLACEMENTS MAY BE OBTAINED AT ANY TIME FROM THE MEDICAL DEPARTMENT REPRESENTATIVE.

MEMBER COUNSELED ON THE PROVISIONS OF THE HEARING CONSERVATION PROGRAMS AS TO THE EFFECTS OF HAZARDOUS NOISE AND THE NEED TO WEAR PROTECTION WHEN EXPOSED TO HAZARDOUS NOISE LEVELS.

MEMBER PLACED NOT PLACED IN THE HEARING CONSERVATION PROGRAM

EAR PLUGS ISSUED THIS DATE: 4/8/06 FORMIES.

SINGLE FLANGE: ✓ TRIPLE FLANGE: CASE:

HEARING PROTECTION SIZE: RIGHT EAR XS: SM: MED: LRG: XL:

HEARING PROTECTION SIZE: LEFT EAR XS: SM: MED: LRG: XL:

I CERTIFY THAT I HAVE BEEN FITTED FOR AND ISSUED EARPLUGS AS OF THIS DATE: 4/8/06

R. V. DINULONG
HMCS(SW/PMF) IDC USN

MEMBER SIGNATURE: Daniel MerwinMEDICAL DEPT REP SIGNATURE: [Signature]

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS
MAINTAINED
AT:

USS ESSEX LHD-2
MEDICAL DEPARTMENT
FPO AP 96643-1661

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

MERWIN, DANIEL

SEX

Male

RELATIONSHIP TO SPONSOR
N/A

STATUS

- ADU -

RANK/GRADE

ABTAN

SPONSOR'S NAME
N/A

ORGANIZATION

APR/V3

DEPART./SERVICE
DOD/

SSN/IDENTIFICATION NO.

20/ [Redacted]

DATE OF BIRTH

[Redacted] 1985

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 6240 (Rev. 5-84)

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

18APR2006/1513 USS ESSEX LHD-2

DATE: MEDICAL DEPARTMENT USS ESSEX (LHD-2) FPO AP 96643-1661

03Jan06

~~CHECK-IN~~ / CHECK OUT / ANNUAL / CLOSE OUT VERIFICATION

PMT REVIEW

PART ONE: PREVENTIVE MEDICINE Completed by:

() Medical Surveillance Questionnaire completely filled out?

REQUIRED SURVEILLANCE PROGRAM: NONE

() Asbestos Questionnaire Asbestos Physical Frequency: _____

Last Asbestos Physical: N/A

() Special PMT physical (for all CSs, SHs, HTs, All R div. All AIMD Painters, or other special physical)

() Respirator Questionnaire (E1-E6 Only) () PPD Converter? Y/NIf no: Last screening: N/A() LAST PPD: 11/05/05 PPD Converters: INH Complete? Y/N.

LAST MONTHLY/ANNUAL EVAL: _____

() Immunizations:

ANTHRAX: 1 _____ 2 _____ 3 _____ 4 _____ 5

6 _____ B _____

SMALLPOX: _____

INFLUENZA: 11/01/05TETANUS: 11/8/05TYPHOID: 8/14/06 TYPE: PREVENTER 2HEPATIS-A: #1 11/8/05 #2 12/14/05HEPATISTIS-B: #1 11/8/05 #2 12/14/05 #3 _____MMR: 11/8/05POLIO: 11/8/05YELLOW FEVER: 12/14/05

LABORATORY REVIEW

PART TWO: LABORATORY

Completed by:

() Last annual PAP Smear NA F/u for PAP Smear due on _____

() Sick Cell Pos Neg Counseling complete? Yes/No/N/A

() G6PD (Norm/Deficient) Counseling complete? Yes/No/N/A

() HIV Date: 11/06/05() Blood type: 11/06/05() DNA DRAW DATE: 11/05/05 VERIFIED? Y / N DATE: _____

PHYSICAL REVIEW

PART THREE: PHYSICAL

Complete by:

() Last Preventative Health Assessment (PHA): 4/14/06() Special Physicals required? Y Last conducted: FLUGAT 14 APR 06() Wears Glasses? Last exam: 11/7/05 # of Glasses/GMI: 1

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS

MAINTAINED

AT:

USS ESSEX LHD-2

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

MERWIN DANIEL

SEX

Male

RELATIONSHIP TO SPONSOR

N/A

STATUS

AD

RANK/GRADE

ABHAN/E03

SPONSOR'S NAME

N/A

ORGANIZATION

USS ESSEX LHD-2

DEPART./SERVICE

DOD/USN

SSN/IDENTIFICATION NO.

DATE OF BIRTH

5985
AR 3225

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

Issued/Ordered/N/A Date Issued: _____
 () Flight Deck screening (for personnel in V-1 and V-4 Div) 4/14/86
 () Ear Plug size: L: _____ R: _____ TYPE: _____
 () Hearing Conservation screening for personnel in ACU-1, AIR, DECK, ENG, AIMD. 11/7/05 11/7/05
 Date of last 2215: _____ Date of last 2216: _____ Next 2216 due: 11/7/16
 () Sight Conservation Screening for personnel in ACU-1, AIR, AIMD DECK, ENG, LAB, X-RAY, PMT.
 () AMMO Driver/Explosive Ordinance Physical for WEPS division and some AIMD personnel (given annually)

MEDICAL ADMIN

PART FOUR: HEALTH RECORDS Completed by: _____
 () Year Blackened on Jacket? () Pencil entries on inside cover?
 () Current rate in pencil on jacket?
 () Privacy Act entries/signature inside back cover?
 () Pink card complete? () Line out blank SF 600s
 () Update Problem Summary list () 6150/4? _____
 () Allergy Dog tag required? Y/N/N/A
 Patient Signature: _____ HM Signature: _____ Date: _____
 () Health Record in Good Repair? Replace/Repair if not: _____
 Ensure that forms are in the right location.
 () SAMS data entry complete?: Y / N
 () Enrolled in TRICARE?: Y / N

CLINICAL REVIEW

() Operational Duty Screening conducted as required? () Y / N
 () Any presence of CHRONIC OR SIGNIFICANT ILLNESS? Y / N
 DIAGNOSIS: _____
 LAST FOLLOW-UP: _____
 () On maintenance medication? Y / N
 MEDICATION: _____
 ENROLLED ON MAIL ORDER PHARMACY? Y / N
 DRUG ALLERGIES: N/A

SAMS entry
 verified: 4/24/86

R. V. DINI LONG
 HMCS(SW/ME) IDC USN

Esquivel C. Sabijon Jr
 000-06-4735
 HM1 (SW/A, USN
 Advance Lab Tech

LENDALL H. B.
 000-00-
 HA AVT USN

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:	USS ESSEX LHD-2		
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) MERWIN DANIEL			SEX Male
RELATIONSHIP TO SPONSOR N/A	STATUS AD	RANK/GRADE ABHAN/E03	
SPONSOR'S NAME N/A		ORGANIZATION USS ESSEX LHD-2	
DEPART./SERVICE DOD/USN	SSN/IDENTIFICATION NO. [REDACTED]	DATE OF BIRTH [REDACTED] 5985 AR 3226	

Apr 07 005

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
<u>Time</u> 14 APR 06	Annual Flight Deck Personnel Medical Screening Examination Reference - Manual of the Medical Department Chapter 15, Article 15-65
T - 96.8	Prospective Flight Deck Position: <input type="checkbox"/> Critical <input checked="" type="checkbox"/> Non Critical <input type="checkbox"/> Special
P - 70	➤ Date of Last Physical Examination: <u>14 APR 06</u> Date of Last Eye Examination: <u>07 NOV 05</u>
BP - 137/70	➤ Current Visual Acuity as transcribed from last Comprehensive Eye Examination: Uncorrected OS <u>20/40</u> OD <u>20/50</u> OU _____ Corrected OS _____ OD _____ OU _____
<u>SMKR</u> None	➤ Critical: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye Uncorrected OS _____ OD _____ OU _____ Corrected OS _____ OD _____ OU _____
<u>ETOH</u> None	➤ Non Critical: Distant/near visual acuity-No limits uncorrected however must correct to 20/40 or better in one eye, 20/30 or better in the other Uncorrected OS <u>20/50</u> OD <u>20/30</u> OU _____ Corrected OS <u>20/20</u> OD <u>20/20</u> OU _____
<u>Allergies</u> Feathers	➤ Special: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye Uncorrected OS _____ OD _____ OU _____ Corrected OS _____ OD <u>2</u> OU _____
<u>Meds</u> None	➤ All: Field of Vision: OS <u>FULL</u> OD <u>FULL</u> OU <u>FULL</u> ➤ All: Depth Perception, did member pass <u>Verhoeff</u> or AFVBT <u>14/14</u> <input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail ➤ All: Color Vision, <u>FALANT</u> Results <u>9/9</u> <input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail
	Was member issued regular glasses? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes what is the date of issue: <u>07 NOV 05</u>
	Members Acknowledgement. "I understand that I am required to maintain my current eyewear onboard at all times and that I am required to wear them during all flight deck evolutions."
	Based upon history, records review and physical examination the member is found to be: <input checked="" type="checkbox"/> Qualified <input type="checkbox"/> Disqualified <input type="checkbox"/> Medically Deferred
	<u>Pauw...</u> Member's Signature <u>Verbrugge, Joel K</u> SMDR Signature LT/MC/USNR 2/AA/

Records Maintained At

Patient's Name (Last, First, Middle Initial)		Sex
MERWIN, DANIEL D		MALE
Relationship to Sponsor	Status	Rank/Grade
Self	Active Duty	ABHAN
Sponsor's Name	Organization	
Self		
Department/Service	SSN	Date of Birth
USN	20/ [REDACTED]	[REDACTED] 3 85

Enclosure (1)

AR 3227

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

4/14/86

USS ESSEX LHD-2

Preventive Health Assessment:

Sex: M F 1. Do you have a history of ulcerative colitis or cancer? Y N
 AGE: 21 If so, which? _____
 Ht: 5'8 2. Do your parents or grandparents have a h/o colon cancer? Y N
 Wt: 136 3. Do you smoke? Number of packs per day ____ No of years ____ Y N
 BMI: _____ 4. Do you have diabetes? Y N
 BP: 137/70 5. Do your parents, siblings, or grandparents have a h/o heart attacks at a young age (<55 in male, <65 in female)? Y N
 P: 70 6. Do you have a history of high blood pressure? Y N
 R: 16 7. Do you have a history of high cholesterol? Y N
 Temp: 96.8 8. Do your parents, siblings, or grandparents have a h/o high cholesterol? Y N
 9. Do you exercise less than 30 min 3 days per week? Y N
 10. Do you have any medical history that prevents deployment? Y N
 What issues? _____
 11. Have you any admin issues that prevent deployment, i.e. EFMP, pregnancy, etc.? Y N
 12. Special Duties, ie. radiation, flight, explosive handlers, diving, SAR swimmer? other: _____ Y N
 Hearing Conservation Program? Y N
 Asbestos Surveillance? Y N

Women's Health:

13. History of abnormal Pap or dysplasia? Treatment: _____ Y N
 14. Do you need to be taught how to perform a self breast exam? Y N
 15. Have you begun screening mammograms? Age began: _____ Y N
 16. Do you need education on family planning, contraception, or STDs? Y N
 17. On average, do you drink more than 7 drinks per week? _____ Y N

Men's Health:

18. Do you have a history of undescended or abnormally small testes? Y N
 19. Do you need to be taught how to do a self testicular exam? Y N
 20. Do you have a family history of prostate cancer in a close relative? Y N
 21. On average, do you drink more than 14 drinks per week? _____ Y N

22. I am taking the following meds/otc/supplements:

N/A23. Allergies: No known drug allergies or causes _____.

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:		
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) <u>MERWIN, DANIEL D</u>		SEX <u>M</u>
RELATIONSHIP TO SPONSOR <u>N/A</u>	STATUS <u>SINGLE</u>	RANK/GRADE <u>ABNAN</u>
SPONSOR'S NAME <u>N/A</u>		ORGANIZATION <u>NAVY</u>
DEPART./SERVICE DOD/	SSN/IDENTIFICATION NO. [REDACTED]	DATE OF BIRTH [REDACTED] <u>285</u>

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

4/14/06

Clinic Review:

Labs documented:

Blood type A B O + 4/-
 Sickie Cell + 0
 G6PD nl abnl
 DNA on file Y N
 HIV w/in 1yr Y N

Immunizations current:

typhoid (2yr) Y N
 Hep A x 2 Y N
 Yellow fever-10 Y N
 IPV Y N
 Td (10y) Y N
 MMR Y N
 Influenza (1y) Y N
 Smallpox (10y) Y N
 PPD (annual) Y N

Tests/Referrals/Education

___ BP checks x ___ days
 ___ fasting lipids
 ___ HIV within 1 year
 ___ Chem 7
 ___ Dental Appt >1 year
 ___ Optometry appt >2 yr
 ___ Nutritionist consult
 ___ Colon Ca Screening@___
 ___ Mammograms @ ___
 ___ Prostate screen @ ___
 ___ Stress Management
✓ Rec: SBE or STE
✓ Rec: aerobic exercises

Equipment on hand:

2 pair of glasses Y N *1 pair*
 1 pair of mask inserts Y N

Follow up in Medical in ___ weeks, with duty doc or

R. V. DINULONG
 HMCS(SW/FMF/IDG/USN)

Provider's sig: 1272*PRN for Annual Audio.*

- ① Need to order 1 pr of glasses & a CMT
 ② Educated on self testicular exam

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL
MPRINT)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)			SEX
RELATIONSHIP TO SPONSOR N/A	STATUS	RANK/GRADE	
SPONSOR'S NAME N/A		ORGANIZATION	
DEPART./SERVICE DOD/	SSN/IDENTIFICATION NO.	DATE OF BIRTH AR 3229	

NATTC NAS PENSACOLA NBHC

Personal Data - Privacy Act of 1974 (PL 93-579)

DIVISION: NATTC NAS PENSAC

Customized Version of SF600

PRINTED: 06 Mar 2006@0802

NATTC SICK CALL

MAYNARD, PENELOPE A

06 Mar 2006@0815

ROUT

BHAK

REF:

CMT: cac-ebc

CHIEF COMPLAINT: abdominal pain

Detail Codes:

INSURANCE YES/NO

PATIENT'S PCM: NO PCM HISTORY

BP: 120/64 PULSE: 60 RESP: 12 TEMP: 97.6 HT: 5'8" AGE: 21 WGT: 126

PAIN ASSESSMENT: Language/Cultural Barriers? Y/N Is Pain Present? Y/N

Intensity: 1 2 3 4 5 6 7 8 9 10

Description:

Action Plan: ☐ Refer to PCM☐ Refer to Note☐ Refer to Pain Mgt

Other:

ALLERGIES: OTHER

Is the reason for your visit today related to deployment? ☐ Yes ☒ No

CLINICAL NOTE:

ALLERGIES

MEDS

TOBACCO

SUPPLEMENTS

PAIN

Denies pain since 5 Dec
No further rectal bleed
colonoscopy showed - internal
hemorrhoids.

1) abd - soft non tender
Dyspepsia

A) fit full last duty
abd pain resolved

B) some sigmoid -

abdominal pain stopped

Dec. 05

Home had CT w/ IV contrast

Barium swallow

All negative

need appr. to help w/
over seas screening.

Has changed diet & using
bathroom more regularly

[Signature]

P.A. MAYNARD, MD

31

GS-14 GMSO

20/ [REDACTED] MERWIN, DANIEL DENNIS
[REDACTED] 1985 MALE
SPON: MERWIN, DANIEL DENNIS

USN ACTIVE DUTY
W: 7600
CIC:

H: 4847672804

AR 3230

NAVAL HOSPITAL GREAT LAKES
USS TRANQUILLITY BRANCH MEDICAL CLINIC BLDG 1007
3420 ILLINOIS STREET
GREAT LAKES IL 60088-5230
(847) 688-6755 ext. 6290, 6291, 6242, 6245, and 6246

Mark boxes to the left indicating that the step in verification has been completed on the date indicated. Correct discrepancies as you go!

X	Verify right record for Division with Divisional Roster.
X	If ASMO'd out of Division. Locate new Division in CETARS.
X	Verify Patients Name matches CHCS Label
X	Note allergies and sensitivities on NAVMED 6150/30. Blocks are marked on the front of the record jacket. Verify ALERT matches on DD Form 2766 and Summary of Care.
X	Verify Record Category is red tape & in place.
X	Verify SSN Tapes are black and covering proper number.
PART I	
X	Verify DD Form 2766 (pages 1-4) is present and completed.
X	Document discrepancies and all health problems on DD2766.
X	Verify Summary of Care is in the record and completed.
X	Verify patient has received all required immunizations, DNA, and PPD documented on SF601.
X	Record Date Recorded, Result, Verified By (Rank and Last Name), Command UIC (00763), and Test or Process MTF (RTCGLAKES) on Chronological Record of HIV Testing Form NAVMED 6000/2.
X	Verify DD Form 2215E is in the record and completed without discrepancies.
PART II	
X	Review sheet first page.
X	Verify Part II is in Chronological order and all follow-ups are met.
X	Verify all forms in the record have Name, SSN, & date of Birth
X	Verify all forms in the record are the patients' forms.
X	FEMALES Verify documented PAP/Pelvic Examination completed. Verify USS Red Rover SF600 concerning Immunizations, Wellness and Record Review is in record and signed.
X	Verify In-processing Eye Exam completed and no discrepancies.
X	Verify Member Meets minimum Standards for Vision and Color.
X	Verify patient signs DD Form 2005.
PART III	
X	Verify 1300/2 is completed.
X	Verify DD Form 2808 and 2807 are in Part III.
X	Verify No pending Waiver on MEPS Physical
X	Verify Abstract & History is completed.
X	Verify Special Physical is Completed if Applicable.
PART IV	
X	Verify all Labs and X-ray reports printed and no discrepancies.
X	Check for LCX.
X	Verified HIPPA Label Signed on back of jacket.
	MEMBER IS NOT FIT FOR TRANSFER. Following Discrepancies found:
	MEMBER IS FIT FOR TRANSFER. (Taken off Hit List)

HN RYALS, MICHAEL

HM'S Signature

(Print Rate/Rank, Full Name)

Today's Date

PATIENT'S INFORMATION:

LAST, FIRST NAME:
E1/SR

SSN: 20/
DOD/USN

DOB:

AR 3231

Personal Data - Private

BOI of 1974 (M, 93-079)

Updated Version: 8/2008

EMERGENCY CARE & TREATMENT - NH GREAT LAKES, 2008

EDS NUMBER: 050113-00002

Arrival Date/Time: 19 Nov 2008 0634

Trans to Hospital: AMBULANCE

History Obtained From: PATIENT

3rd Party Payor: NO

Time Seen: 0634Z

Category: 1

Admit SHIP 06 DIV 041

GREAT LAKES, IL

Phone: HOME

Chief Complaint: ABD PX X 2 WKS WITH BLOODY STOOLS

Sex: MALE

Age: 20

SP02 99

VITAL SIGNS

Temp 0334
BP-SY 146
BP-DI 87
Pulse 87
Resp 18
Temp 97.0 PO

Medications

Any 4/4
4/9/66

CBC
HbS: (const) no SKD
CT: (const) no SKD
LFT
clon

OTHER

Orders Initials Time

UPO
C. W. S. 16/11/2008 0400
CT HbS/Pelvis 16/11/2008
CBC, Chem
LFT, Imx, Uro, Uro
HbS
Bowel Rx 16/11/2008
Bowel Rx 16/11/2008

20 yo M presents to abdomen to lower abdomen this has been occurring intermittently since the last 2 weeks. Pt has been chld & constipation and this pm has noticed bloody stools. No chest pain, no penile testicular/back pain, no other sx, no nausea, no fatigue

1) Constipation
2) Anal fissure/hemorrhoid

3) Hemorrhoid
4) Hemorrhoid

Admitted Date/Until: Day: Mon: Yr:

Admitted to: Emergency
2 hours

Admitted to: Emergency
2 hours

Others:

Condition upon release: Improved Unchanged Deteriorated

Release Time: 0550

USN
HEENT: PERC EARS NOIT
Neck: Supple FROM AND
H: PPR
L: CT
HbS: Soft NTW DORS
Ext: Dckle
Neuro: L Sens Str Gait w/ test
Skin: No lesions

Puff
PSH
PS 240
SH

No other sx
Abd Pain - vibs, AR, CT abd/pelvis
Signature of: [Signature]
Pdenwill E/U on 11/21

Instructions to Patient: Follow up at 1300 to meet Dr Pden in General Surgery Clinic. Unanswered Postoperative Clinical Beryl
Return for any problem
I HAVE RECEIVED AND UNDERSTOOD BY DISCHARGE INSTRUCTIONS
Do not take hydrocodone

HERWIN, CAROL DENNIS

LYDS MALE

LOC: EMERGENCY MEDICAL CARE

SP02: 99% SATURATED

UNITS: NOVELT/STROU

NLS

WINGRE

2008

RECEIVED ON

UNIT: NOVELT/STROU

RECEIVED

AR 3232

NH 6010/14 (REV 06/04)

UNITED STATES NAVAL HOSPITAL, GREAT LAKES

EMERGENCY MEDICAL SERVICES REPORT

DEPARTMENT#

Nature of Call

MM DD YYYY

ABD PAX / BLOODY STOOL 11 / 19 / 2005

Patient Name (Last, First etc...)	SSN	Age	Gender	DOB	Location
MERWIN, DANIEL	[REDACTED]	20	[] F [X] M	[REDACTED] YYYY 1995	7101-00
Address:	City:	State:	Zip:	Unit	Call Sign:
Ship-06 DV-04 / GREAT LAKES	IL	60088	1941		R-1
Chief Complaint:	Status (AD, Recruit, Dep etc)	Incident Number:			
STOMACH PAX	RECRUIT	7299			
Medical History:	Mechanism of Injury [] None	Received Call:			
TONSILECTOMY - 19, WEDNESDAY 2 WKS AGO	UNKNOWN	Enroute:	0511		
Medications: [] None [] Unknown	Allergies: [X] NKDA [] Unknown	On Scene:	0314		
VICODEN, AMOX, PEROLOSEL, IBU, DOXUSATE	PERNIES	Depart Scene:	0324		
	Patient Number	At Hospital:	0330		
	1 of 1	In Service:	0335		

VITAL SIGNS					TREATMENT	
TIME	RESP	B/P	PULSE	SPO2%	IV SOLUTION: NS	LR RATE:
0320	16	130/70	93	99	GLUCOMETER:	DL/ml
					OXYGEN DEVICE:	VENOUS / CAPILLARY
						LPM:

Mental Status	Pupils	Lung Sounds	Respiratory Effort	Skin Color	Appears Normal
[X] Conscious	L R	L R	[X] Normal	Cyanotic	Cold
[] Combative	[X] PERRL	[X] Clear	[] Absent	Flushed	Cool
[] Disoriented	[] Dilated	[] Decreased	[] Decreased	Pale	Hot
[] Lethargic	[] Pinpoint	[] Rales	[] Labored	Pink	Dry
[] Unconscious	[] Unresponsive	[] Stridor	[] Tachypnea		Moist
[X] Oriented		[] Wheezing			

Treatment:	1	2	3	4	Comments:
Vital Signs	[X]	[X]			20 y/o 2% ABD PAX x 2 WKS C SAID SIGNS
Assessment	[X]				UP BLOOD IN STOOL x 2 ARS. @ TIP IN @ QUADS
Glucometer					UP DISTENTION, @ GUARDING, @ REBOUND TENDERNESS, NL
Oral Glucose					BOWEL SOUNDS. PT STATES TX 8/10 AND TYPHOIDING
IV Started					IN NATURE. PT STATES ABNORMAL BM's. PT HAS
IV Missed					BEEN TRA AT 1007 BUT BECAME MORE ALARMED
Blood Draw					WHEN BLOODY STOOL BECAME PRESENT. APTS. ABC,
Airway Nasal					INTERCT. VES. PT AMBULATORY C NL GAIT AND
Airway Oral					TRANSPORTED UP
Nasal Cannula					
Nonrebreather					
Combitube					
Suction					
Ventilation					
Bandaging					
Backboard					
C-Collar					
Splinting					
AED					
Driver					

Assisted By:	Medical Direction NHGL:	Crew	Status
GLPD	By: [Signature]	1. [Signature]	ENT
Name	Transported To:	2. [Signature]	TRIVOK
GLFD	200H ER	3. [Signature]	
Engine #	200H	4. [Signature]	
OTHER	BMC 1007		
Name	BMC 237		
Accepting Signature:	AMA		
Tape #	Other (i.e. Lake Forest):		
QM Review By:			
Forward for further Review:			
Yes	AR 3233	No	

EMERGENCY DEPARTMENT TRIAGE EVALUATION

Arrival time: 03 Date: 11-19 B/P 146/87 P 87 R 97 T 97 Triage category: **Emergent** @
 Method of Arrival: ☐ wheelchair ☒ ambulatory ☐ assisted ☐ gurney ☐ C-Spine Precautions **Urgent** @
 Complaint/Onset: Abd Pain **Non-Urgent** @
 Meds: ☐ Denies ☐ See ETR Allergies: ☐ NKDA ☐ Latex ☐ SI ☐ HI ☐ See Mental Health Triage Note

<u>Pain</u>	<u>Docu</u>

SaO2 99Wt

We routinely screen all patients for domestic violence in their lives. Is this a problem for you in any way?

☐ Yes ☐ No

Do you want help with this today?

☐ Yes ☐ NoMedical Hx: ☐ Denies ☐ Asthma ☐ MI ☐ HTN ☐ DM ☐ Other

Airway: <input checked="" type="checkbox"/> Patent Breathing: <input checked="" type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Clear <input type="checkbox"/> Shallow <input type="checkbox"/> Accessory Muscle Use R Breath Sounds L <input type="checkbox"/> Rales <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Diminished <input type="checkbox"/> <input type="checkbox"/> Rhonchi <input type="checkbox"/>	Skin/Circulation: Color <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Cool <input type="checkbox"/> Bulging <input type="checkbox"/> Pale <input type="checkbox"/> Dry <input type="checkbox"/> Normal <input type="checkbox"/> Mottled <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic <u>Membranes</u> <input type="checkbox"/> Jaundiced <input type="checkbox"/> Moist <input type="checkbox"/> Dry <u>Cap Refill</u> <u>Turgor</u> <input type="checkbox"/> < 2 sec <input type="checkbox"/> Normal <input type="checkbox"/> > 2 sec <input type="checkbox"/> Tenting	Fontanel: Neurological: A+ Ox <u>3</u> <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Weakness <input type="checkbox"/> Age Appropriate <input type="checkbox"/> Steady Gait <input type="checkbox"/> Equal Strength <input type="checkbox"/> PERRLA <input type="checkbox"/> Syncope	GI: <input type="checkbox"/> WNL <input type="checkbox"/> N/A <u>Abd</u> <input type="checkbox"/> Nausea <input type="checkbox"/> Soft <input type="checkbox"/> Vomiting X <input type="checkbox"/> Rigid <input type="checkbox"/> Diarrhea X GU/GYN: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> N/A <input type="checkbox"/> Dysuria <input type="checkbox"/> LBP <input type="checkbox"/> Hematuria <input type="checkbox"/> Frequency LMP <input type="checkbox"/> Discharge G P AB	Extremities/Lacerations: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> N/A TTP: <u> </u> MOI: <u> </u> <input type="checkbox"/> Edema <input type="checkbox"/> Active Bleeding <input type="checkbox"/> Ecchymosis <input type="checkbox"/> Erythema <input type="checkbox"/> Deformity Tetanus <u> </u> CMS <u> </u> Cap Refill <u> </u>
--	--	---	---	--

Pain: 1 2 3 4 5 6 7 8 9 10
History of present illness: C/O blood in stool since

tonight - being treated by Dr. Ditchel
"Makes water red"

Disposition from Triage:

☒ Bed 3 @ ☐ RAD @ Lobby @ Triage RN Patient desires to be seen in Clinic today at and refuses treatment in the Emergency Department.Patient's plan of care discussed with Patient/Guardian Signature:

Time Nursing Notes

0542	IV discontinued, IV cath in tact
0550	PT discharged

Medications/IV/O2

Time	Medications/Fluids/O2	Dose	Route	Rate	Site/Gauge	Initials	Response
0350	N/S	1L	IV	KVO	@ AC 118, 92	<u> </u>	<u> </u>
0355	Pain	10mg	IVP		1	<u> </u>	
0358	Benzocaine	50mg	IVP		1	<u> </u>	
					1		

Discharge to: ☒ Home ☐ Command ☐ Ward ☐ Other☒ Patient/Parents verbalized understanding of discharge instructions☒ Instruction sheet given to pt: 7/8 verbal☐ Ambulatory ☐ Other ☐ Belongings with ptDischarge Time: 0550 Initials: Vitals: B/P 146/87 P 87 R 97 T 97

Patient Identification

MERWIN, DANIEL DENN 051119-00002
 20/ DOB: 1985
 N13 SR NO STATUS
 SPON UNIT: NO763A
 RR: FA COURAGE RECORDS NBHC 1007

Signature/Initials	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>

AR 3234

NAVHOSP GREAT LAKES IL
 Personal Data - Privacy Act of 1974 (PL 93-579)
 Printed: 29 Nov 2005@0739

DIVISION: NH GREAT LAKES, 2
 Automated Version of SF600

INTERNAL MEDICINE FRANKLIN, MALCOM B

29 Nov 2005 0840 EST 20

BAAA

REF: CMT:

RSN:

Detail Codes:

INSURANCE YES/NO:

BP: 109/57 PULSE: 78 RESP: 16 TEMP: 97.7 HT: 68" WT: 118 AGE: 20

ALLERGIES: N/A

Meds
 Docuase
~~Aspirin~~ ^{Aspirin} ~~Tridol~~
 Ibuprofen

PMHx <input type="checkbox"/> Reviewed & Updated Allergic rhinitis	PSHx <input type="checkbox"/> Reviewed & Updated Wisdom teeth extraction Tonsillectomy	Pain Scale: 0/10 Location: _____ Quality: dull sharp Duration: _____ Made worse by: _____ Made better by: _____																																																						
HPI: 20 yo AD & Recruit 3-2 years for evaluation of thrombocytopenia. It was having hematochezia x 1 day. Evaluated to colonoscopy which revealed internal hemorrhoids. Labs to p/bts and bleeding time @ upper limits Norm. Rash, some easy bruising. No prolonged bleeding to wisdom teeth extraction 2 wks ago.																																																								
<table border="1"> <thead> <tr> <th>2 to 9</th> <th>Reviewed</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>ROS Constitutional</td> <td>X</td> <td></td> </tr> <tr> <td>HEENT</td> <td>X</td> <td></td> </tr> <tr> <td>Cardiovascular</td> <td>X</td> <td></td> </tr> <tr> <td>Respiratory</td> <td>X</td> <td></td> </tr> <tr> <td>Hematological</td> <td>X</td> <td></td> </tr> <tr> <td>Lymphatic</td> <td></td> <td>X</td> </tr> <tr> <td>GI</td> <td></td> <td></td> </tr> <tr> <td>GU</td> <td>X</td> <td></td> </tr> <tr> <td>SKIN</td> <td></td> <td></td> </tr> <tr> <td>Musculoskeletal</td> <td>X</td> <td></td> </tr> <tr> <td>Endocrine</td> <td></td> <td></td> </tr> <tr> <td>Psychiatric</td> <td></td> <td></td> </tr> <tr> <td>Allergic</td> <td></td> <td></td> </tr> <tr> <td>Neurologic</td> <td></td> <td></td> </tr> <tr> <td>Renal</td> <td></td> <td></td> </tr> <tr> <td>Immunizations</td> <td></td> <td></td> </tr> <tr> <td>Allergies & Medications</td> <td></td> <td></td> </tr> </tbody> </table>		2 to 9	Reviewed	Comments	ROS Constitutional	X		HEENT	X		Cardiovascular	X		Respiratory	X		Hematological	X		Lymphatic		X	GI			GU	X		SKIN			Musculoskeletal	X		Endocrine			Psychiatric			Allergic			Neurologic			Renal			Immunizations			Allergies & Medications			<p>22 Nov 05 PT 38 PTT 13 WBC 1.063</p> <p>19 Nov 05 9/14/85 40/105</p> <p>Bleeding time 7.5</p> <p>22 Nov 140/102/13 4.1/21/6.9/101</p> <p>6.12/14/86 40/408</p> <p>Exam Thin w/o, w/o J HEENT ABNORMAL, some Neck slightly w/o chest ctn @ CO2 track & m/c Abd @ BS, soft, & 45cm Ext & edema Skin mild ecchymosis RVE & petechia</p> <p>Labs: / / / /</p> <p>AST 26 ALT 28 ALP 75</p> <p>LDL: _____ HDL: _____ Total Chol: _____ TG: _____</p> <p>29 Nov 2005 12.9/13/358 38</p>
2 to 9	Reviewed	Comments																																																						
ROS Constitutional	X																																																							
HEENT	X																																																							
Cardiovascular	X																																																							
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Lymphatic		X																																																						
GI																																																								
GU	X																																																							
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Musculoskeletal	X																																																							
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Allergic																																																								
Neurologic																																																								
Renal																																																								
Immunizations																																																								
Allergies & Medications																																																								
ADDITIONAL COMMENTS: Family History: Cancers: _____ Heart Dz: _____ Social Hx: Tob: _____ ETOH: _____ Occupation: _____ Immunizations: PVAX _____																																																								

20/ [REDACTED] MERWIN, DANIEL DENNIS
 1985 MALE
 Spon: MERWIN, DANIEL DENNIS
 CS:
 Unit: NAVCRUITRACOM

N13
 W: NONE H: NONE
 CIC:
 Rank: SR D: NONE
 RR: FA COURAGE RECORDS NR132351007

2 ✓

NSN 7540-00-634-4176

INTERNAL MEDICINE NAVAL HOSPITAL GREAT LAKES

AUTHORIZED FOR LOCAL REPRODUCTION

Exam Point	N L	Comments	Impression/Plan:
General: NAD W/DWN thin obese ill-looking AOx3			<p>① <u>Thrombocytopenia</u></p> <p>Appears to have been transient phenomenon. Now to Nml p/ls today and on 22 Nov.</p> <p>Cong Nml to bleeding time in upper limits of Nml. Hematocrit resolved.</p> <p>② Fit for full duty.</p> <p>③ If Sx recur ✓ CBC w/ low platelets will return w/o -- Duty status.</p>
Eyes: Conjunctivae & lids			
PERL EOM			
Fundoscopy exam			
ENMT: External ears, nose			
Tympanic membranes			
Hearing assessment			
Nasal mucosa, septum, turb			
Lips, teeth, gums			
Oropharynx, oral mucosa, salivary glands, palates, tongue			
Neck: JVD			
Thyroid			
Respiratory:			
Respiratory effort unlabored			
Auscultation of lungs CTA			
Cardiovascular:			
Auscultation of heart S1S2			
Palpation of heart			
Carotid/abdominal/femoral arteries			
Pedal pulses			
Extremity: varicosities			
Clubbing cyanosis edema			
GI(abdomen):			
NT, ND NABS liver spleen			
Anus, perineum, rectum, hernia			
Prostate			
Lymphatic			
Neck, axillae, supraclavicular			
Inguinal			
Musculoskeletal:			
Gait & Station			
ROM			
Neurologic: CN II-XII			
Deep tendon Reflexes			
Sensation			
Motor strength			
Breast:			
Inspection, palpation or breast & axillae			
Nipple discharge			
Skin:			
No Rash			
Feet			

Counseling, teaching: 15 min. of 20 min. Topic: Diabetes Mammogram HTN Colon Smoking Cessation Exercise

F/u 1 2 3 6 days/wks/mo.

Legible Signature: Malcolm B. Franklin
LT/MC/USNR
2AA

Date: 29 Nov 2005

□ G. Sladek, MD 9145 □ N. Lee, MD 8486 □ R. Juhala 0123 □ D. Landry 3405

Page 2

AR 3236

General Surgery Clinic
United States Naval Hospital
3001 A 6th Street
Great Lakes, IL 60088-5230
Phone: (847)688-2095
Fax: (847)688-3505

OPERATIVE PROCEDURE REPORT - 11/21/2005

PATIENT: **Merwin, Daniel**
BIRTHDATE: [REDACTED] 985
AGE: 20

GENDER: 20 [REDACTED]
male

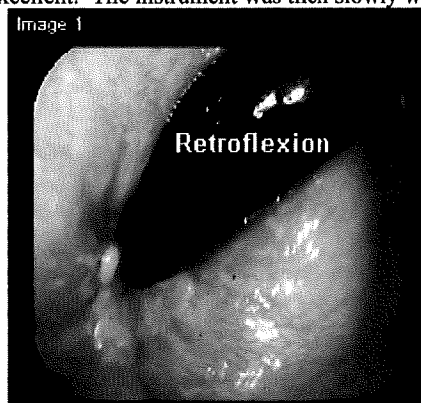
ENDOSCOPIST: Winnie M. Polen, LT/MC
ASSISTANT: Nastarsha N. Bishop, HM3/USN

PROCEDURE: **Flexible Sigmoidoscopy, diagnostic**

INDICATIONS: hematochezia

MEDICATIONS: None

DESCRIPTION OF PROCEDURE: After the risks benefits and alternatives of the procedure were thoroughly explained, informed consent was obtained. Digital rectal exam was performed and revealed no abnormalities. The Pentax ES-3830 endoscope was introduced through the anus and advanced to the proximal transverse colon. The quality of the prep was excellent. The instrument was then slowly withdrawn as the mucosa was fully examined.



The examination was normal with no endoscopic findings. Retroflexed views in the rectum revealed hemorrhoids. Mild grade I internal hemorrhoids. The scope was then completely withdrawn from the patient and the procedure terminated.

COMPLICATIONS: None

ENDOSCOPIC IMPRESSION:

- 1) Normal sigmoidoscopy otherwise
- 2) Internal hemorrhoids

RECOMMENDATIONS:

- 1) fiber rich diet
 - 2) follow-up: primary MD PRN
- Needs work-up for thrombocytopenia

REPEAT EXAM: No

Winnie M. Polen, LT/MC

Bmc
1007

CC:

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Flexible sigmoidoscopy, possible biopsy

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

place a scope into my colon to look for disease

which is to be performed by or under the direction of Dr.

Bacaner / Kamdar / Polen

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgement of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgement of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are:

OBSERVATION

(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissue or parts which may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

8. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above:

(Signature of Counseling Physician/Dentist)

9. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Patient)

(Date and Time)

10. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I,

sponsor/guardian of

understand the nature of the proposed procedure(s), attendant risks involved,

and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name—last, first, middle; grade, rank; rate: hospital or medical facility)

REGISTER NO.

WARD NO.

Mermin, Daniel
Zel [REDACTED]REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES

Medical Record

OPTIONAL FORM 522 (12-94)
Prescribed by GSA/ICMR FIRM (41 CFR)
201-9.202-1

AR 3238

NSN 7540-00-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE
 Date: 22 NOV 05 Branch Medical Clinic 1007, USS TRANQUILLITY, Great Lakes, IL

# of Cold Packs	# of Canteens	Day of Training	ALLERGIES	Current Medications	SIQ Day #
<u>0</u>	<u>6</u>	<u>2-5</u>	<u>FEATHERS</u>	<u>DICLOXAN</u> DAN <u>DO CO SAFE CALCIUM</u>	<u>6087</u>

Temp: 97.3 Pulse: 77 Resp: 14 BP: 110/73 Pulse Ox: 99 % FDLMP: _____ Tylenol _____

20 y/o MALE / FEMALE STAFF / RECRUIT with a NEW / Follow Up Chief Complaint of DIEING / STOMACH PAIN

I request a cold pack / other and DO NOT wish to see a provider. Patient signature _____

REVIEW OF SYMPTOMS:

Fever/Chills _____ Congestion _____ Rhinorrhea _____ Sore throat _____ Nausea _____ Vomiting _____ Diarrhea _____
 Constipation _____ Cough _____ (Productive/ Non-Productive)

Other 20 y/o male with L of abdominal pain / intermittently for

Length of Symptoms 2 days/ weeks about 4-5 yrs now Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

EXAMINATION

Stand-by: DECLINED / ACCEPTED _____

General: WD / WN + / - Distress, A & O x
 HEENT: NC / AT PERRL, EOMI x 6. Pharynx: Normal / Erythema / Exudate / Tonsillar Hypertrophy / Adenopathy
 TM: Normal / Erythema R / L / Bilat. Sinuses: NTTP / TTP @ Frontal / Ethmoid / Maxillary
 HEART: Normal / Tachycardic / Bradycardic pulse w/ Murmur / Rubs / Gallops
 LUNGS: CTA Bilaterally w/ Rales / Ronchi / Wheezes in R / L / Bilat ULF / LLF
 ABDOMEN: Soft / NTTP w/ TTP @ RUQ / RLQ / LUQ / LLQ / Rigidity / Rebound / Guarding. BS noted in _____ Quadrants
 GU/Vaginal: see back
 Rectal: see back
 Skin: Normal
 Extremities: Normal

Radiology/Lab:

Subs 19 Nov
Chol 2 - (N) 11/05
CT - P
XRay - abd pain

ASSESSMENT: Upper Respiratory Infection _____ Viral Syndrome _____ Other: Heavy Breathing / Abdominal Pain

PLAN

____ Continue Current Medications → Bntyl
 ____ Tylenol 325 / 500 mg PO Q 4 hr PRN
 ____ Motrin 400 / 600 / 800 mg PO TID
 ____ Sudafed 30 mg PO q 6 H
 ____ Miraphen / Deconamine 1 tab PO BID
 ____ Afrin / Saline Nasal Spray 2 inh BID x 3 D
 ____ Benzonate 100 mg PO TID
 ____ Robitussin DM / Codeine 2 tsp PO Q 4 H
 ____ Bicillin 1.2 Million units IM x 1 now
 ____ Amoxicillin 500 mg PO TID x 7 D
 ____ Augmentin 875 mg PO BID
 ____ Biaxin XL 500 mg 2 tab PO daily x 10 D
 ____ Z-Pack #1 - Take as directed
 ____ Erythromycin 333 mg PO TID x 10 D
 ____ Keflex 500 mg PO QID
 ____ Hydrocortisone 1% Cream AAA TID

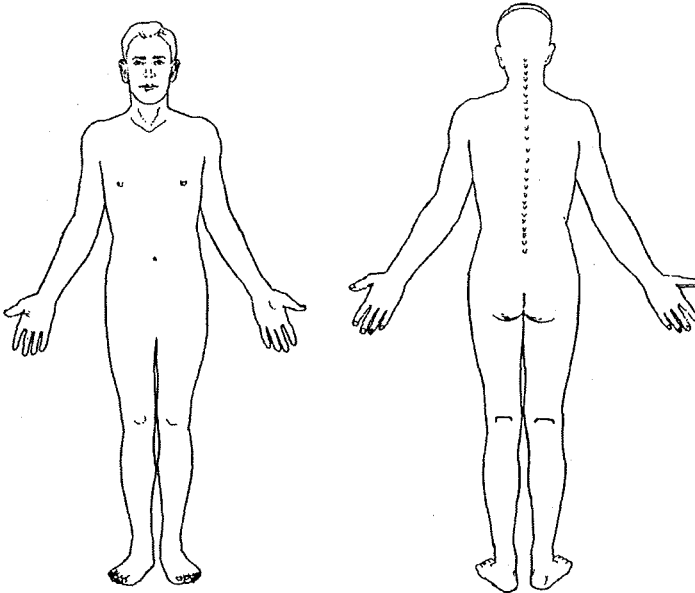
____ IV: 1 / 2 Liters NS / LR
 ____ Nu Tears
 ____ Albuterol MDI 1-2 puffs q 4 to 6 H
 ____ Halls Cough Drops
 ____ Cepacol Lozenges
 ____ Chloraseptic Spray
 ____ Phenergan 25 mg PO Q 6 H
 ____ Benadryl 25 mg PO Q 6 H
 ____ Throat Culture / RST
 ____ X-Ray / Bone Scan
 ____ Other _____

____ Fit for Duty (FFD)
 ____ LD for _____ Days
 ____ SIQ - Follow Up in a.m.
 ____ Patient Educated
 ____ Increase Fluids
 ____ BRAT Diet
 ____ Rest, Ice, Compress, Elevation
 ____ Follow Up w/ _____

CHRONOLOGICAL RECORD OF MEDICAL CARE
 STANDARD FORM 600,
 Prescribed by GSA/CMR

Provider Signature _____

PATIENT'S NAME (Last, First, Middle Initial)		SEX
MERWIN, DANIEL D		M
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
N/A		
SPONSOR'S NAME		ORGANIZATION
N/A		
DEPART./SERVICE	IDENTIFICATION NO.	DATE OF BIRTH
DOD/USN		

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	<div style="text-align: right;">Labs</div>  <p> Stryker Locomotor → w/ D. Polan → Theophile Strydom → - (N) - Disturbed Hemostasis. - Stryker w/ a of thrombolytic penicillin + penicillin of SM - claim easy bruising noted as increased abel. - some smother hands of brush - a smother when he bumps something </p>

NAVHOSP GREAT LAKES IL

Personal Data - Privacy Act of 1974 (PL 93-579)

DIVISION: NH GREAT LAKES, 2

Automated Version of SF600

Printed: 21 Nov 2005@1314

GENERAL SURGERY C POLEN, WINNIE M

21 Nov 2005 1300 SPEC 30

BBAA

REF: DINKEL, TROY A

CMT: nsp

RSN: D/W Dr. Polen, hematochezia (constipation, small fissure, hemorrhoid) reche

Detail Codes:

INSURANCE YES/NO:

BP: 123/69 PULSE: 93 RESP: 18 TEMP: 98.6°F HT: 68" WT: 116 AGE: 20

ALLERGIES:

MEDS: DOCVSATE CALCIUM, TYLENOL, Bertyl

ETOH: N/A

TOB: N/A

PAIN: 2/10

V/S taken by HN MEDINA

ADDITIONAL COMMENTS:

D/W DR POLEN, HEMATOCHYZIA (CONSTIPATION, SMALL FISSURE, HEMORRHOID) NL H/H
WILL RECHECK ON 11/21 AT 1300

PAGE 1

- END OF TEXT -

PMHx
ØPSHx
T+A

S/ 20 yo recruit male DOT 2/?
% abdominal pain intermittently over years. Last 2 weeks has had pain daily. ? Assoc w eating.
Has had occ blood in stool - told it was normal or due to a hemorrhoid
FamHx - father w irritable bowel syndrome?
⊕ gums bleeding & brushing "for a while"

O/ NAD
Ø pale
ABD soft, NT. Ø TTP. Ø masses
Ø umbilical or Ø inguinal hernias. Ø testes ↓
Anal exam → NL tone, Ø masses. Ø fissure. Ø TTP. Ø blood.
Flex sig → NL to prox transverse. Mild grade I int hemorrhoids

A/ Grade I internal hemorrhoids, thrombocytopenia with clinical manifestations (easy bruising/bleeding!)

P/ Needs work-up for thrombocytopenia!
Flu & PCP for repeat CT with Po + IV contrast
↑ fluids, avoid constipation, ↑ fiber

Labs
LFT NL
A/L NL
Lytes NL
9 > 14 (105)
40

LH/Polen

20/ [REDACTED] MERWIN, DANIEL DENNIS
[REDACTED] 1985 MALE
Spon: MERWIN, DANIEL DENNIS

N13

W: NONE

CIC: [REDACTED] H: NONE AR 3241

General Surgery Clinic
United States Naval Hospital
3001 A 6th Street
Great Lakes, IL 60088-5230
Phone: (847)688-2095
Fax: (847)688-3505

OPERATIVE PROCEDURE REPORT - 11/21/2005

PATIENT: Merwin, Daniel
BIRTHDATE: [REDACTED] 1985
AGE: 20

GENDER: 20/ [REDACTED]
male

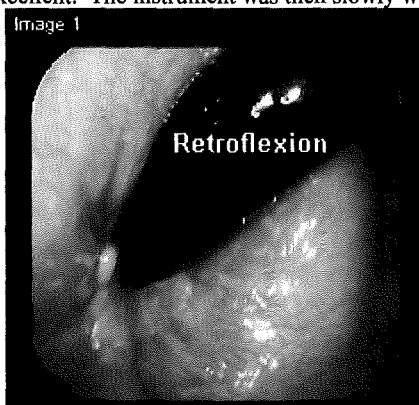
ENDOSCOPIST: Winnie M. Polen, LT/MC
ASSISTANT: Nastarsha N. Bishop, HM3/USN

PROCEDURE: Flexible Sigmoidoscopy, diagnostic

INDICATIONS: hematochezia

MEDICATIONS: None

DESCRIPTION OF PROCEDURE: After the risks benefits and alternatives of the procedure were thoroughly explained, informed consent was obtained. Digital rectal exam was performed and revealed no abnormalities. The Pentax ES-3830 endoscope was introduced through the anus and advanced to the proximal transverse colon. The quality of the prep was excellent. The instrument was then slowly withdrawn as the mucosa was fully examined.



The examination was normal with no endoscopic findings. Retroflexed views in the rectum revealed hemorrhoids. Mild grade I internal hemorrhoids. The scope was then completely withdrawn from the patient and the procedure terminated.

COMPLICATIONS: None

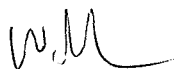
ENDOSCOPIC IMPRESSION:

- 1) Normal sigmoidoscopy otherwise
- 2) Internal hemorrhoids

RECOMMENDATIONS:

- 1) fiber rich diet
 - 2) follow-up: primary MD PRN
- Needs work-up for thrombocytopenia

REPEAT EXAM: No



Winnie M. Polen, LT/MC

CC:

NSN 7540-00-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

Date: 20 NOV 05 Branch Medical Clinic 1007, USS TRANQUILLITY, Great Lakes, IL

# of Cold Packs	# of Canteens	Day of Training	ALLERGIES	Current Medications	SIQ Day #
<u>0</u>	<u>5</u>	<u>2-4</u>	<u>FEATHERS</u>	<u>TYLENOL</u>	<u>2</u>

Temp: 97.1 Pulse: 90 Resp: 20 BP: 116/74 Pulse Ox: 98 % FDLMP: _____ Tylenol _____20 y/o MALE / FEMALE STAFF / RECRUIT with a NEW / (Follow Up) Chief Complaint of BLOOD IN STOOL / STOMACH PAIN

I request a cold pack / other and DO NOT wish to see a provider. Patient signature _____

REVIEW OF SYMPTOMS:

Fever/Chills ☒ Congestion _____ Rhinorrhea _____ Sore throat _____ Nausea ☒ Vomiting _____ Diarrhea ☒
Constipation _____ Cough _____ (Productive/ Non-Productive) _____Other Abdominal pain severe. -Length of Symptoms 2 days weeksPain Scale: 0 1 2 3 4 5 6 7 8 9 10

EXAMINATION

Stand-by: DECLINED / ACCEPTED _____General: WD / WN + - Distress, A & O x

V.S.S - N.D. - W.P. - W.P.

HEENT: NC / AT PERRL, EOMI x 6. Pharynx: Normal / Erythema / Exudate / Tonsillar Hypertrophy / Adenopathy
TM: Normal / Erythema R / L / Bilat. Sinuses: NTTP / TTP @ Frontal / Ethmoid / Maxillary

HEART: Normal / Tachycardic / Bradycardic pulse w/ Murmur / Rubs / Gallops

LUNGS: CTA Bilaterally w/ Rales / Ronchi / Wheezes in R / L / Bilat ULF / LLF

ABDOMEN: Soft / NTTP w/ TTP @ RUQ / RLQ / LUQ / LLQ / Rigidity / Rebound / Guarding. BS noted in 4 Quadrants

GU/Vaginal: see back

Rectal: see back

Skin: Normal

Extremities: Normal

Radiology/Lab:

C.T. of Pelvis/abd (11.19) - reported to be as "Normal"ASSESSMENT: _____ Upper Respiratory Infection _____ Viral Syndrome _____ Other: IBS ??

PLAN

☒ Continue Current Medications
 _____ Tylenol 325 / 500 mg PO Q 4 hr PRN
 _____ Motrin 400 / 600 / 800 mg PO TID
 _____ Sudafed 30 mg PO q 6 H
 _____ Miraphen / Deconamine 1 tab PO BID
 _____ Afrin / Saline Nasal Spray 2 inh BID x 3 D
 _____ Benzonatate 100 mg PO TID
 _____ Robitussin DM / Codeine 2 tsp PO Q 4 H
 _____ Bicillin 1.2 Million units IM x 1 now
 _____ Amoxicillin 500 mg PO TID x 7 D
 _____ Augmentin 875 mg PO BID
 _____ Biaxin XL 500 mg 2 tab PO daily x 10 D
 _____ Z-Pack #1 - Take as directed
 _____ Erythromycin 333 mg PO TID x 10 D
 _____ Keflex 500 mg PO QID
 _____ Hydrocortisone 1% Cream AAA TID

 _____ IV: 1 / 2 Liters NS / LR
 _____ Nu Tears
 _____ Albuterol MDI 1-2 puffs q 4 to 6 H
 _____ Halls Cough Drops
 _____ Cepacol Lozenges
 _____ Chloraseptic Spray
 _____ Phenergan 25 mg PO Q 6 H
 _____ Benadryl 25 mg PO Q 6 H
 _____ Throat Culture / RST
 _____ X-Ray / Bone Scan
 _____ Other _____

 _____ Fit for Duty (FFD)
 _____ LD for _____ Days
 _____ SIQ - Follow Up in a.m. (from) (E.N.)
☒ Patient Educated
☒ Increase Fluids
 _____ BRAT Diet
 _____ Rest, Ice, Compress, Elevation
☒ Follow Up w/ 1007 -
to have Surg. consult

Provider Signature

R.A. STRNAD
10/8/266
KISHER CLINIC 237 STAFFCHRONOLOGICAL RECORD OF MEDICAL CARE
STANDARD FORM 600,
Prescribed by GSA/CMR

PATIENT'S NAME (Last, First, Middle Initial)		SEX
METWIN, DANIEL, D		M
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
N/A		
SPONSOR'S NAME		ORGANIZATION
N/A		DIV: 041 SH: 06
DEPART./SERVICE	SEN/IDENTIFICATION NO.	DATE OF BIRTH
DOD/USN		185

[illegible]

NSN 7540-00-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE
 Date: 08/05/25 Branch Medical Clinic 1007, USS TRANQUILLITY, Great Lakes, IL

# of Cold Packs	# of Canteens	Day of Training	ALLERGIES	Current Medications	SIQ Day #
<u>0</u>	<u>3</u>	<u>P-5</u>	<u>FEATHERS</u>	<u>NONE</u>	

 Temp: 98.7 Pulse: _____ Resp: _____ BP: _____ Pulse Ox: _____ % FDLMP: _____ Tylenol _____

20 y/o MALE / FEMALE STAFF / RECRUIT with a NEW / Follow Up Chief Complaint of VOMITING

I request a cold pack / other and DO NOT wish to see a provider. Patient signature _____

REVIEW OF SYMPTOMS:
 Fever/Chills _____ Congestion _____ Rhinorrhea _____ Sore throat _____ Nausea ☒ Vomiting ☒ Diarrhea _____
 Constipation _____ Cough _____ (Productive/ Non-Productive)

Other _____

Length of Symptoms 1 days/ weeks

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Stand-by: DECLINED / ACCEPTED _____**EXAMINATION**
 General: WD / WN + / - Distress, A & O x 3
 HEENT: NC / AT PERRL, EOMI x 6, Pharynx: Normal / Erythema / Exudate / Tonsillar Hypertrophy / Adenopathy
 TM: Normal / Erythema R / L / Bilat. Sinuses: NTTP / TTP @ Frontal / Ethmoid / Maxillary
 HEART: Normal / Tachycardic / Bradycardic pulse w/ Murmur / Rubs / Gallops
 LUNGS: CTA Bilaterally w/ Rales / Ronchi / Wheezes in R / L / Bilat ULF / LLF
 ABDOMEN: Soft / NBT w/ TTP @ RUQ / RLQ / LUQ / LLQ / Rigidity / Rebound / Guarding. BS noted in 4 Quadrants
 GU/Vaginal: see back BB
 Rectal: see back BB
 Skin: Normal
 Extremities: Normal
Grady
State
prosis
Radiology/Lab:
 ASSESSMENT: _____ Upper Respiratory Infection _____ Viral Syndrome _____ Other: VGE
PLAN

_____ Continue Current Medications _____ Tylenol 325 / 500 mg PO Q 4 hr PRN _____ Motrin 400 / 600 / 800 mg PO TID _____ Sudafed 30 mg PO q 6 H _____ Miraphen / Deconamine 1 tab PO BID _____ Afrin / Saline Nasal Spray 2 inh BID x 3 D _____ Benzonate 100 mg PO TID _____ Robitussin DM / Codeine 2 tsp PO Q 4 H _____ Bicillin 1.2 Million units IM x 1 now _____ Amoxicillin 500 mg PO TID x 7 D _____ Augmentin 875 mg PO BID _____ Biaxin XL 500 mg 2 tab PO daily x 10 D _____ Z-Pack #1 - Take as directed _____ Erythromycin 333 mg PO TID x 10 D _____ Keflex 500 mg PO QID _____ Hydrocortisone 1% Cream AAA TID	_____ IV: 1 / 2 Liters NS / LR _____ Nu Tears _____ Albuterol MDI 1-2 puffs q 4 to 6 H _____ Halls Cough Drops _____ Cepacol Lozenges _____ Chloraseptic Spray _____ Phenergan 25 mg PO Q 6 H _____ Benadryl 25 mg PO Q 6 H _____ Throat Culture / RST _____ X-Ray / Bone Scan _____ Other _____	_____ Fit for Duty (FFD) _____ LD for _____ Days _____ SIQ - Follow Up in a.m. _____ Patient Educated _____ Increase Fluids _____ BRAT Diet _____ Rest, Ice, Compress, Elevation _____ Follow Up w/ _____
--	--	--

 JESUS A. LEDESMA
 8867
 HMC (FMF) IDC USN

Provider Signature _____

PATIENT'S NAME (Last, First, Middle Initial)		SEX
<u>NEDWIN, DANIEL D</u>		<u>M</u>
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
<u>N/A</u>		
SPONSOR'S NAME		ORGANIZATION
<u>N/A</u>		DIV: <u>041</u> SH: <u>06</u>
DEPART./SERVICE	RESIDENTIAL NO.	DATE OF BIRTH
<u>DOD/USN</u>		<u>08/05/25</u>

 CHRONOLOGICAL RECORD OF MEDICAL CARE
 STANDARD FORM 600,
 Prescribed by GSA/CMR

[illegible]

NSN 7540-00-834-4178

NH 6010/40 (12/97)

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)		
14 NOV 95	NAVAL HOSPITAL GREAT LAKES ILLINOIS RECRUIT MEDICINE		
	INGROWN TOENAIL		
	S: 18 y.o. male/female with c/o ingrown toenail to (left/right) 5th digit		
Allergies:	X 5 days duration		
N/CDA	O: Tenderness to palpation of the tibial/fibular nail border of the		
Meds:	(left/right) 5th digit		
Doxy	- Erythema, effusion and elevated skin temperature noted/not noted		
Calcium	- Drainage (noted/not noted) Purulent		
	- Neurovascular status intact left/right foot D/P + P/T + CFT 3 SEC.		
	A: (✓) Paronychia 5 digit(s) (left/right) foot		
	() Onychocryptosis digit(s) left/right foot		
	P: (✓) Pt. education on diagnosis, treatment and local wound care		
	(✓) Consent for local anesthesia lidocaine without epinephrine		
	(✓) Prepare, drape and scrub hallux in a sterile manner		
	(✓) Total/Partial/Simple nail avulsion (left/right) 5th digit(s)		
	(✓) H2O2 flush and dry sterile dressing applied		
	() Domboro's soaks as directed		
	(✓) Light duty for 2 days and tennis shoes for 2 days		
	(✓) Pt tolerated procedure with/without complications		
	(✓) Follow-up PRN Podiatry and Pt advised on care		
	() Dicloxicillin 250mg #40/80 i/ii PO QID till out		
	(✓) Motrin 800mg/600mg i PO TID with food #9		

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

BRANCH MEDICAL CLINIC

LAWRENCE E WALTER
GRCOMC USN

PATIENT'S NAME (Last, First, Middle Initial)

MERWYN, DANIEL

SEX

MALE

RELATIONSHIP TO SPONSOR

N/A

STATUS

URT

RANK/GRADE

SR/E-1

SPONSOR'S NAME

N/A

ORGANIZATION

DIV: 641 SH: 6

DEPART./SERVICE

DBN/USN

SSN/

2

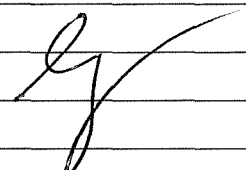

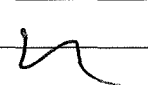


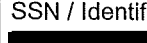

TION NO.

DATE OF BIRTH

85

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 800 (REV. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
Date	Symptoms, Diagnosis, Treatment Treating Organization (Sign each entry)		
	NAVHOSP. BMC 1523. Great Lakes. IL 60088		
NOV 07 2005	S) Review Of Medical History Reveals An Allergy To The Following:		
	Feathers - SOB - No chest pain.		
	History Confirmed By Service Member. Service Member: <input type="checkbox"/> Does Not Wear Contacts.		
	<input type="checkbox"/> Wears Contacts.		
	usually goes away <input type="checkbox"/> Plans To Wear Contacts.		
	w/o any medication when allergen is removed.		
	A) <input checked="" type="checkbox"/> Allergy To: Feather		
	<input type="checkbox"/> No Allergy.		
	A) RTD		
	<input checked="" type="checkbox"/> Allergy Tag Ordered.		
	Provider: 		
	Obedoza, E., MD OBEDFR-  GMO/Staff		
11/8/05 -	In an ear check & eggs up any problem.		
	EDEN U. PADILLA, M.D. 		
	PADIED-  GMO/STAFF		
Patient's Identification (Use This Space For Mechanical Imprint)		Records Maintained At:  NAVHOSP, BMC 1007 RTC GREAT LAKES, GREAT LAKES, IL 60088	
Patient's Name (Last, First, Middle Initial)		Sex	
MERWIN, DANIEL		M	
Relationship To Sponsor		Status	Rank / Grade
		USN	SR
Sponsor's Name		Organization	
		041/	
Depart. / Service	SSN / Identification No		Date Of Birth
USN			 91985

NSN 7540-00-834-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

**USS RED ROVER BRANCH MEDICAL CLINIC
RECRUIT TRAINING COMMAND, GREAT LAKES**

IMMUNIZATIONS: RECRUIT WAS PROVIDED INFORMATION ON: MEASLES, MUMPS, & RUBELLA (MMR), BICILLIN, HEPATITIS-A, MENINGOCOCCAL, YELLOW FEVER, TETANUS-DIPHTHERIA, AND INACTIVATED POLIOVIRUS VACCINES. RECRUIT WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND DISCLOSE KNOWN ALLERGIES AND ADVERSE REACTIONS TO PREVIOUS IMMUNIZATIONS.

WELLNESS TRAINING: RECRUIT ATTENDED TRAINING ON GENDER SPECIFIC SELF-EXAMINATIONS (i.e. BREAST, PAP & TESTICULAR EXAMINATIONS). VIDEOS AND TEACHING AIDS WERE USED FOR DEMONSTRATIONS. TOBACCO CESSATION, BASIC NUTRITION, CONTRACEPTION, SEXUALLY TRANSMITTED DISEASES (i.e. AIDS), GENDER SPECIFIC INFECTIONS, HYGIENE AND GENERAL HEALTH TOPICS WERE DISCUSSED. VARICELLA TITER INDICATES NON IMMUNE. VARICELLA WAS GIVEN. INDIVIDUAL WAS ADVISED TO AVOID PREGNANCY FOR ONE MONTH AFTER RECEIVING VARICELLA & THREE MONTHS AFTER RECEIVING ALL OTHER LIVE VIRUSES. QUESTIONS WERE ENCOURAGED THROUGHOUT THE CLASS.

NOV 07 2005

RECORD REVIEW: RECRUIT MEDICAL SCREENING AND REVIEW OF MEDICAL HISTORY CONDUCTED IAW: MANUAL OF THE MEDICINE, CHAPTER 15, ARTICLE 26. SIGNIFICANT FINDINGS AND DEFECTS, IF ANY, ARE NOTED BELOW.
BICILLIN 1.2MU WAS/ WAS NOT GIVEN ON THIS DATE.

PEN VK 250 MG 1 TAB PO BID WAS/ WAS NOT GIVEN

RECORDS DIVISION STAFF STAMP/SIGNATURE

COLLECTED BY: *[Signature]*

REVIEWED BY: *[Signature]*

MEPS LOCATION:

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART /SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)			REGISTER NO
			WARD NO

MERWIN, DANIEL R20060411
-05 E11Y

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record AR 3250

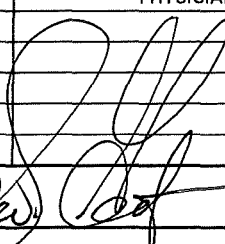
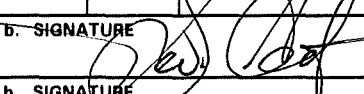
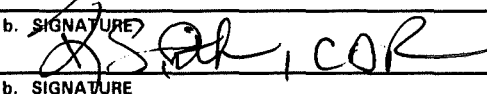
STANDARD FORM 600 (REV 6-97)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-9.202-1

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE					
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)						
NOV 07 2005 MEDS.	Inprocessing Screening Examination Naval Hospital, Branch Optometry Clinic, Great Lakes, IL 60088-5233						
NONE	CONTACT LENSES		TYPE:		WEARER X:		OUT X:
	TRAUMA/SURG ①		GLAU ①		FOH ①		
ALLG.	UNAIDED VA:		VA WITH OLD SPECTACLES:		SPHERE		CYLINDER
NKDA	OD 20/50		OD 20/		OD —		X
	OS 20/40		OS 20/		OS —		X
NCT	FALANT: 4A PASS FAILED						
OD:	P_RRL		APD		EOM		CT
OS:	INTERPUPILLARY DIS DISTANCE NEAR 59		EYE SIZE 48		BRIDGE SIZE 20		TEMPLE LENGTH AND STYLE 45
@	SINGLE VISION						
NEW RX	SPHERE		CYLINDER		AXIS		DECEN- TRATION IN OUT
	R -1.50		-0.150		091		20/20
	L -1.50		0				20/20
	SLE A) MEETS MINIMUM STANDARDS FOR VISION AND COLOR. INT/CD B) SCREENING RX ONLY FOR SPECTACLES F/U IN 3 MONTHS. MACULA						
	HM2 WARE USN/AD						
DROPS FOR DILATION							
OD 1	OS 2	OU 3	A:1.				
— 1/2%ALCAINE	2.						
— 1%MYDRIACYL							
— 21/2%NEOSYN							
— 1%CYCLOGEL							
— 2%CYCLOGEL							
TIME GIVEN	P: 1. FT SRX						
INITIALS	2. RTC ANUAL/PRN						

NAME (Last, First, Middle)				SSN		BRANCH/CLASS	
MERWIN, DANIEL D				R20060411		11	
DATE OF BIRTH		SEX	RACE	DEPARTMENT		ORGANIZATION	
85		M		DOD		RTC GREAT LAKES AR 3251	

REPORT OF MEDICAL EXAMINATION				1. DATE OF EXAMINATION (YYYYMMDD)		2. SOCIAL SECURITY NUMBER [REDACTED]	
PRIVACY ACT STATEMENT							
<p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>							
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) merwin, DANIEL D			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code) PENSACOLA, FL [REDACTED]			5. HOME TELEPHONE NUMBER (Include Area Code) [REDACTED]	
6. GRADE E4	7. DATE OF BIRTH (YYYYMMDD) 1985 [REDACTED]	8. AGE 24	9. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY 3y 10m b. CIVILIAN		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE NIOC PENSACOLA 7495		
14.a. RATING OR SPECIALTY (Aviators Only)			b. TOTAL FLYING TIME			c. LAST SIX MONTHS	
15.a. SERVICE <input checked="" type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement REENLISTMENT <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) NBHC CORRY CLINIC 790 VETERANS WAY PENSACOLA, FL 32511	
CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)							
				Normal	Ab-normal	NE	
17. Head, face, neck, and scalp				/			
18. Nose				/			
19. Sinuses				/			
20. Mouth and throat				/			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				/			
22. Drums (Perforation)				/			
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				/			
24. Ophthalmoscopic				/			
25. Pupils (Equality and reaction)				/			
26. Ocular motility (Associated parallel movements, nystagmus)				/			
27. Heart (Thrust, size, rhythm, sounds)				/			
28. Lungs and chest (Include breasts)				/			
29. Vascular system (Varicosities, etc.)				/			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)						/	
31. Abdomen and viscera (Include hernia)				/			
32. External genitalia (Genitourinary)				/			
33. Upper extremities				/			
34. Lower extremities (Except feet)				/			
35. Feet (See Item 35 Continued)				/			
36. Spine, other musculoskeletal				/			
37. Identifying body marks, scars, tattoos						/	
38. Skin, lymphatics				/			
39. Neurologic				/			
40. Psychiatric (Specify any personality deviation)				/			
41. Pelvic (Females only)						NA	
42. Endocrine				/			
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)			
<input checked="" type="checkbox"/> Acceptable				37. MST- Tattoos ① Deltoid - "USN" with Anchor and Shark ② Dorsal - 5 - 1" Star (Blue Red) ③ Shoulder Blade - Eagle with US Flag CIR			
<input type="checkbox"/> Not Acceptable Class 3				35. FEET (Continued) (Circle category)			
				Normal Arch Mild Asymptomatic			
				Pes Cavus Moderate			
				Pes Planus Severe Symptomatic			

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN, DANIEL D												SOCIAL SECURITY NUMBER [REDACTED]			
LABORATORY FINDINGS															
45. URINALYSIS				a. Albumin		46. URINE HCG				47. H/H		48. BLOOD TYPE O+			
				b. Sugar											
TESTS				RESULTS				HIV SPECIMEN ID LABEL				DRUG TEST SPECIMEN ID LABEL			
49. HIV 020CT08				NEG											
50. DRUGS															
51. ALCOHOL															
52. OTHER RPR				NON-REACTIVE											
a. PAP SMEAR															
b.															
c.															
MEASUREMENTS AND OTHER FINDINGS															
53. HEIGHT 68 in		54. WEIGHT 145 lbs.		55. MIN WGT - MAX WGT				MAX BF %				56. TEMPERATURE 98.4		57. PULSE 12	
58. BLOOD PRESSURE						59. RED/GREEN (Army Only)				60. OTHER VISION TEST					
a. 1ST		b. 2ND		c. 3RD											
SYS. 108		SYS.		SYS.											
DIAS. 64		DIAS.		DIAS.											
61. DISTANT VISION						62. REFRACTION BY AUTOREFRACTION OR MANIFEST						63. NEAR VISION			
Right 20/		Corr. to 20/		20		By		S.		CX		Right 20/ 20		Corr. to 20/ by	
Left 20/		Corr. to 20/		20		By		S.		CX		Left 20/ 20		Corr. to 20/ by	
64. HETEROPHORIA (Specify distance)															
ES°		EX°		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD	
65. ACCOMMODATION						66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT					
Right		Left		PIP		/14				Uncorrected		Corrected			
68. FIELD OF VISION						69. NIGHT VISION (Test used and score)						70. INTRAOCULAR TENSION			
												O.D.			
												O.S.			
71a. AUDIOMETER		Unit Serial Number						71b. Unit Serial Number		72a. READING ALOUD TEST					
Date Calibrated (YYYYMMDD)								Date Calibrated (YYYYMMDD)							
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	SAT	UNSAT
Right	5	5	0	10	10	5	Right								
Left	0	5	15	20	10	15	Left								
72b. VALSALVA															
SAT															
UNSAT															
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)															
CHOLESTEROL: 190 HDL: 56 TRIGLYCERIDE: 221 (H) LDL: 90															

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) Merwin, DANIEL										SO [redacted]		RITY NUMBER [redacted]					
74.a. EXAMINEE/APPLICANT (check one) <input checked="" type="checkbox"/> IS QUALIFIED FOR SERVICE Realismunt <input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE										75. I have been advised of my disqualifying condition. a. SIGNATURE OF EXAMINEE b. DATE (YYYYMMDD)							
b. PHYSICAL PROFILE																	
P		U		L		H		E		S		X		PROFILER INITIALS		DATE (YYYYMMDD)	
76. SIGNIFICANT OR DISQUALIFYING DEFECTS																	
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS				ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED						
											SERVICE		DATE (YYYYMMDD)				
77. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary.)																	
37. MST - NCD																	
73. Noted Elevated triglycerides - discussed Diet - NCD																	
78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (Use additional sheets if necessary.)																	
D/cd pt. Routine Health Maintenance, TSE, Diet																	
79. MEPS WORKLOAD (For MEPS use only)																	
WKID		ST		DATE (YYYYMMDD)		INITIAL		WKID		ST		DATE (YYYYMMDD)		INITIAL			
80. MEDICAL INSPECTION DATE		HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE								
																	
81.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN ROBERTA BRUNNER LCDR USN PA-C 3511										b. SIGNATURE 							
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER										b. SIGNATURE							
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) KAREN S. SMITH CORDCUSN										b. SIGNATURE 							
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY										b. SIGNATURE							
85. This examination has been administratively reviewed for completeness and accuracy.																	
a. SIGNATURE										b. GRADE			c. DATE (YYYYMMDD)				
86. WAIVER GRANTED (If yes, date and by whom)														87. NUMBER OF ATTACHED SHEETS			
<input type="checkbox"/> YES <input type="checkbox"/> NO														AD 2254			

REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)		OMB No. 0704-0413 OMB approval expires Mar 31, 2010
The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.		
PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.		
PRIVACY ACT STATEMENT		
AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN). PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. ROUTINE USE(S): None. DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.		
WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.		
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN, DANIEL D	2. SOCIAL SECURITY NUMBER [REDACTED]	3. TODAY'S DATE (YYYYMMDD) 28 SEP 07
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code) [REDACTED] PENSACOLA FL [REDACTED]	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code) NBHC CORRY CLINIC 790 VETERANS WAY PENSACOLA FL, 32511	
b. HOME TELEPHONE (Include Area Code) [REDACTED]		
X ALL APPLICABLE BOXES:		7.a. POSITION (Title, Grade, Component) CTN
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input checked="" type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program
8. CURRENT MEDICATIONS (Prescription and Over-the-counter) NONE		7.b. USUAL OCCUPATION Crypto Tech
9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance) NONE		
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		12. (Continued)
10.a. Tuberculosis YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO b. Lived with someone who had tuberculosis YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO c. Coughed up blood YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO d. Asthma or any breathing problems related to exercise, weather, pollens, etc. YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO e. Shortness of breath YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO f. Bronchitis YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO g. Wheezing or problems with wheezing YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO h. Been prescribed or used an inhaler YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO i. A chronic cough or cough at night YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO j. Sinusitis YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO k. Hay fever YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO l. Chronic or frequent colds YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	f. Foot trouble (e.g., pain, corns, bunions, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO g. Impaired use of arms, legs, hands, or feet YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO h. Swollen or painful joint(s) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO l. Bone, joint, or other deformity YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO m. Plate(s), screw(s), rod(s) or pin(s) in any bone YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO n. Broken bone(s) (cracked or fractured) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	
11.a. Severe tooth or gum trouble YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO b. Thyroid trouble or goiter YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO c. Eye disorder or trouble YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO d. Ear, nose, or throat trouble YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO e. Loss of vision in either eye YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO f. Worn contact lenses or glasses YES NO <input checked="" type="radio"/> YES <input checked="" type="radio"/> NO g. A hearing loss or wear a hearing aid YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO h. Surgery to correct vision (RK, PRK, LASIK, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	13.a. Frequent indigestion or heartburn YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO b. Stomach, liver, intestinal trouble, or ulcer YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO c. Gall bladder trouble or gallstones YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO d. Jaundice or hepatitis (liver disease) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO e. Rupture/hernia YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO f. Rectal disease, hemorrhoids or blood from the rectum YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO h. Frequent or painful urination YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO i. High or low blood sugar YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO j. Kidney stone or blood in urine YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO k. Sugar or protein in urine YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO b. Arthritis, rheumatism, or bursitis YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO c. Recurrent back pain or any back problem YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO d. Numbness or tingling YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO e. Loss of finger or toe YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	14.a. Adverse reaction to serum, food, insect stings or medicine YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO b. Recent unexplained gain or loss of weight YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO c. Currently in good health (If no, explain in Item 29 on Page 2.) YES NO <input checked="" type="radio"/> YES <input checked="" type="radio"/> NO d. Tumor, growth, cyst, or cancer YES NO <input type="radio"/> YES <input checked="" type="radio"/> NO	

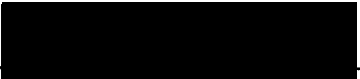

Page 2 of 3 Pages

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN IDAVIS D		SOCIAL SECURITY NUMBER [REDACTED]
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)		
a. COMMENTS		
[Large diagonal line across the comments section]		
b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial) ROGER GUNTER LCDR USN PA-C [REDACTED]		c. SIGNATURE [Signature]
		d. DATE SIGNED (YYYYMMDD) 20090916

REPORT OF MEDICAL HISTORY			Form Approved OMB No. 0704-0413 Expires Oct 31, 2006
(This information is for official and medically confidential use only and will not be released to unauthorized persons.)			
The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.			
PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.			
PRIVACY ACT STATEMENT			
AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN). PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. ROUTINE USE(S): None. DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.			
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) <u>MERWIN, DANIEL, D</u>	2. SOCIAL SECURITY NUMBER <u>[REDACTED]</u>	3. TODAY'S DATE (YYYYMMDD) <u>02/23/06</u>	
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code) <u>ABRAHAM LINCOLN BARBERS</u>	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code) <u>NATTC BRANCH MEDICAL</u> <u>760 EAST AVENUE</u> <u>PENSACOLA, FL 32508</u>		
b. HOME TELEPHONE (Include Area Code) <u>[REDACTED]</u>			
X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component) <u>STUDENT</u>
6.a. SERVICE <input checked="" type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <u>OSS</u> <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	b. USUAL OCCUPATION <u>STUDENT</u>
8. CURRENT MEDICATIONS (Prescription and Over-the-counter) <u>N/A</u>		9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance) <u>NKDA FEATHERS</u> <u>(D.D. McIn. initials)</u>	
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.			
HAVE YOU EVER HAD OR DO YOU NOW HAVE: YES NO		12. (Continued) YES NO	
10.a. Tuberculosis <input type="radio"/> YES <input checked="" type="radio"/> NO b. Lived with someone who had tuberculosis <input type="radio"/> YES <input checked="" type="radio"/> NO c. Coughed up blood <input type="radio"/> YES <input checked="" type="radio"/> NO d. Asthma or any breathing problems related to exercise, weather, pollens, etc. <input type="radio"/> YES <input checked="" type="radio"/> NO e. Shortness of breath <input type="radio"/> YES <input checked="" type="radio"/> NO f. Bronchitis <input type="radio"/> YES <input checked="" type="radio"/> NO g. Wheezing or problems with wheezing <input type="radio"/> YES <input checked="" type="radio"/> NO h. Been prescribed or used an inhaler <input type="radio"/> YES <input checked="" type="radio"/> NO i. A chronic cough or cough at night <input type="radio"/> YES <input checked="" type="radio"/> NO j. Sinusitis <input type="radio"/> YES <input checked="" type="radio"/> NO k. Hay fever <input type="radio"/> YES <input checked="" type="radio"/> NO l. Chronic or frequent colds <input type="radio"/> YES <input checked="" type="radio"/> NO		f. Foot trouble (e.g., pain, corns, bunions, etc.) <input type="radio"/> YES <input checked="" type="radio"/> NO g. Impaired use of arms, legs, hands, or feet <input type="radio"/> YES <input checked="" type="radio"/> NO h. Swollen or painful joint(s) <input type="radio"/> YES <input checked="" type="radio"/> NO i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) <input type="radio"/> YES <input checked="" type="radio"/> NO j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint <input type="radio"/> YES <input checked="" type="radio"/> NO k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. <input type="radio"/> YES <input checked="" type="radio"/> NO l. Bone, joint, or other deformity <input type="radio"/> YES <input checked="" type="radio"/> NO m. Plate(s), screw(s), rod(s) or pin(s) in any bone <input type="radio"/> YES <input checked="" type="radio"/> NO n. Broken bone(s) (cracked or fractured) <input type="radio"/> YES <input checked="" type="radio"/> NO	
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LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN, DANIEL, D		SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px; margin: 0 auto;"></div>
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO	YES NO
15.a. Dizziness or fainting spells <input type="radio"/> YES <input checked="" type="radio"/> NO b. Frequent or severe headache <input type="radio"/> YES <input checked="" type="radio"/> NO c. A head injury, memory loss or amnesia <input type="radio"/> YES <input checked="" type="radio"/> NO d. Paralysis <input type="radio"/> YES <input checked="" type="radio"/> NO e. Seizures, convulsions, epilepsy or fits <input type="radio"/> YES <input checked="" type="radio"/> NO f. Car, train, sea, or air sickness <input type="radio"/> YES <input checked="" type="radio"/> NO g. A period of unconsciousness or concussion <input type="radio"/> YES <input checked="" type="radio"/> NO h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> YES <input checked="" type="radio"/> NO 16.a. Rheumatic fever <input type="radio"/> YES <input checked="" type="radio"/> NO b. Prolonged bleeding (as after an injury or tooth extraction, etc.) <input type="radio"/> YES <input checked="" type="radio"/> NO c. Pain or pressure in the chest <input type="radio"/> YES <input checked="" type="radio"/> NO d. Palpitation, pounding heart or abnormal heartbeat <input type="radio"/> YES <input checked="" type="radio"/> NO e. Heart trouble or murmur <input type="radio"/> YES <input checked="" type="radio"/> NO f. High or low blood pressure <input type="radio"/> YES <input checked="" type="radio"/> NO 17.a. Nervous trouble of any sort (anxiety or panic attacks) <input type="radio"/> YES <input checked="" type="radio"/> NO b. Habitual stammering or stuttering <input type="radio"/> YES <input checked="" type="radio"/> NO c. Loss of memory or amnesia, or neurological symptoms <input type="radio"/> YES <input checked="" type="radio"/> NO d. Frequent trouble sleeping <input type="radio"/> YES <input checked="" type="radio"/> NO e. Received counseling of any type <input type="radio"/> YES <input checked="" type="radio"/> NO f. Depression or excessive worry <input type="radio"/> YES <input checked="" type="radio"/> NO g. Been evaluated or treated for a mental condition <input type="radio"/> YES <input checked="" type="radio"/> NO h. Attempted suicide <input type="radio"/> YES <input checked="" type="radio"/> NO i. Used illegal drugs or abused prescription drugs <input type="radio"/> YES <input checked="" type="radio"/> NO 18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder <input type="radio"/> YES <input checked="" type="radio"/> NO b. A change of menstrual pattern <input type="radio"/> YES <input checked="" type="radio"/> NO c. Any abnormal PAP smears <input type="radio"/> YES <input checked="" type="radio"/> NO d. First day of last menstrual period (YYYYMMDD) <input type="radio"/> YES <input checked="" type="radio"/> NO e. Date of last PAP smear (YYYYMMDD) <input type="radio"/> YES <input checked="" type="radio"/> NO	19. Have you been refused employment or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. <input type="radio"/> YES <input checked="" type="radio"/> NO b. Inability to perform certain motions <input type="radio"/> YES <input checked="" type="radio"/> NO c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> YES <input checked="" type="radio"/> NO d. Other medical reasons (If yes, give reasons.) <input type="radio"/> YES <input checked="" type="radio"/> NO 20. Have you ever been treated in an Emergency Room? (If yes, for what?) <input checked="" type="radio"/> YES <input type="radio"/> NO 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) <input type="radio"/> YES <input checked="" type="radio"/> NO 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) <input checked="" type="radio"/> YES <input type="radio"/> NO 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) <input type="radio"/> YES <input checked="" type="radio"/> NO 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) <input type="radio"/> YES <input checked="" type="radio"/> NO 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) <input type="radio"/> YES <input checked="" type="radio"/> NO 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) <input type="radio"/> YES <input checked="" type="radio"/> NO 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) <input type="radio"/> YES <input checked="" type="radio"/> NO 28. Have you ever been denied life insurance? <input type="radio"/> YES <input checked="" type="radio"/> NO	
29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.) <div style="font-family: cursive; font-size: 1.2em; padding: 10px;"> <p>11F. GLASSES ISSUED IN BOOT CAMP.</p> <p>13F. ONE HEMOROID SEE MEDICAL RECORD, WAS NOT A ISSUE. JUST A FINDING DURING A COLONOSCOPY</p> <p>20. ABNORMAL PAIN, UNKNOWN CAUSE.</p> <p>22. TONSILLECTOMY</p> </div>		

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) <i>MERWIN, DANIEL, D</i>		SOCIAL SECURITY NUMBER 
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)		
a. COMMENTS <i>11/8 gtr 13 F internal heard son at colonoscopy, 20 add pain resolved 5 Dec 2005 e nail CT colonoscopy - int history initially thrombocytopenia but resolved when seen by Int med</i>		
b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial) <i>DR. WAYNARD, MD</i> GS-183	c. SIGNATURE 	d. DATE SIGNED (YYYYMMDD) <i>2006/03/16</i>

BUMEDINST 1300.2
17 Feb 2000**MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING
FOR SERVICE AND FAMILY MEMBERS**

SERVICE MEMBER NAME MERWIN, DANIEL D	GRADE / RATE E2 / ABH	SSN [REDACTED]
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	SSN
NEXT DUTY STATION: SESABA, JAPAN USS ESSOV LHD-2	NEXT UNIT IDENTIFICATION CODE (UIC):	

PART I

Medical Screening. Completed by the medical provider to identify special needs and determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. Complete the Report of Medical History (SF 93) and attach to this form.

Yes	No	N/A	ITEM
✓			1. All health records (military and civilian) reviewed?
✓			2. Physical examinations are current?
✓			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
✓			4. Immunizations are up-to-date and meet destination country requirements?
✓			5. Reference audiogram documented on DD 2215?
✓			6. Latest audiogram (DD 2216) reviewed?
✓			7. HIV testing completed or drawn?
✓			8. DNA testing completed and documented?
	✓		9. Are there pending consults or tests that have a bearing on assignment suitability?
	✓		10. Any past limited duty or medical board(s)? (document on SF 93)
		✓	11. Pap smear and pelvic/breast examination within past year?
		✓	12. Mammogram current (based on age)?
		✓	13. Pregnancy screening (verbal inquiry)?
		✓	14. If pregnant? (EDC:)
	✓		15. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			16. Are there any conditions requiring ongoing care in the following areas? (document on SF 93)
	✓	✓	a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
	✓	✓	b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
	✓		c. Gynecologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
	✓		d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
	✓		e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
	✓		f. Mental health or behavioral conditions (e.g., depression, adjustment/personality disorder, ADD/ADHD)
	✓		g. Recurrent or frequent medications (list on SF 93)
	✓		h. Alcohol abuse or dependence
	✓		i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
	✓		j. Other conditions or concerns? (explain):
		✓	17. For service/family members requiring medication in excess of 90 days: (if not applicable, check block and skip to #18)
			a. Is the patient in the maintenance phase of treatment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Is the medical staff at the gaining MTF/operational platform competent to manage the medication manipulation(s) if the underlying condition exacerbates?
			d. Can the pharmacy at the gaining MTF/operational platform obtain the medication for the duration of the assignment? Non-authorized medical allowance list (AMAL) medications may be provided by the supporting MTF for up to 180 days or obtained through the national mail order pharmacy program.

NAVMED 1300/1 (Rev. 02-00)

BUMEDINST 1300.2
17 Feb 2000

Yes	No	N/A	ITEM
		✓	18. For service/family members with underlying medical conditions: (if not applicable, check block and skip to #19)
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Can the gaining MTF/operational platform provide the current required medical support?
			d. Can the gaining MTF/operational platform provide required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated?
			e. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? (document on SF 93)
			f. If required, were potential environmental concerns and possible health effects communicated to each service and family member? (document on appropriate SF 600 overprint)
		✓	19. For infants and toddlers (birth through age 2 inclusive) with a disability, is the child receiving or eligible to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
		✓	20. For preschool and school children (ages 3 to 21) with a disability, is the child receiving or eligible to receive special education and related services as evidenced by an Individualized Education Program (IEP) and Special Education Worksheet (NAVPERS 1754/4)?
	✓		21. Other concerns? (specify)

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, QUERY THE GAINING MILITARY TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY OR OPERATIONAL LOCATION CONCERNING LOCAL CAPABILITIES TO PROVIDE REQUIRED SUPPORT. (attach reply)

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (completed by a MTF designated military medical screener only)
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Military Medical Screener (Signature) <i>P.A. Maynard</i> Date <i>17 Feb 2000</i></p> <p>Printed Name, Rank or Grade P.A. MAYNARD, MD</p> <p>MTF or Duty Station 31 GS-14 GMD</p> <p>Telephone Number (include area/country code)</p> <p>DSN Number</p> <p>Telefax Number (include area/country code)</p> <p>E-mail Address</p> </div> <div style="width: 45%;"> <p>Civilian Medical Screener (Signature) _____ Date _____</p> <p>Printed Name _____</p> <p>Address _____</p> <p>City, State, and Zip Code _____</p> <p>Telephone Number (include area/country code) _____</p> <p>Telefax Number (include area/country code) _____</p> <p>E-mail Address _____</p> </div> </div>		

NAVMED 1300/1 (Rev. 02-00) BACK

MERWIN, DANIEL
 [REDACTED] 00060411
 85 ELLY

BUMEDINST 1300.2
 17 Feb 2000



PART II		
Dental Screening. Completed by the dental screener to assess and match the dental needs of service or family member to the support capabilities during an overseas, remote duty, or operational assignment.		
Yes	No	N/A
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Dental Classifications: Class 1 - Patients who do not require dental treatment. Class 2 - Patients who have dental conditions that are unlikely to result in a dental emergency within 12 months. Class 3 - Patients who have dental conditions that are likely to cause a dental emergency in the next 12 months. Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) examination by a dental officer within the past 12 months or, (2) A patient's dental record does not exist, or the dental record is not held by the responsible dental treatment facility or Medical Department activity.</p>		
<p>IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, QUERY THE GAINING DENTAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY OR OPERATIONAL LOCATION CONCERNING LOCAL CAPABILITIES TO PROVIDE REQUIRED SUPPORT. (attach reply)</p>		
Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (completed by a DTF designated military dental screener only)
<p><i>Kevin T. Kalanta</i> Military Dental Screener (Signature) KEVIN T. KALANTA, CDR, DC, USN Printed Name, Rank or Grade NATTC, NBHC PENSACOLA DTF or Duty Station 850-452-8970 x 106/107 Telephone Number (include area/country code) 922-8970 x 106/107 DSN Number 850-452-8892 Telefax Number (include area/country code) E-mail Address</p>		<p><i>23 FEB 06</i> Date Civilian Dental Screener (Signature) Date Printed Name Address City, State, and Zip Code Telephone Number (include area/country code) Telefax Number (include area/country code) E-mail Address</p>

NAVMED 1300/1 (Rev. 02-00)

AR 3263



REPORT OF MEDICAL EXAMINATION				1. DATE OF EXAMINATION (YYYYMMDD) 20051013		2. SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px;"></div>	
PRIVACY ACT STATEMENT							
<p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>							
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN DANIEL DENNIS			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code) BETHLEHEM, PA			5. HOME TELEPHONE NUMBER <div style="background-color: black; width: 100px; height: 20px;"></div>	
6. GRADE CIVILIAN	7. DATE OF BIRTH (YYYYMMDD) 1985	8. AGE (20)	9. SEX <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input checked="" type="checkbox"/> Not Hispanic/Latino	
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY <input type="radio"/> b. CIVILIAN <input type="radio"/>		12. AGENCY (Non-Service Members Only) DN			13. ORGANIZATION UNIT AND UIC/CODE		
14.a. RATING OR SPECIALTY (Aviators Only)			b. TOTAL FLYING TIME			c. LAST SIX MONTHS	
15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input checked="" type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) HARRISBURG MEPS 4641 Westport Drive Mechanicsburg, PA 17055-4843	
CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)							
				Normal	Ab-normal	NE	
17. Head, face, neck, and scalp				/			
18. Nose				/			
19. Sinuses				/			
20. Mouth and throat				/			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				/			
22. Drums (Perforation)				/			
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				/			
24. Ophthalmoscopic				/			
25. Pupils (Equality and reaction)				/			
26. Ocular motility (Associated parallel movements, nystagmus)				/			
27. Heart (Thrust, size, rhythm, sounds)				/			
28. Lungs and chest (Include breasts)				/			
29. Vascular system (Varicosities, etc.)				/			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				/			
31. Abdomen and viscera (Include hernia)				/			
32. External genitalia (Genitourinary)				/			
33. Upper extremities				/			
34. Lower extremities (Except feet)				/			
35. Feet (See Item 35 Continued)				/			
36. Spine, other musculoskeletal				/			
37. Identifying body marks, scars, tattoos				/			
38. Skin, lymphatics				/			
39. Neurologic				/			
40. Psychiatric (Specify any personality deviation)				/			
41. Pelvic (Females only)				/			
42. Endocrine				/			
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in item 44.)				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)			
<input checked="" type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____				35. FEET (Continued) (Circle category) <input checked="" type="radio"/> Normal Arch <input type="radio"/> C - Pes Cavus <input type="radio"/> P - Pes Planus 1 - Mild 2 - Moderate 3 - Severe A - Asymptomatic S - Symptomatic			

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS						DNR		SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 1.2em;"></div>												
LABORATORY FINDINGS																				
45. URINALYSIS			a. Albumin NEG			46. URINE HCG			47. H/H		48. BLOOD TYPE									
			b. Sugar NEG																	
TESTS			RESULTS			  06085320 Initial: <div style="border: 1px solid black; width: 40px; height: 30px; display: inline-block;"></div> 20051013 (YYYYMMDD)			SECOND SPECIMEN ID LABEL											
			FIRST TEST									CODE			SECOND TEST			CODE		
49. HIV																				
50. DRUGS																				
51. ALCOHOL																				
52. OTHER																				
a. PAP SMEAR																				
b. EKG																				
c. CXR																				
MEASUREMENTS AND OTHER FINDINGS																				
53. HEIGHT 6800		54. WEIGHT 110 lbs.		55.a. MIN WGT - MAX WGT 181		55.b. ACTUAL BF % - MAX BF %		56. TEMPERATURE		57. PULSE 96										
58. BLOOD PRESSURE				59. RED/GREEN (Army Only)				60. OTHER VISION TEST:												
a. 1ST		b. 2ND		c. 3RD						a. COLOR HAIR		b. COLOR EYES								
SYS. 131		SYS.		SYS.						Red		Right:								
DIAS. 74		DIAS.		DIAS.								Left: Other								
61. DISTANT VISION				62. REFRACTION BY <u>AUTOREFRACTION</u> OR MANIFEST				63. NEAR VISION												
Right 20/ 40		Corr. to 20/ 20		By -1.00 S. +0.50 CX 180		Right 20/ 20		Corr. to 20/		by										
Left 20/ 50		Corr. to 20/ 20		By -0.75 S. +0.50 CX 180		Left 20/ 20		Corr. to 20/		by										
64. HETEROPHORIA (Specify distance)																				
ES°		EX°		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD						
65. ACCOMMODATION				66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT												
Right		Left		PIP Passed /14				Uncorrected				Corrected								
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION												
								O.D.				O.S.								
71a. AUDIOMETER		Unit Serial Number 11042539						71b. Unit Serial Number		72a. READING ALOUD TEST										
Date Calibrated (YYYYMMDD)		20041111						Date Calibrated (YYYYMMDD)												
HZ		500		1000		2000		3000		4000		6000		SAT		UNSAT				
Right		05		10		15		15		15		05								
Left		10		15		15		20		10		15								
72b. VALSALVA												SAT		UNSAT						
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																				

DD FORM 2808, OCT 2005



LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)

DNR

SOCIAL SECURITY NUMBER

MERWIN, DANIEL DENNIS



88. Additional Remarks (extension of blocks 77 or 78).





REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate of Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no persons shall be subject to any penalty for failing to comply with a collection of information if it does not display a current valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members for the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

MERWIN
DANIEL DENNIS

2. SOCIAL SECURITY NUMBER

[REDACTED]

3. TODAY'S DATE (YYYYMMDD)

20051013

4.a. HOME ADDRESS (Street, Apartment No., City, State, ZIP Code)

[REDACTED]
BETHLEHEM, PA [REDACTED]

5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)

Harrisburg Meps
4641 Westport Drive
Mechanicsburg, PA 17055-4843

b. HOME TELEPHONE (Include Area Code)

[REDACTED]

X ALL APPLICABLE BOXES:

6.a. SERVICE

☐ Army ☐ Coast Guard
☒ Navy
☐ Marine Corps
☐ Air Force

b. COMPONENT

☒ Active Duty
☐ Reserve
☐ National Guard

c. PURPOSE OF EXAMINATION

☒ Enlistment ☐ Medical Board ☐ Other (Specify)
☐ Commission ☐ Retirement
☐ Retention ☐ U.S. Service Academy
☐ Separation ☐ ROTC Scholarship Program

7.a. POSITION (Title, Grade, Component)

CIVILIAN

b. USUAL OCCUPATION

Technical Care
Representative

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)

None

9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)

None

Mark each item "YES" or "NO".

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	YES	NO
10. a. Tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input checked="" type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input checked="" type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input checked="" type="radio"/>
f. Bronchitis	<input type="radio"/>	<input checked="" type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input checked="" type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input checked="" type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input checked="" type="radio"/>
j. Sinusitis	<input type="radio"/>	<input checked="" type="radio"/>
k. Hay fever	<input type="radio"/>	<input checked="" type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input checked="" type="radio"/>
11. a. Severe tooth or gum trouble	<input type="radio"/>	<input checked="" type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input checked="" type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input checked="" type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input checked="" type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input checked="" type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input checked="" type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input checked="" type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
12. a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input checked="" type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input checked="" type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input checked="" type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input checked="" type="radio"/>

12. (Continued)

	YES	NO
f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input checked="" type="radio"/>
h. Swollen or painful joint(s)	<input type="radio"/>	<input checked="" type="radio"/>
i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input checked="" type="radio"/>
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input checked="" type="radio"/>
l. Bone, joint, or other deformity	<input type="radio"/>	<input checked="" type="radio"/>
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input checked="" type="radio"/>
n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input checked="" type="radio"/>
13. a. Frequent indigestion or heartburn	<input type="radio"/>	<input checked="" type="radio"/>
b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input checked="" type="radio"/>
c. Gall bladder trouble or gallstones	<input type="radio"/>	<input checked="" type="radio"/>
d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input checked="" type="radio"/>
e. Rupture/hernia	<input type="radio"/>	<input checked="" type="radio"/>
f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input checked="" type="radio"/>
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
h. Frequent or painful urination	<input type="radio"/>	<input checked="" type="radio"/>
i. High or low blood sugar	<input type="radio"/>	<input checked="" type="radio"/>
j. Kidney stone or blood in urine	<input type="radio"/>	<input checked="" type="radio"/>
k. Sugar or protein in urine	<input type="radio"/>	<input checked="" type="radio"/>
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input checked="" type="radio"/>
14. a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input checked="" type="radio"/>
b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input checked="" type="radio"/>
c. Currently in good health (If no, explain in Item 29 on page 2)	<input checked="" type="radio"/>	<input type="radio"/>
d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input checked="" type="radio"/>

DoD exception to SF 93 approved by ICMR, August 3, 2000.

DD FORM 2807-1, OCT 2003



Page 1 of 4 Pages

AR 3268

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS			SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px;"></div>		
Mark each item "YES" or "NO".			Mark each item "YES" or "NO". For Items 19 - 28, every item marked "YES" must be fully explained in Item 29 below.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15. a. Dizziness or fainting spells	<input type="radio"/>	<input checked="" type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:		
b. Frequent or severe headache	<input type="radio"/>	<input checked="" type="radio"/>	a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input checked="" type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input checked="" type="radio"/>	b. Inability to perform certain motions	<input type="radio"/>	<input checked="" type="radio"/>
d. Paralysis	<input type="radio"/>	<input checked="" type="radio"/>	c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input checked="" type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input checked="" type="radio"/>	d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input checked="" type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input checked="" type="radio"/>	20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input checked="" type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/>	<input checked="" type="radio"/>	21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	<input checked="" type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input checked="" type="radio"/>	22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input checked="" type="radio"/>	<input type="radio"/>
16. a. Rheumatic fever	<input type="radio"/>	<input checked="" type="radio"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input checked="" type="radio"/>	<input type="radio"/>
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input checked="" type="radio"/>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>	<input checked="" type="radio"/>
c. Pain or pressure in the chest	<input type="radio"/>	<input checked="" type="radio"/>	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input checked="" type="radio"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input checked="" type="radio"/>	26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>	<input checked="" type="radio"/>
e. Heart trouble or murmur	<input type="radio"/>	<input checked="" type="radio"/>	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	<input checked="" type="radio"/>
f. High or low blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	28. Have you ever been denied life insurance?	<input type="radio"/>	<input checked="" type="radio"/>
17. a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input checked="" type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)		
b. Habitual stammering or stuttering	<input type="radio"/>	<input checked="" type="radio"/>	(2) Tonsillectomies, Had it Done, 200409		
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input checked="" type="radio"/>	(23) Chicken Pox		
d. Frequent trouble sleeping	<input type="radio"/>	<input checked="" type="radio"/>	Stacy Lynn Rhoades (Mother)		
e. Received counseling of any type	<input type="radio"/>	<input checked="" type="radio"/>	Same as block #4		
f. Depression or excessive worry	<input type="radio"/>	<input checked="" type="radio"/>			
g. Been evaluated or treated for a mental condition (If yes, fully explain in Item 29 below.)	<input type="radio"/>	<input checked="" type="radio"/>			
h. Attempted suicide	<input type="radio"/>	<input checked="" type="radio"/>			
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input checked="" type="radio"/>			
18. FEMALES ONLY. Have you ever had or do you now have:					
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>			
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>			
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>			
d. First day of last menstrual period (YYYYMMDD).					
e. Date of last PAP smear (YYYYMM).					

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED, MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."





LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

MERWIN, DANIEL DENNIS

SOCIAL SECURITY NUMBER



31. ADDITIONAL REMARKS. (Extension of blocks 29 or 30).





LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS		SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 1.2em; margin: 0 auto;"></div>																					
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 8 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>																							
a. COMMENTS <div style="margin-top: 20px;"> <p>22 Tonsillectomy - 2004, Sept age 19.</p> <p>23 UCD : churhipx -</p> </div>																							
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">QUESTIONING REVEALS</th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:50%;">DETAILS</th> </tr> </thead> <tbody> <tr> <td>MARIJUANA USE</td> <td></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>OTHER DRUG ABUSE</td> <td></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>ALCOHOL ABUSE</td> <td></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				QUESTIONING REVEALS	YES	NO	DETAILS	MARIJUANA USE		<input checked="" type="checkbox"/>		OTHER DRUG ABUSE		<input checked="" type="checkbox"/>		ALCOHOL ABUSE		<input checked="" type="checkbox"/>					
QUESTIONING REVEALS	YES	NO	DETAILS																				
MARIJUANA USE		<input checked="" type="checkbox"/>																					
OTHER DRUG ABUSE		<input checked="" type="checkbox"/>																					
ALCOHOL ABUSE		<input checked="" type="checkbox"/>																					
EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.																							
b. TYPED OR PRINTED NAME OF EXAMINEE DANIEL S. LINDY, D.D.		c. SIGNATURE <div style="text-align: center;"> EXAMINEE SIGNATURE </div>																					
d. DATE SIGNED 20051013		DATE 20051013																					



ABSTRACT OF SERVICE AND MEDICAL HISTORY

NAVMED 6150/4 (Rev. 12-67)

(Formerly NAVMED 1406)

[illegible]

NAME (Last, First, Middle)			SSN	BRANCH/CLASS
MERWIN, DANIEL D R20060411				11
DATE OF BIRTH	SEX	RACE	DEPARTMENT	ORGANIZATION
05	M		DOD	RTC GREAT LAKES 3272

ABSTRACT OF SERVICE AND MEDICAL HISTORY
NAVMED 6150/4 (Rev. 12-67)
(Formerly NAVMED 1406)

[illegible]

Casupanan, Reiner S. HM1

From: E. A. McGuigan, CDR, MC, USN [EAMcguigan@bethesda.med.navy.mil]
Sent: Monday, February 19, 2007 11:26 PM
To: CC; telmed-results@bethesda.med.navy.mil; dacundiff@bethesda.med.navy.mil; ALL TELERAD; CC; CC
Subject: LHD2 || MERWIN, DANIEL || 20/ [REDACTED] || upper extremities || Study: 2/17/2007 8:08:16 AM || Sent: 2/19/2007 9:26:18 AM

Preliminary Interpretation:

Right Hand Series X3

Follow up films from exam taken 10Feb07 for fractured right 5th metacarpal.,,

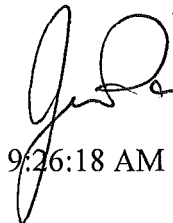
Radiologist Interpretation: Compared to 2/10/2007. Right 5th metacarpal head fracture with volar angulation and impaction of the distal fracture fragment, appearance not significantly changed from prior study. Soft tissue swelling noted over the dorsum of the hand at the level of the injury.

E. A. McGuigan, CDR, MC, USN

Staff Radiologist

NNMC Radiology

Electronically Signed By: E. A. McGuigan, CDR, MC, USN. On 2/19/2007 - 9:26:18 AM



This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.

Casupanan, Reiner S. HM1

y

From: W.R. Carter [wrcarter@bethesda.med.navy.mil]**Sent:** Tuesday, February 13, 2007 12:30 AM**To:** CC; telmed-results@bethesda.med.navy.mil; dacundiff@bethesda.med.navy.mil; ALL TELERAD; CC**Subject:** LHD2 || Merwin, Daniel || 20[REDACTED] || upper extremities || Study: 2/10/2007 8:54:50 AM || Sent: 2/12/2007 10:30:19 AM

Preliminary Interpretation:

Right Hand Series X3

Fracture fifth metacarpal.,,

Radiologist Interpretation:

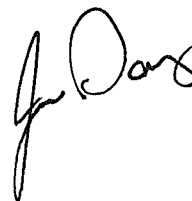
5th metacarpal neck fx with impaction/volar angulation

W.R. Carter, LCDR, MC, USN

Staff Radiologist

NNMC Bethesda

Electronically Signed By: W.R. Carter. On 2/12/2007 - 10:30:19 AM



This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at! once and destroy any copies you have made.

NH OKINAWA PSC 482 FPO AP 96362-1600

09 Feb 2007@2146

Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
Review Results

Report requested by: SORTOR, BRETT V

MERWIN, DANIEL
Ph: 642-2378

20/

M/21

Reg #:

Military Unit: LHD 2 ESSEX

01 Feb 07 @ 1522 (Coll)

SWAB (NASAL CAVITY)

Order comment: recurrent abscesses

R/O MRSA: Final Report

Bacteriology Result:

NO METHICILLIN RESISTANT STAPH AUREUS ISOLATED.

Javier
LT
2

MC

Agraz Jr.

=====
L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult
=====

*** End of Report ***

AR 3276

NAVHOSP GREAT LAKES IL

20 Dec 2005@1301

Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 07 Aug 04 - 19 Dec 05

Report requested by: WALSH, KIMBERLY A

MERWIN, DANIEL DENNIS

20/

M/20

Reg f:

Ph: NONE

Military Unit: NAVCRUITRACOM

051129 HE 1549

Col: 29Nov05@0827

BLOOD

STAT

Hcp: FRANKLIN, MALCOM B

Req Loc: INTERNAL

WBC	12.90	H	(3.4-10.8)	x10(9)/L	C:BCP29Nov05@0841
RBC CNT	4.42		(4.2-5.6)	x10(12)/L	
HGB	13.1	L	(13.2-17.0)	G/DL	
HCT	38.0	L	(38.1-49.3)	%	
MCV	86.1		(80-100)	FL	
MCH	29.7		(27-31)	PG	
MCHC	34.5		(31-36)	G/DL	
RDW	10.3		(9.8-12.8)	%	
PLATELETS	358		(130-400)	X10(9)/L	
MPV	7.8		(7.4-10.4)	FL	
NEUT/100 WBC	85.1	H	(43.3-74.3)	%	
LYMPHS/100 WBC	7.2	L	(12.4-46)	%	
MONO/100 WBC	6.6		(4-14.6)	%	
EOS/100 WBC	0.7		(0-3.3)	%	
BASO/100 WBC	0.361		(0-2)	%	
NEUTf	10.90	H	(1.0-7.5)	x10(9)/L	
LYMPHf	0.93		(0.9-3.0)	x10(9)/L	
MONOf	0.85		(0.2-1.0)	x10(9)/L	
EOSf	0.09		(.0-.40)	X10(9)/L	
BASOf	0.046		(.0-.20)	X10(9)/L	

051122 CO 1294

Col: 22Nov05@1320

PLASMA

APTT	38.00		(21.1-40.7)	SECS	Req Loc: COURAGE
PT	13.00		(9.7-13.9)	SECS	C:MAV22Nov05@1442
INR	1.063		(0.81-1.197)		C:MAV22Nov05@1442

051122 HE 1276

Col: 22Nov05@1320

BLOOD

WBC	6.12		(3.4-10.8)	x10(9)/L	Req Loc: COURAGE
RBC CNT	4.67		(4.2-5.6)	x10(12)/L	C:BCP22Nov05@1350
HGB	14.1		(13.2-17.0)	G/DL	
HCT	40.0		(38.1-49.3)	%	
MCV	85.6		(80-100)	FL	
MCH	30.2		(27-31)	PG	
MCHC	35.3		(31-36)	G/DL	
RDW	10.0		(9.8-12.8)	%	
PLATELETS	408	H	(130-400)	X10(9)/L	
MPV	7.3	L	(7.4-10.4)	FL	
NEUT/100 WBC	67.7		(43.3-74.3)	%	
LYMPHS/100 WBC	23.0		(12.4-46)	%	

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susp I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

NAVHOSP GREAT LAKES IL

20 Dec 2005@1301

Page 2

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

AR 3277

For: 07 Aug 04 - 19 Dec 05

Report requested by: WALSH, KIMBERLY A

MERWIN, DANIEL DENNIS
Ph: NONE

20/

M/20 Reg f:
Military Unit: NAVCRUITRACOM

051122 HE 1276

Col: 22Nov05@1320
Hcp: ARTATES, NEMESIA FBLOOD
Req Loc: COURAGE

MONO/100 WBC.	7.2	(4-14.6)	%
EOS/100 WBC.	1.5	(0-3.3)	%
BASO/100 WBC.	0.662	(0-2)	%
NEUTf.	4.14	(1.0-7.5)	x10(9)/L
LYMPHf.	1.41	(0.9-3.0)	x10(9)/L
MONOf.	0.44	(0.2-1.0)	x10(9)/L
EOSf.	0.09	(.0-.40)	X10(9)/L
BASOf.	0.041	(.0-.20)	X10(9)/L

051122 CO 1295

Col: 22Nov05@1320
Hcp: ARTATES, NEMESIA FBLOOD
Req Loc: COURAGE
C:JW23Nov05@0742

BLEEDING TIME . . . 7.5 (2.5-8) MINUTES

051119 CH 3363

Col: 19Nov05@0355
Hcp: DINKEL, TROY ASERUM
Req Loc: EMERGENC
C:WTJ19Nov05@0419

STAT			
PROTEIN TOTAL	8.2	(6.3-8.2)	MG/DL
ALBUMIN	4.6	(3.9-5.1)	MG/DL
GLOBULIN.	3.6	(2.4-3.5)	G/DL
A/G RATIO	1.3	(1.1-2.2)	
ALK PHOS.	75	(38-126)	U/L
AST	26	(5-40)	U/L
ALT	28	(7-56)	U/L
LDH	495	(313-618)	U/L
GGT	17	(8-78)	U/L
TBILI	0.4	(0.2-1.3)	MD/DL
DBILI	0.0	(0.0-0.4)	MD/DL
AMYLASE	44.	(30-110)	IU/L
LIPASE.	66	(23-230)	U/L
GLUCOSE	101	(75-110)	MG/DL
BUN	13	(9-21)	MG/DL
BUN/CR RATIO.	14.7	(7-25)	MG/DL
NA+	140	(137-145)	MMOL/L
K	4.1	(3.6-5.0)	MMOL/L
CL-	102	(98-107)	MMOL/L
CO2	29.4	(22-40)	MMOL/L
ANION GAP	12.	(10-20)	MMOL/L
CREAT9	(0.8-1.5)	MG/DL
GFR	114	(>/= 90)	cc/min

Interpretations:

A result of "0" (zero) for ages 17 and under is the same
as not performed.

=====

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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NAVHOSP GREAT LAKES IL

20 Dec 2005@1301

Page 3

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 07 Aug 04 - 19 Dec 05

Report requested by: WALSH, KIMBERLY A

MERWIN, DANIEL DENNIS

20/

M/20

Page 3278

Ph: NONE

Military Unit: NAVCRUITRACOM

051119 CH 3363

Col: 19Nov05@0355

SERUM

STAT

Hcp: DINKEL, TROY A

Req Loc: EMERGENC

Interpretations: (Cont'd)

Reference Values:

≥ 90 = Normal GFR
 60-89 = Mildly decreased GFR
 30-59 = Moderately decreased GFR
 15-29 = Severely decreased GFR
 < 15 = Kidney Failure

This is an estimated GFR only. The value has been derived from the modified MDRD equation: $GFR = 270 \times \text{serum creatinine}^{-1.007} \times \text{age}^{-0.180} \times \text{BUN}^{-0.169} \times 0.755$ if female). Values for African Americans should be adjusted by multiplying by 1.18. As with all estimations, results may not be valid for certain sub-groups including: pediatric patients (0-17 years old), severely hypoalbuminemic patients, patients not in steady state (including acute renal failure), dialysis patients, and patients with atypical body habitus. If a more accurate estimation is required, consider obtaining a Nuclear Medicine GFR determination or Nephrology consultation.

051119 HE 1164

Col: 19Nov05@0355

BLOOD

STAT

Hcp: DINKEL, TROY A

Req Loc: EMERGENC

WBC	8.98		(3.4-10.8)	x10 (9) /L	C:WTJ19Nov05@0416
RBC CNT	4.68		(4.2-5.6)	x10 (12) /L	
HGB	14.4		(13.2-17.0)	G/DL	
HCT	39.8		(38.1-49.3)	%	
MCV	85.0		(80-100)	FL	
MCH	30.8		(27-31)	PG	
MCHC	36.3	H	(31-36)	G/DL	
RDW	10.1		(9.8-12.8)	%	
PLATELETS	105	L	(130-400)	X10 (9) /L	
MPV	7.8		(7.4-10.4)	FL	
NEUT/100 WBC	79.5	H	(43.3-74.3)	%	
LYMPHS/100 WBC	15.0		(12.4-46)	%	
MONO/100 WBC	3.9	L	(4-14.6)	%	
EOS/100 WBC	1.2		(0-3.3)	%	
BASO/100 WBC	0.388		(0-2)	%	
NEUT%	7.14		(1.0-7.5)	x10 (9) /L	

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
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NAVHOSP GREAT LAKES IL

20 Dec 2005@1301

Page 4

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 07 Aug 04 - 19 Dec 05

Report requested by: WALSH, KIMBERLY A

MERWIN, DANIEL DENNIS

20/

M/20

Reg f:

Ph: NONE

Military Unit: NAVCRUITRACOM

051119 HE 1164

Col: 19Nov05@0355

BLOOD

STAT

Hcp: DINKEL, TROY A

Req Loc: EMERGENC

AR 3279

LYMPHE	1.35	(0.9-3.0)	x10(9)/L
MONOE	0.35	(0.2-1.0)	x10(9)/L
EOSe	0.10	(.0-.40)	X10(9)/L
BASOE	0.035	(.0-.20)	X10(9)/L

051103 INP 35604	Col: 03Nov05@1749	BLOOD
	Hcp: PADILLA, EDEN U	Req Loc: MED. ASS
INPROCESSING AB	O	C:NRF04Nov05@0929
INPROCESSING RH		
	POSITIVE	
G6PD	NORMAL	C:NRF04Nov05@0934
INPROCESS RPR		C:NRF04Nov05@0924
	NON-REACTIVE	
SICKLE SCREEN		C:CMB04Nov05@0904
	NEGATIVE	

051103 UIP 529	Col: 03Nov05@1749	VOIDED URINE
	Hcp: PADILLA, EDEN U	Req Loc: MED. ASS
LEUK ESTERASE		C:JG07Nov05@0836
	NEGATIVE	

Interpretations:
THIS IS A LEUKOCYTE ESTERASE SCREEN NOT SPECIFIC FOR CHLAMYDIA.

051103 REC 33454	Col: 03Nov05@1749	SERUM
	Hcp: PADILLA, EDEN U	Req Loc: MED. ASS
VARICELLA	IMMUNE	C:JG04Nov05@1113

051103 CH 867	Col: 03Nov05@1749	SERUM
	Hcp: PADILLA, EDEN U	Req Loc: MED. ASS
GLUCOSE	96	C:WJA04Nov05@1323
	(75-110)	MG/DL

051103 N08 388784	Col: 03Nov05@1749	SERUM
	Hcp: PADILLA, EDEN U	Req Loc: MED. ASS
Performing Lab: NAVY CENTRAL HIV SERVICE		
HIV-1 AB		C:CAC06Nov05@1854
	Negative	

Order Required Data:
P_PHYSICAL EXAM

```
=====
L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult
=====
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*****End of report*****

NAVHOSP GREAT LAKES IL 20 Dec 2005@1301 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 07 Aug 04 - 19 Dec 05

Report requested by: WALSH, KIMBERLY A

MERWIN, DANIEL DENNIS

20/

M/20

Reg f:

Ph: NONE

Military Unit: NAVCRUITRACOM

OrdFor: 22Nov05@1043

BLOOD

Hcp: ARTATES, NEMESIA F

Req Loc: COURAGE

CBC/DIFF. . . . DISCONTINUED

=====
L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult
=====

*****End of report*****

AR 3281

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 20 Dec 2005@1327
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN,DANIEL DENNIS

FMP/SSN: 20/ [REDACTED]

NH GREAT LAKES, 200H
Procedure: CT, ABD/PELVIS W/ CONTRAST
Requested by: ARTATES,NEMESIA F
Ward/Clinic: COURAGE (WHITE) 1007

COMPUTED TOMOGRAPHY 200H
Exam Date: 23 Nov 2005@0926
Status: COMPLETE
Exam #: 05050343
Pregnant:

Reason for Order:

20y/o male dot 2-5 with intermittent abdominal pain x 4-5 years with rectal bleeding on 19th of NOV.Had normal sigmoidoscopy to proximal transverse colon and mild int hemorrhoids done on Nov 21.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

ba/DICTATION DATE: 23 November 2005

CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST:

Technique: 7.5 mm cross-sectional images of the abdomen and pelvis were obtained following oral and intravenous introduction of contrast.

Findings: There is a normal appearance of the liver, spleen, and pancreas. There is no gallstones. No dilatation of biliary ducts or pancreatic duct identified. There is no enlargement of the adrenal glands. There is no hydronephrosis. No renal stones are seen. There is no lymphadenopathy. No abnormal collection of fluid in the abdomen or pelvis identified. Moderate amount of fecal material noted throughout the colon. There is no changes of appendicitis. No aneurysmal dilatation of the abdominal aorta noted. There is no signs of bowel obstruction.

IMPRESSION: NORMAL COMPUTED TOMOGRAPHY OF THE ABDOMEN AND PELVIS.

MODERATE AMOUNT OF FECAL MATERIAL THROUGHOUT THE COLON.

Transcription Date/Time: 29 Nov 2005@1002

Interpreted by: B V MARINBERG
Supervised by:

20/ [REDACTED] MERWIN,DANIEL DENNIS
[REDACTED] 1985 / MALE

USN AD RECRUIT
H:NONE W:NONE

LOC:
Spon: MERWIN,DANIEL DENNIS
SF519-B Unit: NAVCRUITRACOM

Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBHC 10

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN,DANIEL DENNIS

FMP/SSN: 20/

Approved by: B V MARINBERG 29 Nov 2005@1225

Supervised by:

20/ MERWIN,DANIEL DENNIS
1985 / MALE
Loc:
Spon: MERWIN,DANIEL DENNIS
Unit: NAVCRUITRACOM

USN AD RECRUIT
H:NONE W:NONE
Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBHC 10

SF519-B

Transparent print on

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 20 Dec 2005@1327
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN,DANIEL DENNIS

FMP/SSN: 20/ [REDACTED]

NH GREAT LAKES, 200H
Procedure: CT, ABD/PELVIS W/O CONTRAST
Requested by: DINKEL,TROY A
Ward/Clinic: EMERGENCY MEDICAL CARE 200H

COMPUTED TOMOGRAPHY 200H
Exam Date: 19 Nov 2005@0428
Status: COMPLETE
Exam #: 05050058
Pregnant:

Reason for Order:
KIDNEY STONE PROTOCOL

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

djk/Dictated 11-19-2005

CT OF THE ABDOMEN AND PELVIS:

Examination is limited due to lack of IV or oral contrast.

As visualized, the liver, spleen, pancreas, abdominal aorta and both kidneys are intact. No evidence of renal stones or hydronephrosis is seen. The gallbladder is moderately distended.

Substantial amount of fecal matter is noted in the colon. No obvious inflammatory changes, masses or abnormal fluid collections are seen in the abdomen.

Imaging into the pelvic shows a large amount of fecal matter within the distal colon. The urinary bladder is intact.

IMPRESSION:

NO CLEAR INDICATION OF ACUTE INTRA-ABDOMINAL ABNORMALITY.

SIGNIFICANT AMOUNT OF FECAL MATTER IS NOTED IN THE COLON.

OTHER FINDINGS AS DESCRIBED.

Transcription Date/Time: 23 Nov 2005@1343

Interpreted by: A KAMENETSKY

20/ [REDACTED] MERWIN,DANIEL DENNIS
[REDACTED] 1985 / MALE
Loc:
Spon: MERWIN,DANIEL DENNIS
Unit: NAVCRUITRACOM

USN AD RECRUIT
H:NONE W:NONE

Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBH-10

SF519-B

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN,DANIEL DENNIS

FMP/SSN: 20/

Supervised by:

Approved by: A KAMENETSKY 23 Nov 2005@1451

Supervised by:

20/ MERWIN,DANIEL DENNIS
1985 / MALE
Loc:
Spon: MERWIN,DANIEL DENNIS
SF519-B Unit: NAVCRUITRACOM

USN AD RECRUIT
H:NONE W:NONE
Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBHC 10

Transparent print on

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 20 Dec 2005@1327
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN, DANIEL DENNIS

FMP/SSN: 20/ [REDACTED]

NH GREAT LAKES, 200H
Procedure: *ACUTE ABDOMINAL SERIES
Requested by: DINKEL, TROY A
Ward/Clinic: EMERGENCY MEDICAL CARE 200H

MAIN RADIOLOGY 200H
Exam Date: 19 Nov 2005@0418
Status: COMPLETE
Exam #: 05050057
Pregnant:

Reason for Order:
ABD
PAIN

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

djk/Dictated 11-20-2005

ABDOMEN OBSTRUCTIVE SERIES:

Views of the abdomen demonstrate a normal bowel-gas pattern.
Pneumoperitoneum is not present. The psoas shadows are adequately
visualized. There is no evidence of intra-abdominal mass or significant
calcifications. The visualized osseous structures show no abnormality.
The heart and lungs are normal

IMPRESSION: NORMAL OBSTRUCTIVE SERIES OF THE ABDOMEN.

Transcription Date/Time: 23 Nov 2005@1416

Interpreted by: A KAMENETSKY
Supervised by:

Approved by: A KAMENETSKY 23 Nov 2005@1451
Supervised by:

20/ [REDACTED] MERWIN, DANIEL DENNIS
[REDACTED] 1985 / MALE

USN AD RECRUIT
H:NONE W:NONE

SF519-B
Loc:
Spon: MERWIN, DANIEL DENNIS
Unit: NAVCRUITRACOM

Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBHC 10

Transparent print on

AR 3286

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 20 Dec 2005@1327
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN,DANIEL DENNIS

FMP/SSN: 20/[REDACTED]

NBHC 1007/1017

RADIOLOGY NBHC 1007

Procedure: *ACUTE ABDOMINAL SERIES

Exam Date: 10 Nov 2005@1525

Requested by: MADAMBA,LUNINGNING G

Status: COMPLETE

Ward/Clinic: COURAGE (WHITE) 1007

Exam #: 05048946

Pregnant:

Reason for Order:

pain in lower abd. across umbilical area from r-l

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

ba/DICTATION DATE: 14 November 2005

ACUTE ABDOMINAL SERIES:

Reason: 20 year old male with lower abdominal pain.

Comparison studies: None.

Findings: Single frontal view of the chest reveals normal cardiac and mediastinal silhouette. Lungs are clear without infiltrate, effusion, mass, or pneumothorax. Remaining bones and soft tissues are otherwise unremarkable. No free air is seen under the diaphragm.

Frontal views of the supine and upright abdomen reveal no dilated loops of bowel or abnormal air fluid levels. No abnormal calcifications or masses are seen. Remaining bones and soft tissues are otherwise unremarkable.

IMPRESSION: NO EVIDENCE OF ACUTE PULMONARY PROCESS.

NORMAL BOWEL GAS PATTERN.

Transcription Date/Time: 16 Nov 2005@0528

Interpreted by: D K NAUGLE

Supervised by:

Approved by: D K NAUGLE 17 Nov 2005@1437

20/[REDACTED] MERWIN,DANIEL DENNIS

USN AD RECRUIT

[REDACTED] 1985 / MALE

H:NONE

W:NONE

Loc:

SF519-B

Spon: MERWIN,DANIEL DENNIS

Rank: SEAMAN RE D:NONE

Unit: NAVCRUITRACOM

RR: FA COURAGE RECORDS NBHC 10

RADIOLOGIC EXAMINATION REPORT

Patient: MERWIN, DANIEL DENNIS

FMP/SSN: 20/ [REDACTED]

Supervised by:

20/ [REDACTED] MERWIN, DANIEL DENNIS
[REDACTED] 1985 / MALE
LOC:
Spon: MERWIN, DANIEL DENNIS
Unit: NAVCRUITRACOM

USN AD RECRUIT
H:NONE W:NONE
Rank: SEAMAN RE D:NONE
RR: FA COURAGE RECORDS NBHC 10

SF519-B

LABORATORY 200H

29 Nov 2005@0841 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

Report requested by: System Generated

MERWIN, DANIEL DENNIS

20/ [REDACTED] M/20
Mil. Unit: NAVCRUITRACOM

phf NONE

Ordered by: FRANKLIN, MALCOM

Col: 29 Nov 2005@0827

Accf: 051129 HE 1549

Specimen: BLOOD (BLOOD)

Pri: STAT

Ord: 051129-00529

Res Lab: LABNH

Req Loc: INTM

Test name	Result	Units	Normal range
WBC	12.90 H	x10(9)/L	3.4 - 10.8
RBC CNT	4.42	x10(12)/L	4.2 - 5.6
HGB	13.1 L	G/DL	13.2 - 17.0
HCT	38.0 L	%	38.1 - 49.3
MCV	86.1	FL	80 - 100
MCH	29.7	PG	27 - 31
MCHC	34.5	G/DL	31 - 36
RDW	10.3	%	9.8 - 12.8
PLATELETS	358	X10(9)/L	130 - 400
MPV	7.8	FL	7.4 - 10.4
NEUT/100 WBC	85.1 H	%	43.3 - 74.3
LYMPHS/100 WBC	7.2 L	%	12.4 - 46
MONO/100 WBC	6.6	%	4 - 14.6
EOS/100 WBC	0.7	%	0 - 3.3
BASO/100 WBC	0.361	%	0 - 2
NEUT%	10.90 H	x10(9)/L	1.0 - 7.5
LYMPH%	0.93	x10(9)/L	0.9 - 3.0
MONO%	0.85	x10(9)/L	0.2 - 1.0
EOS%	0.09	X10(9)/L	.0 - .40
BASO%	0.046	X10(9)/L	.0 - .20

*** End of Report ***

PENCIL ENTRIES	
N106 MD	CTN7/E
COMMAND	TITLE

Active duty: Specify grade or rate.

Retired Military: Specify preferred form of address: military grade or rate of civilian title.

Civilian: Specify preferred form of address (Mr. Mrs. Ms. Miss, Dr., etc.).

- ☒ Outpatient Treatment Record
☐ Dental Treatment Record

Military (provide grade or rate and, if family member, provide sponsor's service and status)

- ☒ Navy _____
☐ Marine Corps _____
☐ Other _____
☐ Retired _____
☐ Family Member _____
Family Member Insurance Yes _____ No _____
☐ Civilian
☐ Personnel Reliability Program
☒ Blood Type **O AB5**
☐ Flight Status
☐ Food Handler
☐ Radiation Exposure
☐ Asbestos Surveillance
☐ Medical Condition
☐ _____

MERWIN	DANIEL	D
LAST	FIRST	MIDDLE

PATIENT IDENTIFICATION (WRITE ABOVE OR AFFIX PREPRINTED LABEL)

WNNMC BETHESDA, MD

NMMC MEDICAL READINESS RECORDS

Instruct Name: MERWIN, DANIEL DENNIS

This treatment record will be used as an Outpatient Treatment Record or Treatment Record.

20/

DOB: 1985

Sex: MALE

PT CATEG: N11

GRADE/RANK: NES

STATION/UNIT: 21 NMT

CURRENT DATE: 17 Aug 2017/01210

1. Place a check in the appropriate box which type of treatment you wish this to be.

2. Fill in all information on the reverse side of this record.

3. Follow Manual of the Medical Department, chapters 6 (for dental) and 16 (for medical).



Vol: 1

N0016831001197156

N0262499922611

NATTC
NBHCNATTC
NBHCNATTC
NBHCNATTC
NBHC**Alert**

- ☒ Allergies
☐ Sensitivities

USS ESSEX LHD-2
FPO AP 96643-1661

U.S. Navy Medical Outpatient and Dental Treatment Record

NAVMED 6150/28 (11-96)

SN 0105-LF-113-9500

Warning: Property of US Government. Possession by individual without proper authorization is prohibited. Removal of this record or its contents from the treatment facility is prohibited unless authorized by appropriate authority. Postmaster, forward to the nearest US naval medical or dental treatment facility.

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

7. SCREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Note Indicated) (= Next Due)

a. TEST	b. FREQUENCY	c. YEAR d. AGE	2011 25	2010 25			
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL						
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY		147	150	153.6		
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY		69 in	69.5 in	69		
* (4) BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85. ANNUAL IF GREATER		120/60	102/60	127/60		
* (5) CHOLESTEROL**	q 5 YRS FOR AGE ≥ 18 q YR IF PREV ABN		194	170	+C 200 101/112		
(6) HEARING	CLINICIAN'S DISCRETION						
(7) SKIN EXAM (Cancer)	ANNUAL IF AT RISK						
(8) ORAL/DENTAL**	ANNUAL			15 NOV 2010			
(9) EYE/VISION**	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUALLY GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 yrs age 40-64	08 FEB 2011		17 MAR 2010			
(10) BREAST EXAM	ANNUAL: ≥ 40 YRS				N/A		
(11) MAMMOGRAM**	BASELINE @40, q 2 YRS 40-50. ANNUALLY ≥ 50						
(12) PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS. PERFORM q 1-3 YEARS						
(13) FECAL OCCULT BLOOD	ANNUAL: ≥ 50 YRS						
(14) SIGMOID	EVERY 3-5 YRS: ≥ 50 YRS						
(15) COLONOSCOPY**	HIGH RISK q 5 YRS: ≥ 40 YRS						
(16) TESTICULAR**	HIGH RISK ANNUAL 13-39 YRS						
(17) PROSTATE** ** (Digital Rectal Exam)	WITH P.E. ≥ 40 YRS (Presently recommended annually)				SELF		
(18) RUBELLA SCREEN (Females)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)				N/A		
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES						
(20)							
(21)							
(23)							

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

1. ALLERGIES

Allergen	Reaction	Information Source	Onset Date
OTHER	Unknown	Unknown Source of Info	11/07/2005

2. CHRONIC ILLNESSES

Chronic Illness	Date
Skin Neoplasm Of Uncertain Behavior	24 NOV 2010
Removal Of Sutures	04 OCT 2010
Extrinsic Asthma	01 SEP 2010
Folliculitis	20 JUL 2010
Rosacea	14 JUN 2010
Lattice Peripheral Retinal Degeneration	23 APR 2010
Myopia	23 APR 2010
Allergic Rhinitis	17 MAR 2010
Visit For: Occupational Health/Fitness Exam	17 MAR 2010
Parent Education About Immunizations	23 SEP 2009
Visit For: Military Services Physical	16 SEP 2009
Exposure To Venereal Disease	20 AUG 2009
Visit For: Administrative Purposes	07 MAY 2009
Inquiry And Counseling About Contraceptive Practices	07 MAY 2009

3. MEDICATIONS

Medication	Sig	Expiration Date
Cetirizine Hcl, 10 Mg, Tablet, Oral	T1 Tab Po Hs #30 Rf5	24 Jan 2012
Fluticasone Propionate 0.05%, Spray, Nasal	Inhale 2 Sprays In Each Nostril Once A Day #1 Rf3	24 Jan 2012
Ketoconazole, 2 %, Shampoo, Topical	Use On Trunk And Scalp Bid As Directed	13 Oct 2011
Non-Formulary Drug Request (Nfdr) Device Not Specified Miscellaneous	Ketoconazole 2% Shampoo-- Use On Trunk And Scalp Twice Daily As Directed #2 Rf4	12 Oct 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Inhale 1 Puff Orally Bid #1 Rf1	01 Sep 2011
Albuterol Sulfate 90mcg, Aerosol Powder, Inhalation, Hfa	Inh 2 Pf Po Q4h For Wheezing #1 Rf1	01 Sep 2011
Fexofenadine Hcl, 180 Mg, Tablet, Oral	T1 Tab Po Qd F Allergies Ud #30 Rf2	25 Aug 2011
Cetaphil/Aquanil Cleanser Lotion Topical	Instead Of Soap Ud (But The Best Soap Is No Soap) #2 Rf6	20 Jul 2011

4. HOSPITALIZATIONS / SURGERIES**5. Counseling****6. FAMILY HISTORY** (M = Mother, F = Father, S = Son, D = Daughter, B = Brother, N = Niece, MGM/PGM = Maternal/Paternal Grandmother, MGF/PGF = Maternal/Paternal Grandfather, MNU = Maternal/Paternal Uncle, MPA = Maternal/Paternal Aunt, Other = Other)

DD FORM 2766, MAR 1998 (Automated Version) (EF-V2)

PAGE 1 OF 4 PAGES

**ADVANCED DIRECTIVES:
PATIENT'S IDENTIFICATION**

Name: MERWIN, DANIEL DENNIS
 Sex: M DOB: [REDACTED] 1985
 SSN: [REDACTED]
 FMP/Sponsor SSN: 20/[REDACTED]

RECORDS MAINTAINED AT:

CARRY OUTPAT RECS

RELATIONSHIP TO SPONSOR

Sponsor

STATUS

Active Duty

RANK/GRADE

SEAMAN APPRENTICE

SPONSOR'S NAME (Last, First, Middle Initial)

MERWIN, DANIEL DENNIS

DEPT/SERVICE

Navy AR 3292

ORGANIZATION

N4197660

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP	YES	X	NO
b. FLYING STATUS	YES	X	NO

9. IMMUNIZATIONS (Enter numeric calls in sub block)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)
a. HEP A #1	08 NOV 2005	f. MMR #1	08 NOV 2005	j. TD (q 10 yrs) (Last)	08 NOV 2005		
b. HEP A #2	14 DEC 2005	g. MMR #2		k. TD (Due)	08 NOV 2015		
c. HEP B #1	08 NOV 2005	h. PNEUMOCOCCUS		l. YELLOW FEVER (Last)	14 DEC 2005		
d. HEP B #2	14 DEC 2005	i. POLIO OPV = 0 IPV = 1	08 NOV 2005	m. YELLOW FEVER (Due)	14 DEC 2015		
e. HEP B #3							
n. TYPHOID (Enter numeric class in sub block) ORAL = 0 TYPHIM Vi = 1, TYPHOID USP = 2	(1) DATE 2 14 APR 2006	(2) DATE 2 19 FEB 2008		(3) DATE	(4) DATE	(5) DATE	(6) DATE
o. ANTHRAX	(1) INITIAL DATE 01 OCT 2007	(2) 2 WEEK DATE 20 OCT 2007	(3) 4 WEEK DATE 13 NOV 2007	(4) 6 MONTH DATE 05 MAY 2008	(5) 12 MONTH DATE 09 MAR 2010	(6) 18 MONTH DATE	
p. IPPD (Enter mm and date)	(1)(a) mm 0	(2)(a) mm	(3)(a) mm	(4)(a) mm	(5) (a) mm	(6)(a) mm	(7)(a) mm
	(b) DATE 17 MAR 2010	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE
q. INFLUENZA	(1) DATE 08 NOV 2005	(2) DATE 23 SEP 2009	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE
s. MENINGO	(1) DATE 08 NOV 2005	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE	
t. ADENO	(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE	

10. READINESS

* (Glucose-6-phosphate dehydrogenase)

a. DNA	DATE:	b. BLOOD TYPE	DATE:	RESULT:	c. G6PD*	DATE:	RESULT:	d. SICKLE CELL	DATE:	RESULT:
						06 NOV 2005	Normal		06 NOV 2005	Negative
e. PERMANENT PROFILE CHANGE	(1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:			
f. GLASSES/GAS MASK Rx:	(1) DATE 08 FEB 2011	(2) DATE 17 MAR 2010	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
g. DENTAL EXAM (Enter numeric class in sub block)	(1) DATE 1 11 SEP 2009	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
h. HIV TESTING	(1) DATE 09 MAR 2010	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
i. FITNESS (in sub block enter P=Pass, F=Fail, W=Waiver)	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION	(1) PREDEPLOYMENT	(2) POSTDEPLOYMENT
	(a) DATE	(b) DATE
	(c) DATE	(d) DATE
	(e) DATE	(f) DATE
b. LOCATION		
	(a) DATE	(b) DATE
	(c) DATE	(d) DATE
	(e) DATE	(f) DATE
c. CHART AUDIT		

PRIVACY ACT STATEMENT***THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU*****AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN).**

Sections 133, 1071.87, 3012, 5031 and 8012, title 10, United States Codes and Executive Order 9397.

PRINCIPLE PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) is required to identify and retrieve health records.

ROUTINE USES

The primary use of this information is to provide, plan, and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state or local government upon request in the pursuit of their official duties.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the information is not furnished, comprehensive health care may not be possible, but CARE WILL.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

By printing and placing in the medical record, providers are verifying that the vaccines annotated were administered and current CDC published Vaccine Information Sheets (VIS) or Important Information Sheet was given to the parent, legal guardian or patient. This form complies with all federal record keeping requirements of the National Childhood Vaccine Injury Act of 1986 as amended 14 December 1993. Parent, guardian, or patient signature is not required unless state law mandates a guardian signature and proof of informed consent. Local VIS's may be developed for vaccines not covered by CDC Publications. This document complies with article 80 of the WHO International health regulations and can be used in place of the PHS 731 when traveling outside the United States.

Vaccine	Series	Date	Manufacturer	Lot Number	Dose/Site	Exemption	Administering Tech
Anthrax	1	1 Oct 2007	Other	FAV114	/	None	
VIS Version(s): N/A							
Anthrax	2	20 Oct 2007	Other	FAV114	/	None	
VIS Version(s): N/A							
Anthrax	3	13 Nov 2007	Other	FAV114	/	None	
VIS Version(s): N/A							
Anthrax	4	5 May 2008	Unknown	UNK	/	None	
VIS Version(s): N/A							
Anthrax	5	9 Mar 2010	Emergent BioDefense Operations Lansing	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Hep A (Adult)	1	8 Nov 2005	Unknown	UNKNOWN	/	None	
VIS Version(s): N/A							
Hep A (Adult)	2	14 Dec 2005	Unknown	UNKNOWN	/	None	
VIS Version(s): N/A							
Hep A - Hep B (Twinrix)	1	8 Nov 2005	Other	AHABB043BA	/	None	
VIS Version(s): N/A							
Hep A - Hep B (Twinrix)	1	14 Dec 2005	Other	AHABB043BA	/	None	
VIS Version(s): N/A							
Hep B - Adult	1	8 Nov 2005	Unknown	UNKNOWN	/	None	
VIS Version(s): N/A							
Hep B - Adult	2	14 Dec 2005	Unknown	UNKNOWN	/	None	
VIS Version(s): N/A							
Influenza	0	23 Sep 2009	MedImmune, Inc.	500719P	.25 mL/Intranasal	None	
VIS Version(s): N/A							
Influenza	1	2 Nov 2011	Sanofi Pasteur	ut423aa	.5 mL/Unknown	None	
VIS Version(s): N/A							
Influenza NOS	1	1 Nov 2005	MedImmune, Inc.	500388P	/	None	
VIS Version(s): N/A							
Influenza NOS	0	12 Nov 2006	Other	AFLUA219BA	/	None	
VIS Version(s): N/A							
Influenza NOS	0	16 Jan 2008	Unknown	UNKNOWN	/	None	
VIS Version(s): N/A							
Influenza Split Virus	0	8 Nov 2005	Other	U1911AA	/	None	
VIS Version(s): N/A							
Influenza, H1N1 (Injectable)	0	22 Dec 2009	Novartis Pharmaceutical Corp.	104040P1	.5 mL/Left Arm	None	
VIS Version(s): N/A							
Influenza, Live, Intranasal	0	23 Sep 2009	MedImmune, Inc.	500719P	/	None	
VIS Version(s): N/A							

IMMUNIZATION KI 2480 LLEWELLYN AVE FORT GEORGE G MEADE, MARYLAND 20755	Name:	MERWIN DANIEL DENNIS	Sex:	M
	Status:	AD / N2153370	Rank:	PO2
	Service:	Navy	Sponsor's SSN:	20 / [REDACTED]
			DOB:	[REDACTED] 1985



FILE AS PAGE DIRECTLY BEHIND DD FORM 2766 ON LEFT SIDE OF MEDICAL RECORD

VACCINE ADMINISTRATION RECORD**(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)**


This document complies with Article 36 and Annex 6 of the World Health Organization International Health Regulations (IHR) of 2005. International Health Regulations call for this document to be accepted in lieu of the International Certificate of Vaccination (PHS Form 731) when traveling outside the United States. In accordance with the IHR, this automated record is an equivalent document issued by the United States Armed Forces.

By inserting the Vaccine Information Statement (VIS) version date in the applicable field, providers verify that the vaccine(s) annotated were administered and current VISs were given to the parent, legal guardian or patient. This form complies with federal record-keeping requirements of the National Childhood Vaccine Injury Act of 1986 as amended 14 December 1993. Parent, guardian, or patient signature is not required unless state law mandates a guardian signature and proof of informed consent.

Vaccine (Series)	Date	Manufacturer	Lot Number	Dosage	VIS Version	Administering Tech
Anthrax(1)	1 Oct 2007	Other	FAV114			
Anthrax(2)	20 Oct 2007	Other	FAV114			
Anthrax(3)	13 Nov 2007	Other	FAV114			
Anthrax(4)	5 May 2008	Unknown	UNK			
Anthrax(5)	9 Mar 2010	Biopart Corporation	UNK			
Hep A (Adult)(1)	8 Nov 2005	Unknown	UNKNOWN			
Hep A (Adult)(2)	14 Dec 2005	Unknown	UNKNOWN			
Hep A-Hep B(1)	8 Nov 2005	Other	AHABB043BA			
Hep A-Hep B(1)	14 Dec 2005	Other	AHABB043BA			
Hep B - Adult(1)	8 Nov 2005	Unknown	UNKNOWN			
Hep B - Adult(2)	14 Dec 2005	Unknown	UNKNOWN			
Influenza Split Virus	8 Nov 2005	Other	U1911AA			
Influenza, live, intranasal	23 Sep 2009	MedImmune, Inc.	500719P			
Influenza, live, intranasal	15 Nov 2010	MedImmune, Inc.	501061P			
Influenza, live, intranasal	24 Oct 2012	CSL Biotherapies, Inc.	AH2139			
Influenza, unspecified	1 Nov 2005	MedImmune, Inc.	500388P			
Influenza, unspecified	12 Nov 2006	Other	AFLUA219BA			
Influenza, unspecified	16 Jan 2008	Unknown	UNKNOWN			
Influenza, whole	2 Nov 2011	Unknown	UNK			
IPV(1)	8 Nov 2005	Other	Y0535			
Meningococcal MPSV4	8 Nov 2005	Other	UE359AA			
MMR(1)	8 Nov 2005	Merck & Co., Inc.	0298R			
Novel Influenza-H1N1-09(0)	22 Dec 2009		104040P1			
PPD N/0mm	19 Mar 2013	Parkedale Pharmaceutic	293238	0.1 mL		Wray, KIM
Td (Adult), adsorbed	8 Nov 2005	Other	U1586BA			
Td (Adult), adsorbed	19 Mar 2013	Sanofi Pasteur	u4422aa			
Tdap	19 Mar 2013	Sanofi Pasteur	u4422aa	0.5 mL		Wray, KIM
Typhoid, parenteral	14 Apr 2006	Unknown	UNKNOWN			
Typhoid, parenteral	19 Feb 2008	Unknown	UNKNOWN			
Typhoid, VICPs	19 Mar 2013	Sanofi Pasteur	h1481	0.5 mL		Wray, KIM
Yellow Fever	14 Dec 2005	Other	UE351AA			

LAST ITEM**DO NOT MAKE ENTRIES BELOW THIS BLOCK**

Allergy and Immunization Clinic
2480 LLEWELYN AVE STE 5800
FORT GEORGE G. MEADE, MD 20755-5129
301-677-8522



Kimbrough Ambulatory Care Center 2480 LLEWELYN AVE FORT GEORGE G. MEADE, MARYLAND 20755-5800 301 677 8242	Name: Merwin Daniel D		Sex: M
	Status: AD		Rank: E5
	Service: Navy	Sponsor's SSAN: [REDACTED]	DOB: [REDACTED] 1985

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

1. ALLERGIES

Allergen	Reaction	Information Source	Onset Date
OTHER	Unknown	Unknown Source of Info	11/07/2005

Feathers, CATS

2. CHRONIC ILLNESSES

Chronic Illness	Date
Allergic Rhinitis	17 MAR 2010
Visit For: Occupational Health/fitness Exam	17 MAR 2010
Parent Education About Immunizations	23 SEP 2009
Visit For: Military Services Physical	16 SEP 2009
Exposure To Venereal Disease	20 AUG 2009
Inquiry And Counseling About Contraceptive Practices	07 MAY 2009
Visit For: Administrative Purposes	07 MAY 2009

3. MEDICATIONS

4. HOSPITALIZATIONS / SURGERIES

5. Counseling

6. FAMILY HISTORY

DD FORM 2766, MAR 1998 (Automated Version) (EF-V2)

PAGE 1 OF 4 PAGES

ADVANCED DIRECTIVES:
PATIENT'S IDENTIFICATION

Name: MERWIN, DANIEL DENNIS
 Sex: M DOB: [REDACTED] 1985
 SSN: [REDACTED]
 FMP/Sponsor SSN: 20/[REDACTED]

RECORDS MAINTAINED AT:

CORRY OUTPAT RECS

RELATIONSHIP TO SPONSOR	STATUS
Sponsor	Active Duty

SPONSOR'S NAME (Last, First, Middle Initial)
 MERWIN, DANIEL DENNIS

ORGANIZATION
 N4197660

RANK/GRADE
PETTY OFFICER THIRD CLASS

DEPT/SERVICE
Navy

AR 3297

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

7. SCREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Note Indicated) (= Next Due)

a. TEST	b. FREQUENCY	c. YEAR d. AGE	2010 25	2009 24	e. DATES
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL				
*(2) WEIGHT	ANNUAL FOR ACTIVE DUTY		150	145	
*(3) HEIGHT	ANNUAL FOR ACTIVE DUTY		69.5 in	68 in	
*(4) BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85. ANNUAL IF GREATER		102/60	120/79	
*(5) CHOLESTEROL**	q 5 YRS FOR AGE >= 18 q YR IF PREV ABN		170	190	
(6) HEARING	CLINICIAN'S DISCRETION				
(7) SKIN EXAM (Cancer)	ANNUAL IF AT RISK				
(8) ORAL/DENTAL**	ANNUAL			11 SEP 2009	
(9) EYE/VISION**	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUALLY GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 yrs age 40-64	17 MAR 2010			
(10) BREAST EXAM	ANNUAL: > 40 YRS				
(11) MAMMOGRAM**	BASELINE @40, q 2 YRS 40-50, ANNUALLY > 50				
(12) PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS. PERFORM q 1-3 YEARS				
(13) FECAL OCCULT BLOOD	ANNUAL: > 50 YRS				
(14) SIGMOID	EVERY 3-5 YRS: > 50 YRS				
(15) COLONOSCOPY**	HIGH RISK q 5 YRS: > 40 YRS				
(16) TESTICULAR**	HIGH RISK ANNUAL 13-39 YRS				
(17) PROSTATE** ** (Digital Rectal Exam)	WITH P.E. > 40 YRS (Presently recommended annually)				
(18) RUBELLA SCREEN (Females)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)				
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES				
(20)					
(21)					
(23)					

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP YES X NO
 b. FLYING STATUS YES X NO

9. IMMUNIZATIONS (Enter numeric calls in sub block)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)
a. HEP A #1	08 NOV 2005	f. MMR #1	08 NOV 2005	j. TD (q 10 yrs) (Last)	08 NOV 2005		
b. HEP A #2	14 DEC 2005	g. MMR #2		k. TD (Due)	08 NOV 2015		
c. HEP B #1	08 NOV 2005	h. PNEUMOCOCCUS		l. YELLOW FEVER (Last)	14 DEC 2005		
d. HEP B #2	14 DEC 2005	i. POLIO OPV = 0 IPV = 1	08 NOV 2005	m. YELLOW FEVER (Due)	14 DEC 2015		
e. HEP B #3							
n. TYPHOID (Enter numeric class in sub block) ORAL = 0 TYPHIM VI = 1. TYPHOID USP = 2		(1) DATE 2 14 APR 2006	(2) DATE 2 19 FEB 2008	(3) DATE	(4) DATE	(5) DATE	(6) DATE
o. ANTHRAX	(1) INITIAL DATE 01 OCT 2007	(2) 2 WEEK DATE 20 OCT 2007	(3) 4 WEEK DATE 13 NOV 2007	(4) 6 MONTH DATE 05 MAY 2008	(5) 12 MONTH DATE 09 MAR 2010	(6) 18 MONTH DATE	
p. IPPD (Enter mm and date)	(1)(a) mm (b) DATE	(2)(a) mm (b) DATE	(3)(a) mm (b) DATE	(4)(a) mm (b) DATE	(5) (a) mm (b) DATE	(6)(a) mm (b) DATE	(7)(a) mm (b) DATE
q. INFLUENZA	(1) DATE 08 NOV 2005	(2) DATE 23 SEP 2009	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE
s. MENINGO	(1) DATE 08 NOV 2005	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE	
t. ADENO	(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE	

10. READINESS

* (Glucose-6-phosphate dehydrogenase)

a. DNA DATE	b. BLOOD TYPE DATE	RESULT	c. G6PD* DATE	RESULT	d. SICKLE CELL DATE	RESULT
15 Dec 05	06 Nov 05	0 pos	06 NOV 2005	Normal	06 NOV 2005	Negative
e. PERMANENT PROFILE CHANGE (1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:
f. GLASSES/GAS MASK Rx: (1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	
17 MAR 2010						
g. DENTAL EXAM (Enter numeric class in sub block) (1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	
11 SEP 2009						
h. HIV TESTING (1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	
09 MAR 2010						
i. FITNESS (in sub block enter P=Pass, F=Fail, W=Waiver) (1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION

(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE

b. LOCATION

(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE

c. CHART AUDIT

PRIVACY ACT STATEMENT

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU

AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN).

Sections 133, 1071.87, 3012, 5031 and 8012, title 10, United States Codes and Executive Order 9397.

PRINCIPLE PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) is required to identify and retrieve health records.

ROUTINE USES

The primary use of this information is to provide, plan, and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state or local government upon request in the pursuit of their official duties.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the information is not furnished, comprehensive health care may not be possible, but CARE WILL.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

1. ALLERGIES
MEDICATION ALLERGIES

{ FEATHERS }

b. OTHER ALLERGIES

3. MEDICATIONS

FEATHERS, CATS

2. CHRONIC ILLNESSES

4. HOSPITALIZATIONS / SURGERIES

TONSILLECTOMY

AGE 13

5. COUNSELING

F FITNESS

D DENTAL

I INJURY PREVENTION

N NUTRITION / FOLATE

C CANCER PREVENTION

S SAFE SEX

FP FAMILY PLANNING

Rx PRESENT MEDICATIONS

MH MENTAL HEALTH / STRESS / SUICIDE / OCCUPATIONAL STRESS

H HORMONE / CALCIUM REPLACEMENT

To TOBACCO

A ALCOHOL / SUBSTANCE ABUSE

T TRAVEL

O OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES / CUMULATIVE TRAUMA DISORDER)

a. DATE

b. AGE

c. TOPIC

4/10/13

F, D, C, S

d. DATE

e. AGE

f. TOPIC

g. DATE

h. AGE

i. TOPIC

j. DATE

k. AGE

l. TOPIC

ADVANCED DIRECTIVES: DATE FILED

(Use this space for mechanical imprint)

PATIENT'S IDENTIFICATION

RECORDS MAINTAINED AT: USS ESSEX

PATIENT'S NAME

LAST

MERWIN

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME (Last, First, Middle Initial)

ORGANIZATION

USS ESSEX

FIRST

DANIEL

STATUS

ADULT PREVENTIVE AND CHRONIC CARE FLOW SHEET

(Continuation Sheet)

FAMILY HISTORY (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather)

F-MI PGF-MI
Sub, E, PGF & PGM

CANCER (SPECIFY)

CARDIOVASCULAR DISEASE (SPECIFY)

DIABETES (SPECIFY)

MENTAL ILLNESS / CHEMICAL DEPENDENCY (SPECIFY)

7. SCREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Not Indicated) (● = Next Due)

a. TEST	b. FREQUENCY	c. YEAR	d. AGE	e. DATES
* (1) CLINICAL DISEASE PREV EVAL / PHA (HEAR)	ANNUAL			
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY			
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY			
* (4) BLOOD PRESSURE	ONCE q 2 YRS FOR BP			
* (5) CHOLESTEROL **	130 / 85, ANNUAL IF GREATER			
(6) HEARING	q 5 YRS FOR AGE ≥ 18			
(7) SKIN EXAM (CANCER)	q YR IF PREV ABN			
(8) ORAL / DENTAL **	CLINICIAN'S DISCRETION			
(9) EYE / VISION **	ANNUAL IF AT RISK			
(10) BREAST EXAM **	ANNUAL			
(11) MAMMOGRAM **	ROUTINE ACUITY WITH PERIODIC ASSESSMENT			
(12) PAP	DIABETES ANNUALLY			
** DIGITAL RECTAL EXAM	GLAUCOMA CHECK:			
(13) FECAL OCCULT BLOOD	BLACKS q 3-5 YRS AGE 20-39			
(14) SIGMOID	ALL q 2-4 YRS AGE 40-54			
(15) COLONOSCOPY **	q ANNUAL: ≥ 40 YRS			
(16) TESTICULAR **	BASELINE @ 40, q 2 YRS 40-50			
(17) PROSTATE **	ANNUAL > 50			
** DIGITAL RECTAL EXAM	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY			
(18) RUBELLA SCREEN (FEMALES)	AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 YEARS			
(19) OCCUPATIONAL SCREENING EXAMS	ANNUAL: ≥ 50 YRS			
(20)	EVERY 3-5 YRS: ≥ 50 YRS			
(21)	HIGH RISK q 5 YRS: ≥ 40 YRS			
(22)	HIGH RISK ANNUAL 13-35 YRS			
	WITH P.E.: ≥ 40 YRS PRESENTLY			
	RECOMMENDED ANNUALLY			
	ONCE BETWEEN AGES 12-18 YRS			
	(UNLESS PREV VACCINATED)			
	APPROPRIATE TO EXPOSURES			

DD FORM 2786

AR 3302

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(Continuation Sheet)

8. OCCUPATIONAL HISTORY / RISK

a. PRP ☐ YES ☒ NO

b. FLYING STATUS ☐ YES ☐ NO

9. IMMUNIZATIONS (ENTER NUMERIC CLASS IN SUB BLOCK)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)
a. HEP A #1	08NOV2005	f. MMR #1	08NOV2005	j. TD (q 10 YRS) (LAST)	08NOV2005		
b. HEP A #2	14DEC2005	g. MMR #2		k. TD (DUE)	06NOV2015		
c. HEP B #1	08NOV2005	h. PNEUMOCOCCUS		l. YELLOW FEVER (LAST)	14DEC2005		
d. HEP B #2	14DEC2005	i. POLIO OPV = 0 IPV = 1	I 08NOV2005	m. YELLOW FEVER (DUE)	12DEC2015		
e. HEP B #3							
n. TYPHOID (ENTER NUMERIC CLASS IN SUB BLOCK) ORAL = 0 TYPHUM VI = 1, TYPHOID USP = 2	(1) DATE <input type="checkbox"/> 2 19FEB2008	(2) DATE <input type="checkbox"/>	(3) DATE <input type="checkbox"/>	(4) DATE <input type="checkbox"/>	(5) DATE <input type="checkbox"/>	(6) DATE <input type="checkbox"/>	
o. ANTHRAX	(1) INITIAL DATE 01OCT2007	(2) 2 WEEK DATE 20OCT2007	(3) 4 WEEK DATE 13NOV2007	(4) 6 MONTH DATE 05MAR08	(5) 12 MONTH DATE 01NOV08	(6) 18 MONTH DATE	
p. PPD (ENTER MM AND DATE)	(1) (a) mm ZERO (b) DATE 22OCT2007	(2) (a) mm (b) DATE	(3) (a) mm (b) DATE	(4) (a) mm (b) DATE	(5) (a) mm (b) DATE	(6) (a) mm (b) DATE	(7) (a) mm (b) DATE
q. INFLUENZA	(1) DATE 16JAN2008	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE
s. MENINGO	(1) DATE 08NOV2005	(2) DATE	v. OTHER (SPECIFY)	(1) DATE	(2) DATE	(3) DATE	
t. ADENO	(1) DATE	(2) DATE	w. OTHER (SPECIFY)	(1) DATE	(2) DATE	(3) DATE	

10. READINESS

GLUCOSE - 6 - PHOSPHATE DEHYDROGENASE

a. DNA VERIFIED	DATE: 27APR2006	b. BLOOD TYPE	DATE: 06NOV2005	RESULT: O-POS	c. G6PD *	DATE: 06NOV2005	RESULT: POS	d. SICKLE CELL	DATE: 06NOV2005	RESULT: NEG
e. PERMANENT PROFILE CHANGE	(1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:			
f. GLASSES / GAS MASK Rx:	(1) DATE 07NOV2005	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
g. DENTAL EXAM (ENTER NUMERIC CLASS IN SUB BLOCK)	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
h. HIV TESTING	(1) DATE 07DEC2006	(2) DATE 02OCT07	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
i. FITNESS (IN SUB BLOCK ENTER P = PASS, F = FAIL, W = WAIVER)	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				

11. PRE / POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	05FEB2008	O	O	O	O	O

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

[illegible]

REMARKS

PATIENT'S IDENTIFICATION (Use this space for mechanical imprint)	RECORDS MAINTAINED AT:		
	USS ESSEX		
	PATIENT'S NAME		SEX
	LAST	FIRST	M.I.
	MERWIN	DANIEL	M
	RELATIONSHIP TO SPONSOR		STATUS
		RANK / GRADE	
		ABH3	
SPONSOR'S NAME (Last, First, Middle Initial)		DEPT / SERVICE	
		USN	
ORGANIZATION	SSN / ID NUMBER	DATE OF BIRTH	
USS ESSEX		1985	

Scantron System Report

NAVHOPGLAKESINST 6150.3C

Summary Of Care*(This form is subject to the Privacy Act Of 1974)*

	Significant Health Problem	Date	Medical Alert (SBE Prophylaxis, Allergies, Other)		
1			Allergic To: FEATHERS		
2					
3					
4			Alcohol: Never		
5			Tobacco:		
6			Medications	Start	Stop
7					
8					
9					
10					
11					
	Exceptional Family Member Prog	Date	Health Maintenance	Results	Date of Last Test
	Hospitalization/Surgery				(Pencil Entry)
1			Prostate Exam		
2			RPR	NK	11/6/2005
3			G6PD/GPAB	NK	11/6/2005
4			Stool GUAIAC		
5			Mammogram		
6			Chest X-Ray		
7			ECG		
8			Birth Control Method		
9			PAP Smear		
10	Advance Directive Provided:		Sickle Cell Trait	NEG	11/6/2005
11	Advance Directive Provided:		HIV Screen		
12			Blood Type	OPOS	11/6/2005

(Continue Significant Health Problems, Medications, Hospitalizations / Surgery On Reverse)

Space For Mechanical Imprint		Name Of Patient (Last, First, Middle Initial)		Sex
		MERWIN, DANIEL		USN
		Year Of Birth	Name Of Sponsor	
		1985		
		SSN Or ID No.	Relationship To Sponsor	
Case File Maintained At:			AR 3305	

HEALTH RECORD**IMMUNIZATION RECORD***All entries
made in***VACCINATION AGAINST SMALLPOX** (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	19 Feb 68	.5 cc	HM ² BSBIC	4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type or Print):

Merwin, Daniel
 20/ [REDACTED]
 601-105 USN ABH³ [REDACTED] 85

▶ Patient's Name—last, first, middle initial;
 Sex; Age or Year of Birth; Relationship to Sponsor;
 Component/Status; Department/Service.

▶ Sponsor's Name—last, first, middle initial;
 Rank/Grade; SSN or Identification Number;
 Organization.

IMMUNIZATION RECORD

Standard Form 601—October 1975 (Rev.)
 General Services Administration & Interagency
 Committee on Medical Records
 FIRM (41 CFR) 201-45.505

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	12 NOV 06	.5cc	HMB HALL	3	15 NOV 10	.5cc	HMB CRUMPTON
2	16 JAN 08	.2cc	HMB AL-AMIN	4			

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1					5				
2					6				
3					7				
4					8				

SENSITIVITY TESTS (Tuberculin, etc.)

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	25 SEP 07	PPD	.1 ml	ID (L)FA		
2	000907	PPD	.1 ml	ID (L)FA	Zero mm	HMB Spahr
3	01 NOV 08	PPD	0.1cc	ID		
4	06 FEB 09	PPD	.1 mL	ID (L)FA		
5	17 MAR 10	PPD	.1 mL	ID (L)FA		

REMARKS:

SAFEGUARD IAW PRIVACY ACT 1974

Immunization Record Report

16DEC2005

BRANCH MED CLIN RTC GREAT LAKES

UIC: 45009

Page203

Rank/Rate	Name	SSN	DOB	Sex	Dept	Div
	MERWIN DANIEL	[REDACTED]	[REDACTED] 1985	M	06	041

Immunization Name HEP A - HEP B	BSC # 1/	Last Date 08NOV2005	Dose 1.0 cc	Route IM	Reaction
Manufacture Name SMITHKLINE BEECHAM BIO	Lot ID AHABB043BA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name HEP A - HEP B	BSC # 1/	Last Date 14DEC2005	Dose 1.0 cc	Route IM	Reaction
Manufacture Name SMITHKLINE BEECHAM BIO	Lot ID AHABB043BA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 JACKSON, E				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name INFLUENZA, NOS	BSC # 1/	Last Date 01NOV2005	Dose 0.5 cc	Route NASAL	Reaction
Manufacture Name MEDIMMUNE INC	Lot ID 500388P			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. TYLER WATSON				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name INFLUENZA, SPLIT	BSC # A/	Last Date 08NOV2005	Dose 0.5 cc	Route IM	Reaction
Manufacture Name AVENTIS PASTEUR INC	Lot ID U1911AA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Date	Type	Dose	Route	Results	Physician's Name
05NOV05	PPD 1/5	TBU 0.1ml	Intradermal	ZERO	HM3 Mitchell
05NOV05	DNA drawn at BMC 1523 Great Lakes, IL				HM3(SW)Verner

Immunization Record Report

16DEC2005

BRANCH MED CLIN RTC GREAT LAKES

UIC: 45009

Page204

Rank/Rate	Name	SSN	DOB	Sex	Dept	Div
	MERWIN DANIEL	[REDACTED]	[REDACTED] 1985	M	06	041

Immunization Name IPV	BSC # 1/	Last Date 08NOV2005	Dose 0.5 cc	Route SC	Reaction
Manufacture Name AVENTIS PASTEUR INC	Lot ID Y0535			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name MENINGOCOCCAL	BSC # 1/	Last Date 08NOV2005	Dose 0.5 cc	Route SC	Reaction
Manufacture Name AVENTIS PASTEUR INC	Lot ID UE359AA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name MMR	BSC # 1/	Last Date 08NOV2005	Dose 0.5 cc	Route SC	Reaction
Manufacture Name MERCK & CO INC	Lot ID 0298R			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Immunization Name TD (ADULT)	BSC # 1/	Last Date 08NOV2005	Dose 0.5 cc	Route IM	Reaction
Manufacture Name AVENTIS PASTEUR INC	Lot ID U1586BA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 (SW) Verner				
Read Date / /	Result	Health Care Prov. Reading			

Date	Type	Dose	Route	Results	Physician's Name
05NOV05	PPD 1/5	TBU 0.1ml	Intradermal	ZERO	HM3 Mitchell
05NOV05	DNA drawn at BMC 1523 Great Lakes, IL				HM3(SW)Verner

SAFEGUARD IAW PRIVACY ACT 1974

16DEC2005

Immunization Record Report

Page 205

BRANCH MED CLIN RTC GREAT LAKES

UIC: 45009

Rank/Rate	Name	SSN	DOB	Sex	Dept	Div
	MERWIN DANIEL	[REDACTED]	[REDACTED] 1985	M	06	041

Immunization Name YELLOW FEVER	BSC # 1/	Last Date 14DEC2005	Dose 0.5 cc	Route SC	Reaction
Manufacture Name AVENTIS PASTEUR INC	Lot ID UE351AA			Exception Code	
Admin. Facility BRANCH MED CLIN RTC GREAT LAKES	Health Care Prov. HM3 JACKSON, E				
Read Date / /	Result	Health Care Prov. Reading			

MERWIN 2489
 DNA Verified with AFRSSIR
 Collection Date: 12/15/05
 Date Verified: 4/27/06

Date	Type	Dose	Route	Results	Physician's Name
05NOV05	PPD 1/5	TBU 0.1ml	Intradermal	ZERO	HM3 Mitchell
05NOV05	DNA drawn at BMC 1523 Great Lakes, IL				HM3(SW)Verner

HEALTH RECORD**ANTHRAX IMMUNIZATION RECORD**All entries in ink to be
made in block letters

Date Vaccine Information Sheet Provided

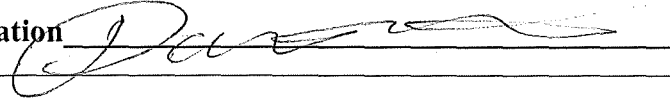
Date Given	Dosage No. or booster	Dosing Schedule (From day 0)	Dose (ml)	Site (left or right arm)	Lot Number	Provider	Administering Facility	Comments
6 OCT 07	1	Day 0	0.5	① ARM	FAV 114	AMZ DEAMENY	USC ESSEX	
20 OCT 07	2	2 weeks	0.5	② ARM	FAV 114	1 FOR 10H	ESSEX	
13 NOV 07	3	4 weeks	0.5	③ ARM	FAV 114	Claus	ESSEX	
25 MAY 08	4	6 months	0.5	④	FAV 173	RONDE	ESSEX	
01 NOV 08	5	12 months	0.5	⑤	FAV 143	Grace	Essex	
20 MAR 09	6	18 months	0.5	⑥	FAV 226	AM3 WILLIAMS	NORFOLK	
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					
	Booster	Annual	0.5					

Anthrax Vaccine Dosing

Basic vaccination series consists of 6 shots over 18 months, given as indicated above. The following intervals between doses must be maintained: the 2nd dose is given 2 weeks after the 1st dose; the 3rd dose is given 2 weeks after the 2nd dose; the 4th dose is given 5 months after the 3rd dose; the 5th dose is given 6 months after the 4th dose; and the 6th dose is given 6 months after the 5th dose. If one is late for a dose, or strays from the established schedule, the next dose due should be given, with the intervals for the remaining doses maintained. A booster dose should be administered every 12 months. If an adverse reaction occurs following an anthrax vaccination, note in "comments" block above and on a SF 600. If a severe reaction occurs, further administration of anthrax vaccine should be discontinued.

Unless otherwise indicated, the manufacturer of Anthrax Vaccine, Adsorbed, is Michigan Biologic Products Institute.

I have been briefed on the Anthrax Vaccination


PATIENT'S IDENTIFICATION

Use this space for mechanical imprint:

RECORDS

MAINTAINED AT:

PATIENT'S NAME

M. BROWN, DANIEL

RELATIONSHIP TO SPONSOR

STATUS

A

SEX

M

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

NAVY

DEPT./SERVICE

AIR/US

SSN/ID NO.

DATE OF BIRTH

10/18/85

Chronological Record of HIV Testing

<u>Barcode</u>	<u>Last Name</u>	<u>HIV Result</u>	<u>Source of Test</u>	<u>Date Drawn</u>	<u>Specimen UIC</u>
N31B077456	MERWIN	Negative	F	10/2/08	21533
N08 388784	MERWIN	Negative	P	11/3/05	N00211
DMDC332301	MERWIN	Negative	E	10/13/05	

Patient Identification:**Name:** MERWIN, DANIEL D**SSN:** [REDACTED]**Command/UIC:** 21533**Branch:** Navy **Gender:** Male**DOB:** [REDACTED] 85 **Status:** Active **Rank:** E04

REFERENCE AUDIOGRAM										1. ZIP CODE/APO/FPO/PAS				
(This form is subject to the Privacy Act of 1974 - use Blanket PAS - DD Form 2005)										45943				
2. DOD COMPONENT					3. SERVICE COMPONENT									
<div style="display: flex; justify-content: space-between;"> N A - ARMY N - NAVY F - AIR FORCE M - MARINE CORPS 1 - OTHER </div>					<div style="display: flex; justify-content: space-between;"> R R - REGULAR V - RESERVE G - NATIONAL GUARD 1 - OTHER </div>									
4. SOCIAL SECURITY NUMBER			5. NAME (Last, First, Middle Initial)						6. DATE OF BIRTH		7. SEX			
[REDACTED]			MERWIN, DANIEL D						[REDACTED] 1985		<div style="display: flex; justify-content: space-between;"> M M - MALE F - FEMALE </div>			
8. PAY GRADE UNIFORMED SERVICES		9. PAY GRADE CIVILIAN		10. SERVICE DUTY OCCUPATION CODE			11. MAILING ADDRESS OF ASSIGNMENT							
E01				9999			00763 GREAT LAKES IL 60088							
12. LOCATION - PLACE OF WORK					13. MAJOR COMMAND			14. DUTY TELEPHONE (Include area code)						
60088					NAVCROUTCOM			() - -						
AUDIOMETRY														
15. REASON FOR CONDUCTING AUDIOGRAM														
<div style="display: flex; justify-content: space-between;"> 1 1 - REFERENCE ESTABLISHED PRIOR TO INITIAL DUTY IN HAZARDOUS NOISE AREAS 2 - REFERENCE ESTABLISHED FOLLOWING EXPOSURE IN NOISE DUTIES 3 - REFERENCE RE-ESTABLISHED AFTER FOLLOW-UP PROGRAM </div>														
16. AUDIOMETRIC DATA RE: ANSI S3.6 - 1996		LEFT						RIGHT						
		500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000	
17. DATE OF AUDIOGRAM		5	10	10	15	10	5	5	10	5	15	15	0	
07 Nov 2005														
18. MEETS REFERRAL CRITERIA			19. MILITARY TIME OF DAY (Optional)			20. HOURS SINCE LAST NOISE EXPOSURE			21. EAR, NOSE, AND THROAT PROBLEM AT TIME OF TEST					
<div style="display: flex; justify-content: space-between;"> N/A 1 - NO 2 - YES </div>			09:49			14			<div style="display: flex; justify-content: space-between;"> 3 1 - NO 2 - YES 3 - UNKNOWN </div>					
22. EXAMINER														
a. NAME (Last, First, Middle Initial)					b. TRAINING CERTIFICATION NUMBER			c. SERVICE DUTY OCCUPATION CODE		d. OFFICE SYMBOL				
BARON, LUCIANO A					0412109N			0640		BHDJ				
23. AUDIOMETER														
a. TYPE			b. MODEL			c. MANUFACTURER			d. SERIAL NUMBER		e. LAST ELECTROACOUSTIC CALIBRATION DATE			
<div style="display: flex; justify-content: space-between;"> 3 1 - MANUAL 2 - SELF-RECORDING (Automatic) 3 - MICROPROCESSOR </div>			CCA-200			MAICO Inc.			20624		04 August 2005			
24. PERSONAL HEARING PROTECTION														
a. TYPE ISSUED				b. SIZE EARPLUGS			c. DOUBLE PROTECTION USED		d. GLASSES WORN		e. FREQUENCY GLASSES WORN			
<div style="display: flex; justify-content: space-between;"> 7 1 - SINGLE FLANGE (V51R) 2 - TRIPLE FLANGE 3 - HANDFORMED EARPLUG 4 - EAR CANAL CAPS </div>				<div style="display: flex; justify-content: space-between;"> L R </div>			<div style="display: flex; justify-content: space-between;"> 1 - XS 2 - S 3 - M 4 - L 5 - XL </div>		<div style="display: flex; justify-content: space-between;"> 1 1 - NO 2 - YES </div>		<div style="display: flex; justify-content: space-between;"> 1 1 - NO 2 - YES </div>		<div style="display: flex; justify-content: space-between;"> 3 1 - ALWAYS 2 - SELDOM 3 - N/A </div>	
25. REMARKS (Include Exposure Data)														
Navy 8 kHz Left Ear : NT Navy 8 kHz Right Ear : NT Steady Noise Exp(TWA dBA): Not Entered, Impulse Noise Exp(dBP): Not Entered.														

NON-HEARING CONSERVATION HEARING TEST										ZIP CODE/APO/FPO/PAS 32561			
(This report contains data subject to the Privacy Act of 1974.)													
DOD COMPONENT A - ARMY F - AIR FORCE C - COAST GUARD N N - NAVY M - MARINE CORPS 1 - OTHER						SERVICE COMPONENT R - REGULAR G - GUARD R V - RESERVE 1 - OTHER							
SOCIAL SECURITY NUMBER [REDACTED]				NAME (Last, First, Middle Initial) MERWIN, DANIEL						DATE OF BIRTH [REDACTED] 1985		SEX M	
PAY GRADE UNIFORMED SERVICES E04		PAY GRADE CIVILIAN		SERVICE DUTY OCCUPATION CODE CTO9199		MAJOR COMMAND (Optional) NETC				ENT PROBLEM AT TIME OF TEST 1 - NO 2 - YES 3 - UNKNOWN 1			
HEARING TEST (Audiometric Data RE: ANSI S3.6 - 1989)													
AUDIOGRAM DATE		LEFT						RIGHT					
		500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
09/16/09		0	5	15	20	10	15	5	5	0	10	10	-5
EXAMINER													
NAME (Last, First, Middle Initial) THOMAS, JOSHUA L						TRAINING CERTIFICATE NO. 093015N				SERVICE DUTY OCCUPATION CODE HM8404			
AUDIOMETER													
TYPE 3				MODEL CCA-200m						MANUFACTURER MAICO Inc.			
SERIAL NUMBER 62223							LAST ELECTROACOUSTIC CALIBRATION DATE 19 Nov 2008						

HEARING CONSERVATION DATA

(This form is subject to the Privacy Act of 1974 - use Blanket PAS - DD Form 2005)

1. ZIP CODE/APO/FPO/PAS

21533

2. DOD COMPONENT

N

A - ARMY
N - NAVYF - AIR FORCE
M - MARINE CORPSC - COAST GUARD
1 - OTHER

R

3. SERVICE COMPONENT

R - REGULAR
V - RESERVEG - NATIONAL GUARD
1 - OTHER

4. SOCIAL SECURITY NUMBER

5. NAME (Last, First, Middle Initial)

6. DATE OF BIRTH

7. SEX

[REDACTED]

MERWIN, DANIEL D

[REDACTED] 1985

M

M - MALE
F - FEMALE8. PAY GRADE
UNIFORMED SERVICES
E049. PAY GRADE
CIVILIAN10. SERVICE DUTY
OCCUPATION CODE
ABH70H911. MAILING ADDRESS OF ASSIGNMENT
MEDICAL DEPARTMENT

21533

FPO

AP 96643-1661

12. LOCATION - PLACE OF WORK

AIR V-3

13. MAJOR COMMAND
CINCPACFLT14. DUTY TELEPHONE
(315) 252-3365

(Include area code)

15. AUDIOMETRY

2

a. PURPOSE

1 - 90 DAY

2 - ANNUAL

3 - TERMINATION

4 - OTHER

AUDIOMETRIC DATA
RE: ANSI S3.6

LEFT

RIGHT

500

1000

2000

3000

4000

6000

500

1000

2000

3000

4000

6000

b. CURRENT AUDIOGRAM

DATE 11 Nov 2007

5

15

15

25

20

10

5

10

15

15

15

5

c. REFERENCE AUDIOGRAM

DATE 07 Nov 2005

5M

10M

10M

15M

10M

5M

5M

10M

5M

15M

15M

0M

d. SIGNIFICANT THRESHOLD
SHIFT (STS)e. THRESHOLD
SHIFT

1

1 - NO
2 - YES

----->

5

5

10

10

0

10

0

0

0

f. REMARKS (Include Exposure Data)

Steady Noise Exp(TWA dBA): Not Entered, Impulse Noise Exp(dBP): Not Entered, Health Ed Prov, HPD Prev Fit.

g. TYPE OF PERSONAL HEARING PROTECTION USED

1 - SINGLE FLANGE (V51R)	4 - EAR CANAL CAPS
2 - TRIPLE FLANGE	5 - NOISE MUFFS
3 - HAND FORMED EARPLUG	6 - OTHER
	7 - NONE

h. EXAMINER NAME (Last, First, Middle Initial)

KENDALL, HAROLD B

i. TRAINING CERTIFICATE NO.

056207N

j. SERVICE DUTY
OCCUPATION CODE

HM8406

k. OFFICE SYMBOL

AVT

l. AUDIOMETER TYPE

3	1 - MANUAL	(Automatic)
	2 - SELF-RECORDING	
	3 - MICROPROCESSOR	

m. MODEL

CCA-200

n. MANUFACTURER

MAICO Inc.

o. SERIAL NUMBER

22549

p. LAST ELECTROACOUSTIC
CALIBRATION DATE

26 Jul 2007

16. FOLLOW-UP NO. 1

a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM

(See Item 15.B)

AUDIOMETRIC DATA
RE: ANSI S3.6

LEFT

RIGHT

500

1000

2000

3000

4000

6000

500

1000

2000

3000

4000

6000

b. CURRENT AUDIOGRAM

DATE

c. REFERENCE AUDIOGRAM

DATE

d. SIGNIFICANT THRESHOLD
SHIFT (STS)e. THRESHOLD
SHIFT

1

1 - NO
2 - YES

----->

f. EXAMINER NAME (Last, First, Middle Initial)

g. TRAINING CERTIFICATE NO.

h. SERVICE DUTY
OCCUPATION CODE

i. OFFICE SYMBOL

j. AUDIOMETER TYPE

	1 - MANUAL
	2 - SELF-RECORDING
	3 - MICROPROCESSOR

k. MODEL

l. MANUFACTURER

m. SERIAL NUMBER

n. LAST ELECTROACOUSTIC
CALIBRATION DATE

17. FOLLOW-UP NO. 2

a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM

(See Item 15.B)

AUDIOMETRIC DATA
RE: ANSI S3.6

LEFT

RIGHT

500

1000

2000

3000

4000

6000

500

1000

2000

3000

4000

6000

b. CURRENT AUDIOGRAM

DATE

c. REFERENCE AUDIOGRAM

DATE

d. SIGNIFICANT THRESHOLD
SHIFT (STS)e. THRESHOLD
SHIFT

1

1 - NO
2 - YES

----->

f. EXAMINER NAME (Last, First, Middle Initial)

g. TRAINING CERTIFICATE NO.

h. SERVICE DUTY
OCCUPATION CODE

i. OFFICE SYMBOL

j. AUDIOMETER TYPE

	1 - MANUAL
	2 - SELF-RECORDING
	3 - MICROPROCESSOR

k. MODEL

l. MANUFACTURER

m. SERIAL NUMBER

n. LAST ELECTROACOUSTIC
CALIBRATION DATE

HEARING CONSERVATION DATA										1. ZIP CODE/APO/FPO/PAS			
(This form is subject to the Privacy Act of 1974 - use Blanket PAS - DD Form 2005)										FPO AP 96643-1661			
2. DOD COMPONENT		F - AIR FORCE		1 - OTHER DOD ACTIVITY		3. SERVICE COMPONENT		G - NATIONAL GUARD					
N - NAVY		M - MARINE CORPS				R - REGULAR		1 - OTHER					
4. SOCIAL SECURITY NUMBER		5. NAME (Last, First, Middle Initial)				6. DATE OF BIRTH (YYYYMMDD)		7. SEX					
[REDACTED]		MERWIN, DANIEL D				[REDACTED] 185		M		M - MALE F - FEMALE			
8. PAY GRADE, UNIFORMED SERVICES		9. PAY GRADE, CIVILIAN		10. SERVICE DUTY OCCUPATION CODE		11. MAILING ADDRESS OF ASSIGNMENT							
E3		NA				USS ESSEX LHD-2 FPO AP 96643-1661							
12. LOCATION - PLACE OF WORK						13. MAJOR COMMAND		14. DUTY TELEPHONE (Include area code)					
V3 / AIR						COMNAVSURFOR		7405					
15. AUDIOMETRY		a. PURPOSE 1 - 90 DAY 2 - ANNUAL 3 - TERMINATION 4 - OTHER											
AUDIOMETRIC DATA RE: ANSI S3.6 - 1989		LEFT					RIGHT						
		500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM DATE (YYYYMMDD) 20061103		5	15	20	25	10	15	5	10	15	15	20	0
c. REFERENCE AUDIOGRAM DATE (YYYYMMDD) 20051107		5	10	10	15	10	5	5	10	5	15	15	0
d. SIGNIFICANT THRESHOLD SHIFT (STS) 1 - NO 2 - YES		e. THRESHOLD SHIFT											
1		→		5	10	10	0			0	10	0	5
f. REMARKS (Include exposure data)													
Member educated on the provisions of the Hearing Conservation Program and on the proper use and care of hearing protection. Early signs of significant threshold shift (STS) IS / IS NOT present. Follow-up in 1 yr.													
g. TYPE OF PERSONAL HEARING PROTECTION USED													
2 1 - SINGLE FLANGE (VS1R) 2 - TRIPLE FLANGE 3 - HAND FORMED EARPLUGS 4 - EAR CANAL CAPS 5 - NOISE MUFFS 6 - OTHER													
h. EXAMINER NAME (Last, First, Middle Initial)				i. TRAINING CERTIFICATE NO.		j. SERVICE DUTY OCCUPATION CODE		k. OFFICE SYMBOL					
KENNEDY HAROLD B.				054207N		8406		AVT					
l. AUDIOMETER TYPE		m. MODEL		n. MANUFACTURER		o. SERIAL NUMBER		p. LAST ELECTROACOUSTIC CALIBRATION DATE (YYYYMMDD)					
3 1 - MANUAL 2 - SELF-RECORDING (Automatic) 3 - MICROPROCESSOR		MA - 1000		MAICO		22549		20060618					
16. FOLLOWUP NO. 1		a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM (See item 15.b.)											
AUDIOMETRIC DATA RE: ANSI S3.6 - 1989		LEFT					RIGHT						
		500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM DATE (YYYYMMDD)													
c. REFERENCE AUDIOGRAM DATE (YYYYMMDD)													
d. SIGNIFICANT THRESHOLD SHIFT (STS) 1 - NO 2 - YES		e. THRESHOLD SHIFT											
		→											
f. EXAMINER NAME (Last, First, Middle Initial)				g. TRAINING CERTIFICATE NO.		h. SERVICE DUTY OCCUPATION CODE		i. OFFICE SYMBOL					
j. AUDIOMETER TYPE		k. MODEL		l. MANUFACTURER		m. SERIAL NUMBER		n. LAST ELECTROACOUSTIC CALIBRATION DATE (YYYYMMDD)					
1 - MANUAL 2 - SELF-RECORDING (Automatic) 3 - MICROPROCESSOR													
17. FOLLOWUP NO. 2		a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM (See item 15.b.)											
AUDIOMETRIC DATA RE: ANSI S3.6 - 1989		LEFT					RIGHT						
		500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM DATE (YYYYMMDD)													
c. REFERENCE AUDIOGRAM DATE (YYYYMMDD)													
d. SIGNIFICANT THRESHOLD SHIFT (STS) 1 - NO 2 - YES		e. THRESHOLD SHIFT											
		→											
f. EXAMINER NAME (Last, First, Middle Initial)				g. TRAINING CERTIFICATE NO.		h. SERVICE DUTY OCCUPATION CODE		i. OFFICE SYMBOL					
j. AUDIOMETER TYPE		k. MODEL		l. MANUFACTURER		m. SERIAL NUMBER		n. LAST ELECTROACOUSTIC CALIBRATION DATE (YYYYMMDD)					
1 - MANUAL 2 - SELF-RECORDING (Automatic) 3 - MICROPROCESSOR													

INSTRUCTIONS*(Refer to DoD Component Instructions for additional guidance)*

PURPOSE: This form is used to record the results of periodic and followup audiometry for individuals routinely exposed to hazardous noise. Before this form is used, a DD Form 2215, "Reference Audiogram," must already be filed in the individual's health record.

1. **ZIP CODE/APO/FPO/PAS.** Enter nine digit ZIP Code/APO/FPO/ PAS of where audiometric test is conducted.
2. **DOD COMPONENT.** Enter letter in box of major organizational subdivision of DoD to which military or civilian individual is assigned. Enter "1" if DoD component is not listed.
3. **SERVICE COMPONENT.** Enter letter in box corresponding to primary subdivision of separate military service in which military is assigned (e.g., Regular (R) - standing military component of armed forces in peace and war; Reserve (V) - component of ready trained personnel for military service when needed, etc.; National Guard (G) - component of National Guard personnel in full-time or part-time status). Enter "1" for all others not listed.
4. **SOCIAL SECURITY NUMBER.** Enter nine digit social security number. If foreign national, enter "FN" in middle two blocks.
5. **NAME.** Enter surname, given name and middle initial of individual being tested.
6. **DATE OF BIRTH.** Enter year, month, day.
7. **SEX.** Enter "M" if male, "F" if female.
8. **PAY GRADE, UNIFORMED SERVICES.** For military personnel only, enter military personnel class and pay level serial number as follows:
 - O11 - General of the Army/General of the Air Force/Fleet Admiral
 - O10 - General/Admiral
 - O09 - Lieutenant General/Vice Admiral
 - O08 - Major General/Rear Admiral (Upper Half)
 - O07 - Brigadier General/Rear Admiral (Lower Half)/Commodore
 - O06 - Colonel (A,F,M)/Captain (N)
 - O05 - Lieutenant Colonel/Commander
 - O04 - Major/Lieutenant Commander
 - O03 - Captain (A,F,M)/Lieutenant (N)
 - O02 - First Lieutenant/Lieutenant Junior Grade
 - O01 - Second Lieutenant/Ensign
 - W05 - Chief Warrant Officer, W-5
 - W04 - Chief Warrant Officer, W-4
 - W03 - Chief Warrant Officer, W-3
 - W02 - Chief Warrant Officer, W-2
 - W01 - Warrant Officer, W-1
 - C00 - Cadet/Midshipman
 - E09 - Sergeant Major/Chief Master Sergeant/Master Chief Petty Officer
 - E08 - Master Sergeant (A,M)/Senior Chief Petty Officer/Senior Master Sergeant/First Sergeant(A)
 - E07 - Sergeant First Class/Gunnery Sergeant/Chief Petty Officer/Master Sergeant (F)/Platoon Sergeant (A)/Specialist-7
 - E06 - Staff Sergeant/Technical Sergeant/Petty Officer First Class/Specialist-6
 - E05 - Sergeant (A,M)/Staff Sergeant/Petty Officer Second Class/Specialist-5
 - E04 - Corporal/Sergeant (F)/Petty Officer Third Class/Specialist-4
 - E03 - Private First Class (A)/Airman First Class/Lance Corporal/Seaman
 - E02 - Private (PV1)/Airman/Private First Class (M)/Seaman Apprentice
 - E01 - Private (PV2)/Private (M)/Airman Basic/Seaman Recruit
9. **GRADE, CIVILIAN.** Enter two letters and two numbers of Federal civilian employee rank (e.g., WG05, GS11, etc.). Letter entries will be WG, WL, WS, WN, WD or GS. Number entries will be 01 to 18. Enter "1111" if other (e.g., foreign national, contractor, etc.).
10. **SERVICE DUTY OCCUPATION CODE.** Enter code to which military member's duty occupation is assigned (e.g., MOS, SSI, NEC/Rating, NOBC or AFSC in which individual is actually working). Enter number code of civilian job series in which civilian member is actually working (e.g., for a carpenter enter "4607").
11. **MAILING ADDRESS OF ASSIGNMENT.** Enter installation name (and street address for Navy and Marines), unit, office symbol, and ZIP Code/APO/ FPO/PAS of individual's current duty assignment.
12. **LOCATION - PLACE OF WORK.** Enter specific location where individual is routinely exposed to hazardous noise including building number (e.g., Corpus Christi, NAS, Building 1571, Carpenter Shop). For Air Force personnel, enter 12-digit Workplace Identifier Code per AFOSH Std. 161-17.
13. **MAJOR COMMAND.** Enter authorized abbreviation of military major command to which individual is assigned.
14. **DUTY TELEPHONE.** Enter individual's duty telephone number.
15. **AUDIOMETRY.**
 - a. **Purpose.** Enter number in box for reason to complete audiogram. "1" - First periodic test given 90 days after beginning duties in noise-hazardous area or operation; "2" - Periodic test given at yearly intervals; "3" - Last test given, regardless of noise exposure history, before termination of active duty or employment; "4" - Test at interval for reason not listed above.
 - b. **Current Audiogram Date.** Enter year, month, day (e.g., If January 31, 2000, enter 20000131) that audiometric test is given and current threshold levels determined for this individual at six frequencies in each ear. Results are entered in 5 dB increments (e.g., 0, 5, 10, 15, etc.). If responses exceed maximum limits of audiometer, enter that limit with plus sign (e.g., 110+).

15.c. **Reference Audiogram Date.** Enter year, month, and day reference test results were obtained. See DD Form 2215, "Reference Audiogram," or other appropriate source. Enter threshold levels in 5 dB increments from reference audiogram.

d. **Significant Threshold Shift (STS).** Enter "1" if no STS is present; enter "2" if STS is present.

STS - NO: See DoD component specific manuals for detailed guidance.

STS - YES: Outlines procedures required when a significant threshold shift present: "Notify Supervisor" - Notify individual's supervisor that significant threshold shift has been found and followup audiogram must be done. "Followup No. 1 After Minimum 14 Hours Noise Free" - Schedule individual for first followup audiogram. They must be instructed to stay in a noise free environment (not to exceed 75 dBA or 120 dBp) for at least 14 hours prior to test. They must be told to avoid environments in which noise levels make it necessary to use raised voice to talk at 1 meter (3 feet) distance. If examinee has obvious ear problem (e.g., earache, draining ear, excessive cerumen buildup), he/she should be examined by physician and followup postponed until after any necessary treatment.

e. **Threshold Shift.** Enter difference between current and most recent reference audiogram for 1000, 2000, 3000 and 4000 Hz. Refer to DoD component manuals for established criteria. Enter "+" to indicate positive shift (poorer hearing) or "-" to indicate negative shift (better hearing) on current audiogram.

f. **Remarks.** Print any information considered pertinent. Include the individual's 8-hour TWA noise exposure, when available.

g. **Type of Personal Hearing Protection Used.** Enter number for type of hearing protection that is routinely used by individual.

h. **Examiner Name.** Enter surname, given name and middle initial of individual operating audiometer.

i. **Training Certificate Number.** Enter audiometric technician training certificate number.

j. **Service Duty Occupation Code.** Enter examiner's service duty occupation code (see item 10).

k. **Office Symbol.** Enter complete office symbol where examiner is performing the test.

l. **Audiometer Type.** Enter number for type of audiometer used (e.g., "1" for manual type, etc.).

m. **Model.** Enter manufacturer's designation of audiometer.

n. **Manufacturer.** Enter name of company that produced audiometer.

o. **Serial Number.** Enter manufacturer's serial number of audiometer.

p. **Last Electroacoustic Calibration Date.** Enter year, month and day (see item 15.b.) of last electroacoustic determination of this audiometer's performance specifications.

16. **FOLLOWUP NO. 1.** If significant threshold shift determined on periodic test, record results of first followup audiogram in this section. Mark (X) box to certify "Minimum 14 Hours Noise Free Since Current Audiogram (see item 15.b.)."

b., c., and e., "Current Audiogram," "Reference Audiogram," and "Threshold Shift" completed in same format as above. Note: Hearing threshold levels entered in 16.c. are the same values as those used in 15.c.

d. "STS - NO" - If no STS noted, enter "1" in box and follow steps in "STS - NO" section.

"STS - YES" - If STS remains following this examination (Followup No. 1), follow service component instructions (e.g., supervisor is notified for the second time, individual is scheduled for Followup No. 2 audiogram, and individual is instructed to stay in a noise free environment (not to exceed 75 dBA or 120 dBp) for a minimum of 14 hours of auditory rest since current audiogram (item 15.b.)).

e. through m. Enter the required information according to guidelines for entries on periodic audiogram.

17. **FOLLOWUP NO. 2.** If significant threshold shift determined on Followup No. 1, record results of Followup No. 2 in this section. Mark (X) box to certify "Minimum 14 Hours Noise Free Since Current Audiogram (see item 15.b.)."

b., c., and e., "Current Audiogram," "Reference Audiogram," and "Threshold Shift" completed in same format as above. Note: Hearing threshold levels entered in 17.c. are the same values as those used in 15.c.

d. "STS - NO" - If no STS noted, enter "1" in box and follow steps in "STS - NO" section.

"STS - YES" - If STS remains following this examination (Followup No. 2), enter "2" in box. Refer to DoD component instructions for appropriate patient disposition.

e. through m. Enter the required information according to guidelines for entries on periodic audiogram.

See specific DoD component manuals regarding followup procedures required in addition to those listed above. For example, if the annual test indicates a "negative" threshold shift and is confirmed on the first followup, the reference audiogram may be reestablished at this time without any further followup testing for DA personnel.

OPNAVINST 5100.23B

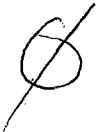
MEDICAL SURVEILLANCE QUESTIONNAIRE

PRIVACY ACT STATEMENT

"The authority to collecting this information is Section 19 of the Occupational Safety and Health Act and the Code of Federal Regulations (29 CFR 50). This information will be used by the Occupational Health Physician, and/or such clinical staff as he may designate to help identify the causes of adverse health effects and for future epidemiology studies. Providing the information is voluntary; however, failure to provide the information could unnecessarily hamper the identification of potential health problems and preclude any redress of problems identified in the future."

PART 1 - OCCUPATIONAL HISTORY

Instructions: Please complete the following work history in chronological order from your first job to the present, and list all part-time and full-time jobs you have held. Be as specific as possible; if you held more than one job with the same employer, list each title and activity. Use additional sheets as needed.

TODAY'S DATE	DATES		NO. HRS/WK	JOB TITLE AND WORK ACTIVITIES (include employer if not Navy)	POTENTIAL HAZARDS (Be as specific as possible.)	PROTECTIVE EQUIPMENT (Respirator, ear plugs, protective clothing, etc.)
	FROM MO/YR	TO MO/YR				
						

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

PATIENT'S Name (Last, First, Middle initial)

: METWU, DAWIEC D

SEX
N

YEAR OF BIRTH

1985

RELATIONSHIP TO SPONSOR

COMPONENT/STATUS

DEPART/SERVICE

SPONSOR'S NAME

SSAN OR IDENTIFICATION NO.

ORGANIZATION AR 3319

NAVY

DATE:

10 APR 13

PERIODIC HEALTH ASSESSMENT (PHA)

S: SUBJECTIVE

26 year old () male () female reports for an annual PHA which includes record review/verification, assessment and counseling of health risk factors, clinical preventive services, deployment health history, and individual medical readiness (IMR) assessment.

Allergies (Medication and other): See Block 1 on DD 2766

Chronic Illnesses: See Block 2 on DD 2766

Medications (Rx / OTC / herbals / supplements / performance enhancers): See Block 3 on DD 2766

Hospitalizations/Surgeries since last PHA: See Block 4 on DD 2766

Family History: See Block 6 on DD 2766

Occupational History: See Block 8 on DD 2766

O: OBJECTIVE

Vital Signs noted. Remarkable for: ☒ None ☐ Other:

Visual Acuity: OD: 20/20 OS: 20/20 (Consult if worse than 20/40, no contacts)

Physical examination is otherwise deferred.

Health Record	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> Remarkable for: _____
Dental Readiness	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Dental Classification	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4
Immunization Record	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Lab/Path Results	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Clinical Prev. Services	<input type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Occupational Health	<input type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Hearing Assessment	<input type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan

Deployment Health: See DD 2766

Deployed since previous PHA?

☐ Yes☐ No

Post-Deployment Health Assessment (DD 2796) in record?

☐ Yes☐ No

Post-Deployment Health Reassessment (DD 2900) in record?

☐ Yes☐ No

Any unresolved deployment-related issues or health concerns?

☐ Yes☐ No

Comments:

N/A

MEDICAL

EQUIPMENT:

Prescription Lenses (two pairs)

☐ Y ☐ N ☒ NA

Ballistic Eyewear

☐ Y ☐ N ☒ NA

Gas Mask Inserts

☐ Y ☐ N ☒ NA

Medical Alert Tags

☐ Y ☐ N ☒ NA

A: ASSESSMENT

Health Risk Assessment: Completed and reviewed? ☒ Yes ☐ No

Health Risk Assessment Level:

☐ High☐ Med☒ Low

Cardiovascular Screening (Framingham 10-year risk for Event/Death):

Pain Assessment (zero pain to severe): 0 1 2 3 4 5 6 7 8 9 10

Location:

Any other current health concerns?

flatness scalp sole

PATIENT'S IDENTIFICATION

Use this space for mechanical imprint, telephone number, and e-mail address for follow-up:

PATIENT'S NAME (Last, First, Middle Initial)

MERWIN DANIEL D

SEX

M

SSN / IDENTIFICATION NO.

[REDACTED]

STATUS

ACTIVE DUTY

RANK/GRADE

CTN2/ES

RECORDS MAINTAINED AT

Kimbley A

DATE OF BIRTH

[REDACTED] 85

PERIOD HEALTH ASSESSMENT (PHA) (C tinued)

Duty Status Assessment

On Limited Duty (LIMDU) ☐ Yes ☒ No ☐ NA ☐ Comments: _____
 Medical Board ☐ Yes ☒ No ☐ NA ☐ Comments: _____
☐ TNPQ ☐ TNDQ ☐ NPQ ☐ LOD ☐ NA ☐ Comments: _____

P: PLAN / P: PREVENTION

1. Updated DD 2766 Sections: ☒ 1 ☒ 2 ☒ 3 ☒ 4 ☒ 5 ☒ 6 ☒ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11
2. Health counseling performed and documented on the DD 2766: ☒ Yes ☐ No
3. Labs ordered for the following: ☐ Blood Type and RH ☐ G6PD ☒ HIV ☐ DNA ☒ Lipids
☐ Others as required by geographic, occupation, or ISIC
 Electronic verification complete: ☒ Yes ☐ No
4. Immunizations ordered for the following: ☐ MMR ☐ Tdap (1 time booster) or ☐ Td ☐ IPV ☐ Influenza
☐ Hep A #1 #2 ☐ Hep B #1 #2 #3 (required for all new recruits) TWINRIX® may be used (3 shots required)
 Other immunizations: ☐ _____ ☐ _____ ☐ _____
 Electronic verification complete: ☒ Yes ☐ No
5. Tuberculosis Screening: ☒ PPD Placement: 19 MAR 13 Results: Zero mm
6. Clinical Preventive Services recommended: ☐ Pap ☐ Chlamydia ☐ Mammogram ☐ Colorectal
☐ Clinical Breast Exam ☐ Testicular Exam ☐ Prostate ☐ Cholesterol
☐ Other: _____
7. Referred to Dental for: ☐ Annual T-2 Dental Exam ☐ Dental Class 3 ☐ Dental Class 4 ☐ Bitewings ☐ Panograph
8. Referred to PCM for: ☐ Physical Fitness Clearance ☐ Deployment-Related Condition
☐ Current Medications / Supplements ☐ Chronic Medical Conditions ☐ Current Illness / Injury
☐ Other: _____
9. Referred for Preventive / Healthy Lifestyle Counseling:
☐ Tobacco Use ☐ Physical Activity ☐ Safety ☐ Alcohol Use ☐ Dental Care ☐ Nutrition ☐ Mental Health
☐ Sexuality ☐ Other: _____
10. Other indicated referrals:
☐ Audiology ☐ Optometry ☐ Behavioral Health ☐ OB / GYN ☐ Dietician ☐ OCC Health
☐ Chaplain ☐ DAPA ☐ FFSC ☐ Semper Fit ☐ Weight Management
☐ Other: Dem
11. Member readiness reviewed ☒ Yes ☐ No and updated in approved electronic data system ☐ Yes ☒ No
 Member is fully medically ready and requires no follow-up at this time: ☒ Yes ☐ No
12. Additional Comments: Hypocalcemia diet, Fx after fasting
13. Member informed that completion of recommended tests / immunizations / screenings is to be performed within the next 30 days, and he/she is personally responsible for maintaining IMR. Service Member received health risk prevention / healthy lifestyle counseling and voiced understanding.

Member Signature: X [Signature]Date: 4/10/2013HM / MDR Signature: [Signature]Date: 4/10/2013

Provider Signature: _____

Date: _____

AR 3321

HEARING CONSERVATION DATA										1. ZIP CODE/APO/FPO/PAS					
(This form is subject to the Privacy Act of 1974 - use Blanket PAS - DD Form 2005)										20755					
2. DOD COMPONENT					3. SERVICE COMPONENT										
N		A - ARMY N - NAVY		F - AIR FORCE M - MARINE CORPS		C - COAST GUARD 1 - OTHER		R		R - REGULAR V - RESERVE		G - NATIONAL GUARD 1 - OTHER			
4. SOCIAL SECURITY NUMBER				5. NAME (Last, First, Middle Initial)				6. DATE OF BIRTH				7. SEX			
[REDACTED]				MERWIN, DANIEL				[REDACTED] 1985				M M - MALE F - FEMALE			
8. PAY GRADE UNIFORMED SERVICES		9. PAY GRADE CIVILIAN		10. SERVICE DUTY OCCUPATION CODE		11. MAILING ADDRESS OF ASSIGNMENT									
E05				9999		3000B FT MEADE MD 20765 FT MEADE MD 20765									
12. LOCATION - PLACE OF WORK						13. MAJOR COMMAND				14. DUTY TELEPHONE (Include area code)					
NIOC						NSA				(410) 854-0400					
15. AUDIOMETRY		2		a. PURPOSE											
				1 - 90 DAY 2 - ANNUAL 3 - TERMINATION 4 - OTHER											
AUDIOMETRIC DATA		RE: ANSI S3.6		LEFT						RIGHT					
				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM		DATE 19 Mar 2013		5	10	10	20	15	15	0	20	0	15	0	5
c. REFERENCE AUDIOGRAM		DATE L: 07 Nov 2005 R: 07 Nov 2005		5	10	10	15	10	5	5	10	5	15	15	0
d. SIGNIFICANT THRESHOLD SHIFT (STS)		e. THRESHOLD SHIFT													
L: 1 R: 1		1 - NO 2 - YES													
				0	0	5	5			10	-5	0	-15		
f. REMARKS (Include Exposure Data)										g. TYPE OF PERSONAL HEARING PROTECTION USED					
Steady Noise Exp(TWA dBA): Not Entered, Impulse Noise Exp(dBP): Not Entered, H-1, Health Ed Prov, HPD Prev Fit.										2 1 - SINGLE FLANGE (V51R) 2 - TRIPLE FLANGE 3 - HAND FORMED EARPLUG 4 - EAR CANAL CAPS 5 - NOISE MUFFS 6 - OTHER 7 - NONE					
h. EXAMINER NAME (Last, First, Middle Initial)						i. TRAINING CERTIFICATE NO.				j. SERVICE DUTY OCCUPATION CODE		k. OFFICE SYMBOL			
PERRY, CHARLES C						085909A				0650		W6F2AA			
l. AUDIOMETER TYPE				m. MODEL				n. MANUFACTURER				o. SERIAL NUMBER		p. LAST ELECTROACOUSTIC CALIBRATION DATE	
3 1 - MANUAL 2 - SELF-RECORDING (Automatic) 3 - MICROPROCESSOR				CCA-200m				Benson Co.				61714		13 Jun 2012	
16. FOLLOW-UP NO. 1				a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM (See Item 15.B)											
AUDIOMETRIC DATA				LEFT RIGHT											
RE: ANSI S3.6				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM															
DATE															
c. REFERENCE AUDIOGRAM															
DATE															
d. SIGNIFICANT THRESHOLD SHIFT (STS)				e. THRESHOLD SHIFT											
1 - NO 2 - YES				1 - NO 2 - YES											
f. EXAMINER NAME (Last, First, Middle Initial)						g. TRAINING CERTIFICATE NO.				h. SERVICE DUTY OCCUPATION CODE		i. OFFICE SYMBOL			
j. AUDIOMETER TYPE				k. MODEL				l. MANUFACTURER				m. SERIAL NUMBER		n. LAST ELECTROACOUSTIC CALIBRATION DATE	
1 - MANUAL 2 - SELF-RECORDING 3 - MICROPROCESSOR															
17. FOLLOW-UP NO. 2				a. MINIMUM 14 HOURS NOISE FREE SINCE CURRENT AUDIOGRAM (See Item 15.B)											
AUDIOMETRIC DATA				LEFT RIGHT											
RE: ANSI S3.6				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
b. CURRENT AUDIOGRAM															
DATE															
c. REFERENCE AUDIOGRAM															
DATE															
d. SIGNIFICANT THRESHOLD SHIFT (STS)				e. THRESHOLD SHIFT											
1 - NO 2 - YES				1 - NO 2 - YES											
f. EXAMINER NAME (Last, First, Middle Initial)						g. TRAINING CERTIFICATE NO.				h. SERVICE DUTY OCCUPATION CODE		i. OFFICE SYMBOL			
j. AUDIOMETER TYPE				k. MODEL				l. MANUFACTURER				m. SERIAL NUMBER		n. LAST ELECTROACOUSTIC CALIBRATION DATE	
1 - MANUAL 2 - SELF-RECORDING 3 - MICROPROCESSOR															

***** FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE *****

Any misuse or unauthorized disclosure of this information may result in both criminal and civil penalties.

Date: 05-Mar-2012

Force IMR Report

Page: 1

Activity: N6288 - NIOC PENSACOLA

Cmd: 98 - Active Duty Navy

Name	Rate/ Rank	SSN	DOB	Gender	Age	Unit	Blood Type	IMR Status
MERWIN DANIEL DENNIS	CTN2	[REDACTED]	[REDACTED]	1985	M	27 41976	OPOS	Fully Medically Ready
USN	LOD: None	MRR: None	TNPQ: None	TNDQ: None	LIMDU: None	MEDBRD: None		

Waiver Type	Issue Date	Reason
Immunization	Series	Completed

Immunization	Series	Completed	Due	Lot Number	Req	Def	Date Deferred	Reaction
Adenovirus								
Anthrax	5	09-Mar-2010		UNK				
Cholera								
H1N1 Influenza		22-Dec-2009		104040P1				
HPV- Human Papilloma								
Hepatitis A	2	14-Dec-2005		UNK	Y	Y	02-Apr-07	
Hepatitis B	2	14-Dec-2005		UNK		Y	02-Apr-07	
Influenza	0	02-Nov-2011	01-Sep-2012	UNK	Y			
JEV								
MGC								
MMR	0	08-Nov-2005		UNK	Y			
Pneumococcal								
Polio	0	08-Nov-2005		UNK	Y			
Rabies								
Smallpox								
Smallpox Reading								
Tetanus/Diphtheria	0	08-Nov-2005	06-Nov-2015	UNK	Y			
TwinRix	1	14-Dec-2005		UNK	Y			
Typhoid								
Varicella								
Yellow Fever	0	14-Dec-2005		UNK				

Tests

Primary Physical:	Due:	06 Mar 2012	Routine
PHA Exam Date:	08-Feb-2011	PHA Compl Date:	08-Feb-2011
Short Flight Date:	Due:		
Dental Date:	22-Feb-2012	Class:	2
Bitewing Date:	Due:	05-Mar-2012	Panograph Date:
HIV Test Date:	22-Feb-2012	Results Date:	24-Feb-2012
DNA Sent Date:	Due:	15-Dec-2005	
Baseline DD2215:	07-Nov-2005	Results:	N
Sickle Cell Test Date:	06-Nov-2005	G6PD Code:	N
G6PD Date:	06-Nov-2005	Results:	
HBSAB Serology Titre:	Results:		
PAP Smear:	Mammogram:		
Eye Exam Date:	17-Feb-2011	Eye Exam Req:	Y
Gas Mask Inserts Req:	N	Issue Date:	
Pregnant: No	Weeks Pregnant:	Due Date:	
OCC Health Eval Date:	Eval Req:	N	
TST Reading:	19-Mar-2010	PPD Reactor:	N
NAMI Eval Date:	Specialty:		
Health Care Promotion:	N	Health Enrollment Assessment:	N
Allergies (Y/N):	Y	Warning Tag Required:	10-Nov-2008
Due - highlighted		Warning Tag Issued:	10-Aug-2009

AR 3323

20/

CORRU

INTERIM TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT (Check the correct response)

1. Since your last tuberculosis risk assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ Yes ☒ No ☐ Don't Know
If Yes, test the patient.

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; hospitalized patients, prisoners, or homeless shelter populations? ☐ Yes ☒ No
If Yes, test the patient.

3a. Check any countries where you have traveled or deployed to since your last tuberculosis risk assessment.

- | | | | |
|--------------------------------------|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> India | <input type="checkbox"/> Pakistan | <input type="checkbox"/> UR Tanzania |
| <input type="checkbox"/> Brazil | <input type="checkbox"/> Indonesia | <input type="checkbox"/> Philippines | <input type="checkbox"/> Viet Nam |
| <input type="checkbox"/> Cambodia | <input type="checkbox"/> Kenya | <input type="checkbox"/> Russian Federation | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> China | <input type="checkbox"/> Mozambique | <input type="checkbox"/> South Africa | |
| <input type="checkbox"/> DR Congo | <input type="checkbox"/> Myanmar | <input type="checkbox"/> Thailand | |
| <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Nigeria | <input type="checkbox"/> Uganda | |
| <input type="checkbox"/> Other _____ | | | |

If any of these listed countries are selected, test the patient.

If "other" is checked, write in the name of the country or countries and describe further in number 6.

3b. During this travel, did you have prolonged direct contact with the local population? ☐ Yes ☐ No If Yes, test the patient.

3c. Have you traveled to Afghanistan for a reason not part of a deployment that required completion of a Post Deployment Health Assessment (PDHA)? ☐ Yes ☐ No If Yes, test the patient.

3d. Have you recently had any of the following symptoms:

- ☐ Fever ☐ Cough ☐ Weight Loss ☐ Chills ☐ Night Sweats

If any are checked, see the medical officer for evaluation.

FOR THE PROVIDER

(If the answer to questions 1, 2, or 3b is a YES, test the patient. If a country is selected in 3a, test the patient.)

4. Tuberculosis risk assessment, based on above responses ☐ Minimal Risk ☐ Increased Risk

5. Recommend Latent Tuberculosis Infection (LTBI) Testing ☐ Yes ☒ No

6. Provider Comments

LAST PPD 19 Mar 2010.
Neg

LAUREN TREVEN MSPA-C
NAVHOSP PENSACOLA
☎ (850) 452 6326 X4100
LAUREN.TREVEN.CTR@

PROVIDER'S NAME: LAUREN TREVEN, MPA-C

PROVIDER'S SIGNATURE

DATE

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPARTMENT / SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN

RELATIONSHIP TO SPONSOR

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE: <u>2 Nov 11</u>	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (<i>Sign each entry</i>)

ADULT SCREENING AND IMMUNIZATION DOCUMENTATION FORM**Influenza Vaccination Program**

The following questions will help us determine if we should give you the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any, you will receive. Please speak to your healthcare provider, if you have any questions.

CIRCLE ANSWERS TO QUESTIONS 1-12

What is your age? <u>26</u>		
1	Do you currently feel sick or have a fever?	<input checked="" type="radio"/> NO YES
2	Are you taking any prescription medications to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	<input checked="" type="radio"/> NO YES
3	Are you pregnant or planning to become pregnant in the next month?	<input checked="" type="radio"/> NO YES
4	Have you ever had a serious reaction to a flu vaccine?	<input checked="" type="radio"/> NO YES
5	Do you have any allergy to any of the following: eggs, chicken or egg protein, gentamycin, gelatin, arginine, neomycin, polymycin B, thimerosal, formaldehyde, or other vaccine components?	<input checked="" type="radio"/> NO YES
6	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	<input checked="" type="radio"/> NO YES
7	Do you have an active neurological disease?	<input checked="" type="radio"/> NO YES
8	Do you have a history of Guillain-Barre Syndrome (GBS)?	<input checked="" type="radio"/> NO YES
9	Has your doctor ever told you that you have an immune system disorder? Are you taking long-term steroid treatment or immunosuppressants?	<input checked="" type="radio"/> NO YES
10	Do you have HIV, AIDS, cancer, or have you received an organ transplant?	<input checked="" type="radio"/> NO YES
11	Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients)?	<input checked="" type="radio"/> NO YES
12	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	<input checked="" type="radio"/> NO YES

If you are 49 years of age or younger, please list below all the medications you are currently taking (for medication reconciliation):

I have read, or have had explained to me the information in the Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

Signature: [Signature]Date: 2 Nov 11**(CONTINUE ON REVERSE SIDE)**

HOSPITAL OR MEDICAL FACILITY	STATUS <u>ACTIVE</u>	DEPART./SERVICE <u>NAVY</u>	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID. NO. <u>[Redacted]</u>	RELATIONSHIP TO SPONSOR	
<u>MERWIN, DANIEL</u>			
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name – last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (Rev. 6-97)

Prescribed by GSA/ICMR

FIRM (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (<i>Sign each entry</i>)	
BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER		
<input type="checkbox"/> Give injectable seasonal Influenza vaccine <input type="checkbox"/> Give intranasal seasonal Influenza vaccine <input type="checkbox"/> Do not administer Seasonal Influenza vaccine	VIS provided (check box) <input type="checkbox"/> Inactivated Influenza Vaccine (TIV) <input type="checkbox"/> Live, Attenuated Influenza Vaccine (LAIV)	
Interviewer's Signature:		Date:
VACCINE ADMINISTERED		
<input type="checkbox"/> Live Intranasal Influenza (FluMist) Dose: 0.2 mL Route: Intranasal Lot # _____ Manufacturer: MedImmune	<input type="checkbox"/> Inactivated Influenza (Fluzone) Dose: 0.5 mL Route: IM (check one) <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid Lot # _____ Manufacturer: Sanofi Pasteur	
<input type="checkbox"/> Inactivated Influenza (Afluria) Dose: 0.5 mL Route: IM (check one) <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid Lot # _____ Manufacturer: CSL	Comments:	
Administered by:		Date:

KEESLER REFRACTIVE SURGERY NON-LOCAL CHECKLIST

****PACKET WILL NOT BE ACCEPTED IF CHECKLIST IS INCOMPLETE****

2011 JUN 16 AM 10 47

PATIENT:

MERWIN, DANIEL

LAST 4:

[REDACTED]

CELL/HOME #:

[REDACTED]

WORK #:

850-452-0237

SURGEON:
(CIRCLE ONE)

ROPP

O'CONNELL

BROOKS

(CHECK BOXES WHEN COMPLETED/AQUIRED)

☒

Application (page 1)

☒

Exam Form

☒

Commander's Authorization

☒

ID copy (Front & Back)

☐

Scans (pentacam, wave, orbs)

☒

Register with Keesler Medical Center
228-376-4742 or 4743

☒

Managed Care Agreement

☒

Verify adequate retainability
(12 months required from the date of surgery)

☒

21 yrs old or older

☐

~~Pregnancy Consent~~

*****ALL PACKETS MUST BE RECEIVED 3 WEEKS IN ADVANCE TO HAVE SURGERY*****

Corey JC JSD

AR 3327

KEESLER REFRACTIVE SURGERY NON-LOCAL CHECKLIST

****PACKET WILL NOT BE ACCEPTED IF CHECKLIST IS INCOMPLETE****

2011 JUN 16 AM 10 47

PATIENT: MERWIN, DANIEL LAST 4: [REDACTED]
CELL/HOME #: [REDACTED] WORK #: 850-452-0237
SURGEON: ROPP O'CONNELL BROOKS
(CIRCLE ONE)

(CHECK BOXES WHEN COMPLETED/AQUIRED)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Application (page 1) | <input checked="" type="checkbox"/> Exam Form |
| <input checked="" type="checkbox"/> Commander's Authorization | <input checked="" type="checkbox"/> ID copy (Front & Back) |
| <input type="checkbox"/> Scans (pentacam, wave, orbs) | <input checked="" type="checkbox"/> Register with Keesler Medical Center
228-376-4742 or 4743 |
| <input checked="" type="checkbox"/> Managed Care Agreement | <input checked="" type="checkbox"/> Verify adequate retainability
(12 months required from the date of surgery) |
| <input checked="" type="checkbox"/> 21 yrs old or older | |
| <input type="checkbox"/> Pregnancy Consent | |

*****ALL PACKETS MUST BE RECEIVED 3 WEEKS IN ADVANCE TO HAVE SURGERY*****

CORRY JC JBR

Commander's Authorization USAF Refractive Surgery (USAF-RS) Program

I, DANIEL D. MERWIN (COTN2), a member in your command, request to have laser vision correction surgery at a DoD Refractive Surgery Center. The policy letter "**USAF REFRACTIVE SURGERY (USAF-RS) PROGRAM**" dated 21 May 2007 should be reviewed prior to completion of this authorization. Refer to <https://kx.afins.mil/USAF-RS>, it outlines the purpose of this program, issues to consider before authorizing an individual to enter the program and procedures to be followed. Your signature on this form acknowledges an understanding of the policy and willingness to ensure compliance with the requirements of the program.

Access to the DoD laser centers is prioritized according to the Chapter 1, para 1.13 of the policy letter. In your best judgment, indicate which prioritization category applies to this individual:

Priority 1 2 3 Job Title ANALYST
Air Force Personnel: AFSC _____ Branch of Service NAVY

To ensure a return on investment for the Air Force, individuals in the Aviation and Aviation-Related Special Duty Management Group must have one year retainability on active duty from the date of surgery and personnel in the Warfighter Management Group must have a minimum of 6 months retainability on active duty from the date of surgery according to Chapter 3, para 3.2.3.

Current projected separation / end of service commitment / retirement date. Provide which ever is the earliest.
(Date) OCT 2015 *do not specify indefinite*

Is member scheduled to deploy or PCS during the next 6 months? NO

Participation in this program requires a considerable investment of time by the individual resulting in absences from duty. These are the minimum requirements:

- Initial Consultation (1 ½ hr) Mass Consent Briefing (2 ½ hrs.)
- Surgery – up to 8 day of convalescent leave off work
- MANDATORY - Post-operative exams (at local MTF) up to 7 visits in the first year. Int'l _____

****All follow-up visits must be performed by your local RS-certified military eye care provider. ****

***Commander:** recovery from surgery will impact the individual's activities. Expect some limitations on routine duties for up to one month depending on vision standards applicable to individual's AFSC. The wear of sunglasses outdoors for the first year is required to prevent complications. The individual **WILL NOT** be World-Wide Qualified (non-deployable and not eligible to PCS) for up to 4 months while on steroid eye drops. A 4T profile will be issued to cover/prevent both situations. Flight Surgeon (FS) will manage the appropriate grounding actions and profile for AASD personnel. Primary Care Manager (PCM) in conjunction with local optometry will manage the profile for Warfighter personnel.

This original command authorization form must be received in our clinic before we move forward with the RS surgery. This authorization form is valid for 90 days only. Individuals will be required to re-accomplish this authorization letter if on their date of surgery it has expired.

<u>TRAVIS NASET</u>	<u>[Signature]</u>	<u>23 FEB 11</u>	<u>(850) 452-0463</u>
Supervisor Name/ Rank	(print) Signature	Date	Phone Number
<u>Henry M. VIGTER</u>	<u>[Signature]</u>	<u>24 FEB 2011</u>	<u>(850) 452-0202</u>
Unit Mobility officer Name/ Rank	(print) Signature	Date	Phone Number
<u>SEAN HERITAGE</u>	<u>[Signature]</u>	<u>24 FEB 11</u>	<u>(850) 452-0201</u>
Squadron Commander	(stamp or print) Signature	Date	Phone Number

Applicant signature [Signature] Date 17 FEB 11
Your signature states that you agree and commit to the minimum requirements and have the required AD service commitment remaining.

*No surgery will be performed until your Commander signs and dates this form.

USAF REFRACTIVE SURGERY (USAF-RS) APPLICATION					
(READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)					
Application Date:		This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) https://kx.afms.mil/USAF-RS or Public Access http://airforcemedicine.afms.mil/USAF-RS			
APPLICANT INFORMATION			AASD PERSONNEL ONLY		
Last Name: MERWIN	First Name: DANIEL	Middle Initial: D	Actively Flying: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Aircraft of Assignment:	
SSN (last 4): [REDACTED]	DOB: [REDACTED] 85	Age: 26	Crew/Duty Position:	Aviation Service Code (ASC):	
Grade/Rank: E5	Primary AFSC:	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Total # of Military Flying Hours:	Total # of Flying Hours in Last 6 Months:	
Duty Status: <input checked="" type="checkbox"/> AD <input type="checkbox"/> AFRes <input type="checkbox"/> ANG <input type="checkbox"/> AGR <input type="checkbox"/> Other	MAJCOM		FLIGHT SURGEON CONTACT INFORMATION		
Total # months of remaining AD retainability: 36 months			Unit/Squadron & Office Symbol:		
AFTER Refractive Surgery AASD must have minimum 12 months and Warfighter 6 months retainability			Phone (DSN):		
Unit/Squadron & Office Symbol: N10C P			Base / State / Zip + 4:		
Street: [REDACTED]			Duty E-mail:		
Base / State / Zip + 4: PENSACOLA FL PERRY STATION			Flight Surgeon's Name/Rank:		
Duty E-mail: MERWIN.DANIEL@DNRN.MIL			I have read and will comply IAW USAF-RS Policy 21 May 2007		
Planned RS treatment Location: USAF - KEESLER AFB, MS			Flight Surgeon's Signature:		
Preferred RS Treatment: <input checked="" type="checkbox"/> Advanced Surface Ablation (ASA) (PRK, WFG-PRK, LASEK, Epi-LASIK)	<input type="checkbox"/> Intra-Stromal Ablation (ISA) (LASIK, WFG-LASIK, FS-LASIK)	<input type="checkbox"/> Any Approved USAF RS Procedure	PERMISSION TO PROCEED		
Applicant's Signature: [Signature]			USAF-RS REGISTRY REVIEWER USE ONLY		
			Disposition Date:		
			Permission to Proceed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Reviewing Officer's Name/Rank:		
			Reviewing Officer's Signature:		
MANDATORY QUESTIONS (APPLICANT MUST INITIAL)					
Initials: DM	I am responsible for reading the policy and guidelines of USAF-RS Program available at https://www.afms.mil/USAF-RS and I am committed to comply with these guidelines				
Initials: DM	I understand I am NOT authorized to undergo refractive surgery until I have received "Permission to Proceed" from the USAF-RS Registry. If granted "Permission to Proceed", the final treatment decision is not guaranteed, but will be made by the surgeon.				
Initials: DM	I understand that the Command Authorization expires 6 months from the date my commander signed. In addition, if this occurs, I understand I must re-accomplish a new one and present the original copy before I will get treated at this center.				
Initials: DM	I must inform my flight surgeon, primary care provider, and eye care provider of surgery, follow-up care, and any complications. I must accomplish all follow-up examinations as required by policy or I may be restricted from duty or be DNIF until in compliance.				
Initials: DM	I understand that during my evaluation at a DoD RS center, I may be disqualified as a RS candidate and will not be treated. The final decision will be made by my surgeon.				
Initials: DM	If I am disqualified as a RS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)				
Initials: DM	I understand that I may require or continue to require reading and/or distance prescription correction for best vision after surgery. I understand that RS will create a permanent change in my vision and even with an optimal outcome may change over time.				
Initials: DM	Furthermore, I understand there is a chance I cannot be fit with contact lenses after RS.				
Initials: DM	I understand my vision may take time to fully recover following RS Surgery and there is a risk of not meeting relevant vision standards after RS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.				

USAF-RS Application (Page 1), 20080603

USAF Refractive Surgery (USAF-RS) Managed Care Agreement

DAVID D MERWIN
Patient Name

E5
Rank

NAVY / ACTIVE
Service / Status

CORRY STATION
Military Installation

[REDACTED]
Phone Number

☒ NO YES If Yes, when _____
Upcoming PCS/Separation/Retirement/Deployment

KEESLER
Refractive Surgery Center (WHMC / USAFA / WPAFB / Travis / Keesler / Other DoD)

PATIENT AGREEMENT

DDM I request to be returned to my local eye clinic for post-operative care following refractive surgery at the DoD Refractive Surgery Center listed above. The staff on the Refractive Surgery Center will be available for additional consultation as needed.

DDM I will contact my local Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my surgery date.

DDM I understand that I must bring the package of copied exams given to me by the Refractive Surgery Center to the local Optometry Clinic at my first follow-up appointment.

DDM I am aware that I will be placed on a 4T profile after surgery and can not deploy or PCS up to 4 months after surgery.

[Signature]
Patient Signature

17 MAR 11
Date

Post-Operative Appointment Schedule:

AASD: 1, 3, 6, 12, and 24 months, 4 years and then every 5 years

Warfighter: 1, 3, 6, 12 months

Note: ASA (PRK, LASEK, Epi-LASIK, WFG-PRK) requires a 2 month pressure check

REFERRING DOCTOR'S AGREEMENT

I certify that I have gone through the USAF Refractive Surgery Co-Management Course. I will manage this patient and accept responsibility for his/her post-operative care. I agree to refer this patient promptly if a condition arises post-operatively that will require further treatment by the Refractive Surgery Center.

KJ Whitwell, OD, MBA, FAAO
CDR MSC USN

850-452-5242 x 222

Phone

[Signature]
Date

03/29/11 OS 1345
850-452-5205

Fax

HEALTH RECORD

RECORD OF REFRACTIVE SURGERY PREOPERATIVE & TREATMENT PLAN

C/C—Blurred Vision		Right				Left							
Pt Pref: <u>PRK</u> LASIK ReTX		VAs 20/200				VAs 20/200							
CL Hx: N/A	Habitual	-2.75	-0.50	X	103	20/20	-2.50	-0.25	X	069	20/15		
DW SCL	Rx #1 2010	-2.25	-0.50	X	098	20/20	-2.50	-0.25	X	083	20/20		
RGP CL	Date: 21 Apr	-2.50	-0.25	X	095	20/20	-2.75	-0.25	X		20/20		
Last Worn: 30 days	Auto Ref	-2.50	-0.50	X	101		-2.75	-0.25	X	64			
Dominant Eye: R L	Auto Ref K's	40.50 @ 043 40.75 @ 003				40.50 @ 067 40.75 @ 157							
Medical Hx:	Time: 1236	Pent. Pachs 583				Time: 1236				Pent. Pachs 579			
	Ta: 13 mmHg	U.S. Pach. 586				Ta: 13 mmHg				U.S. Pach. 576			
	Pupils: PERRLA <input checked="" type="checkbox"/>	Pupil Size 7 mm				Pupils: PERRLA <input checked="" type="checkbox"/>				Pupil Size 7 mm			
	EOM: Full & Smooth <input checked="" type="checkbox"/>	Manifest -2.75 -0.50 X 100 20/15				-2.75 -0.25 X 075 20/15							
Medications:		Cycloplegic Rx -2.50 -0.50 X 100 20/15-1				-2.75 -0.25 X 100 20/15							
Allergies:		WAMR -2.75 -0.50 X 105 20/15				-2.75 -0.25 X 060 20/15							
Schirmer's @ 5min. With 0.5% Prop.													
R: mm													
L: mm													
Pain: 0—10 (0 = none)													

Notes/Plan:

1. Topo & Pentacam WNL
2. Discussed at length risks, limitations, expectations
3. All questions answered and patient elects to proceed
4. Acceptable Candidate
5. Schedule Procedure

Y	N
Y	N
Y	N
Y	N
Y	N

Slit Lamp Exam				Retina / Fundus			
R	Normal	Normal	L	R	Normal	Normal	L
		LIDS CONJ CORNEA AC ANGLE IRIS LENS			Optic Nerve Macula Periphery		

81 MDG/SGCQXE

James E. Rux, OD Contractor

rms -0.27
rms -0.19

Right: K-Cal: CCT: 583 Flap Thickness: — CCT - Flap: — - Est Abl Depth: 52 =RSB: 531
 Left: K-Cal: CCT: 577 Flap Thickness: — CCT - Flap: — - Est Abl Depth: 48 =RSB: 529

Planned Treatment: STANDARD on/oa CUSTOM on/oa MMC on/oa
 PRK with/without LASIK Micro M / Femto / PRK
 Planned Surgery Date: 17 May

Right	W to W	None Adj	RSB	Left	W to W	None Adj	RSB
Optical Zone	VISX	Alle-gretto	-2.75 -0.50 X 100	Optical Zone	VISX	Alle-gretto	-2.75 -0.25 X 075
Blend Zones Enabled <input checked="" type="checkbox"/> Larger Zones Enabled <input checked="" type="checkbox"/>				Blend Zones Enabled <input checked="" type="checkbox"/> Larger Zones Enabled <input checked="" type="checkbox"/>			

MERWIN, DANIEL DENNIS

20/

29 Mar 2011, 0718

DOB: 1985

Appt Date:

Occupation:

Analyst

Age: 26 Pri: 3

Base: L Army

Branch: US Army

Rank: P02 Grade:

Bartlett H. Hayes, Col, USAF, MC, FS

81 MSGS/CC

Commander, Surgical Operations Squadron

Hoon Jung, Maj, USAF, MC

81 MSGS/SGCX

Chief, Ophthalmology & Refractive Surgery

Jonathan Ellis, Capt, USAF, MC

81 MSGS/SGCX

Staff Ophthalmologist

James C. Hartley, Capt, USAF, MC

81 MSGS/SGCX

Staff Ophthalmologist

Notes:

C. R. Rux m c u s d

AR 3332

Date: _____

Manifest		X		20/
Cyclo		X		20/
WAMR		X		20/
PERRLA <input type="checkbox"/>		TA: @		

		X		20/
		X		20/
		X		20/
PERRLA <input type="checkbox"/>		TA:		

Assessment / Plan:

- myopic.

- Allegedly PRK (on).

James E. Rux, OD Contractor: _____

CONTRAINDICATIONS / WARNINGS (per FDA)

> 0.50 D change in sph or cyl in past 12 mos.	YES	<input checked="" type="radio"/> NO
Pregnant	YES	<input checked="" type="radio"/> NO
Nursing during last 6 months	YES	<input checked="" type="radio"/> NO
Autoimmune disease / immunodeficiency	YES	<input checked="" type="radio"/> NO
Diabetes Mellitus	YES	<input checked="" type="radio"/> NO
Keratoconus or corneal irregularity	YES	<input checked="" type="radio"/> NO
History of HSV / HZV keratitis	YES	<input checked="" type="radio"/> NO
Current use of:		
Accutane (Isotretinoin)	YES	<input checked="" type="radio"/> NO
Imitrex (Sumatriptan)	YES	<input checked="" type="radio"/> NO
Corarone (Amiodarone)	YES	<input checked="" type="radio"/> NO
Steroids	YES	<input checked="" type="radio"/> NO
INH	YES	<input checked="" type="radio"/> NO
Severe dry eyes / atopic disease	YES	<input checked="" type="radio"/> NO
Glaucoma	YES	<input checked="" type="radio"/> NO
Visually significant cataract	YES	<input checked="" type="radio"/> NO
Active Ophthalmic disease	YES	<input checked="" type="radio"/> NO
Corneal NV > 2mm from limbus	YES	<input checked="" type="radio"/> NO
Electronic Pacemaker/similar cardiac device	YES	<input checked="" type="radio"/> NO
Hx of prior refractive surgery	YES	<input checked="" type="radio"/> NO

CONTRAINDICATIONS / WARNINGS (per USAF Policy)

Age < 21	YES	<input checked="" type="radio"/> NO
IOP > 22 / disease predisposing to glaucoma	YES	<input checked="" type="radio"/> NO
Thyroid Disease	YES	<input checked="" type="radio"/> NO

C. P. D. P.
M. E. R. U. X.

Name:
 Last 4:
 DOB:

MERWIN, DANIEL DENNIS
 20/ [REDACTED]
 29 Mar 2011, 0718

HEALTH RECORD

RECORD OF REFRACTIVE SURGERY PREOPERATIVE & TREATMENT PLAN

C/C—Blurred Vision		Right				Left			
Pt Pref: PRK LASIK ReTX		VAsc 20/200				VAsc 20/200			
CL Hx: N A DW SCL <input checked="" type="checkbox"/> RGP CL		Habitual #		-2.25 -0.50		X 103 20		-2.50 -0.25 X 069 20	
Last Worn: 30 days		Rx #1 2010		-2.25 -0.50		X 098 20		-2.50 -0.25 X 083 20	
Dominant Eye: R L		Date: 21 APR							
Medical Hx:		Rx #2				X 20/		X 20/	
		Date:							
		Auto Ref #		-2.75 -0.50		X 095		-3.00 -0.25 X 014	
		Auto Ref K's		40.25 @ 088 / 40.75 @ 178				40.75 @ 103 / 41.00 @ 073	
Medications:		Dilated with Cyclo 1% Trop. 1% @ 0920		Time: 0900 Ta: 15 mmHg Pupils: PERRLA <input checked="" type="checkbox"/> EOM: Full & Smooth <input checked="" type="checkbox"/>		Pent. Pachs U.S. Pach. 586 Pupil Size 7 mm		Time: 0900 Ta: 16 mmHg Pupils: PERRLA <input checked="" type="checkbox"/> EOM: Full & Smooth <input checked="" type="checkbox"/>	
Allergies:		Manifest		-2.50 -0.25		X 095 20/20		-2.75 DS X 20/20	
NKDA/		Cycloplegic Rx		-2.50 -0.50		X 100 20/15		-2.75 -0.25 X 100 20/15	
Schirmer's @ 5min. With 0.5% Prop. R: mm L: mm		WAMR				X 20/		X 20/	
Pain: 0—10 (0 = none)									

Notes/Plan:

1. Topo & Pentacam WNL
2. Discussed at length risks, limitations, expectations
3. All questions answered and patient elects to proceed
4. Acceptable Candidate
5. Schedule Procedure

Y	N
Y	N
Y	N
Y	N
Y	N

Slit Lamp Exam

R	Normal	Normal	L
	<input checked="" type="checkbox"/> LIDS <input checked="" type="checkbox"/> CONJ <input checked="" type="checkbox"/> CORNEA <input checked="" type="checkbox"/> AC <input checked="" type="checkbox"/> ANGLE <input checked="" type="checkbox"/> IRIS <input checked="" type="checkbox"/> LENS		

Retina / Fundus

R	Normal	Normal	L
	<input checked="" type="checkbox"/> Optic Nerve <input checked="" type="checkbox"/> Macula <input checked="" type="checkbox"/> Periphery		

LT Zent, John W, OD USN

flat retinoscopy

Right: K-Cal: CCT: _____ Flap Thickness: _____ CCT - Flap: _____ - Est Abl Depth: _____ =RSB: _____

Left: K-Cal: CCT: _____ Flap Thickness: _____ CCT - Flap: _____ - Est Abl Depth: _____ =RSB: _____

Planned Treatment: STANDARD on/os / CUSTOM on/os / MMC on/os

Planned Surgery Date: _____

☒ PRK ETOH/BRUSH☒ LASIK MICRO-K/FEMTO/EPI

Right: W to W: _____ Nomo Adj: _____ RSB: _____

Left: W to W: _____ Nomo Adj: _____ RSB: _____

Optical Zone	VISX	Allegretto		X	
Blend Zones Enabled <input type="checkbox"/>			Larger Zones Enabled <input type="checkbox"/>		

Optical Zone	VISX	Allegretto		X	
Blend Zones Enabled <input type="checkbox"/>			Larger Zones Enabled <input type="checkbox"/>		

Name: MERWIN, DANIEL D.

SSN: [REDACTED]

DOB: [REDACTED] 1985

Appt Date: 16 MAR 2011

Occupation:

Age: _____ Pri: _____

Base: _____

Branch: _____

Rank: _____ Grade: _____

Bartlett H. Hayes, Col, USAF, MC, FS
81 MSGS/CC
Commander, Surgical Operations SquadronHoon Jung, Maj, USAF, MC
81 MSGS/SGCX
Chief, Ophthalmology & Refractive Surgery

Notes:

Jonathan Ellis, Capt, USAF, MC
81 MSGS/SGCX
Staff OphthalmologistJames C. Hartley, Capt, USAF, MC
81 MSGS/SGCX
Staff Ophthalmologist

Date: _____

Manifest		
Cyclo		
WAMR		
PERRLA <input type="checkbox"/>		

X		20/
X		20/
X		20/
	TA:	@

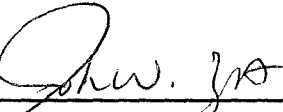
PERRLA <input type="checkbox"/>	

X		20/
X		20/
X		20/
	TA:	

Assessment / Plan:

A ① myopia OU
 ② Probable flat retinoschisis OD
 P ①+② recommended retinal consult pre CBS.

LT Zent, John W, OD USN



CONTRAINDICATIONS / WARNINGS (per FDA)

> 0.50 D change in sph or cyl in past 12 mos.	YES	<input checked="" type="radio"/> NO
Pregnant	YES	<input checked="" type="radio"/> NO
Nursing during last 6 months	YES	<input checked="" type="radio"/> NO
Autoimmune disease / immunodeficiency	YES	<input checked="" type="radio"/> NO
Diabetes Mellitus	YES	<input checked="" type="radio"/> NO
Keratoconus or corneal irregularity	YES	<input checked="" type="radio"/> NO
History of HSV / HZV keratitis	YES	<input checked="" type="radio"/> NO
Current use of:		
Accutane (Isotretinoin)	YES	<input checked="" type="radio"/> NO
Imitrex (Sumatriptan)	YES	<input checked="" type="radio"/> NO
Corarone (Amiodarone)	YES	<input checked="" type="radio"/> NO
Steroids	YES	<input checked="" type="radio"/> NO
INH	YES	<input checked="" type="radio"/> NO
Severe dry eyes / atopic disease	YES	<input checked="" type="radio"/> NO
Glaucoma	YES	<input checked="" type="radio"/> NO
Visually significant cataract	YES	<input checked="" type="radio"/> NO
Active Ophthalmic disease	YES	<input checked="" type="radio"/> NO
Corneal NV > 2mm from limbus	YES	<input checked="" type="radio"/> NO
Electronic Pacemaker/similar cardiac device	YES	<input checked="" type="radio"/> NO
Hx of prior refractive surgery	YES	<input checked="" type="radio"/> NO

CONTRAINDICATIONS / WARNINGS (per USAF Policy)

Age < 21	YES	<input checked="" type="radio"/> NO
IOP > 22 / disease predisposing to glaucoma	YES	<input checked="" type="radio"/> NO
Thyroid Disease	YES	<input checked="" type="radio"/> NO

Name:
 Last 4:
 DOB:

mostly
spherical. \bar{c}
minimal
astigmatism.
(ow) co

Patient: Merwin, Daniel #20

DR. Ropp Naval Hospital Pensacola Ophthalmology

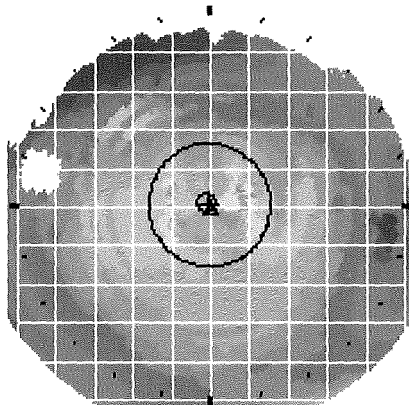
OD/OS Compare Display

Power: 40.8 D
(8.27 mm)
From vertex:
Dist 0.00 mm
S-merid 0°

SimK Values:
40.87D @180
40.62D @90

OD

03/29/11
12:36 PM
[TN]



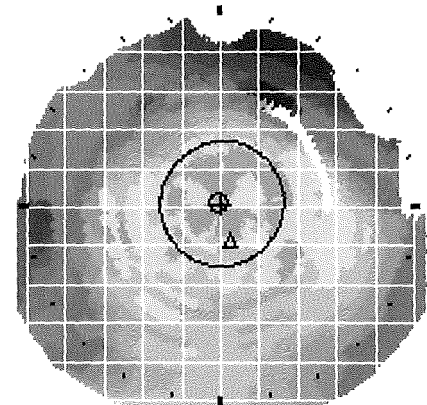
Axial Map

Power: 41.8 D
(8.07 mm)
From vertex:
Dist 0.00 mm
S-merid 0°

SimK Values:
41.62D @36
41.12D @126

OS

03/29/11
12:36 PM
[TN]

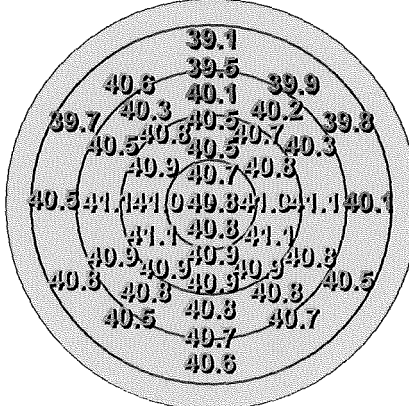


Axial Map

Avg Curvature
Overall = 40.3
10mm = 39.4
8mm = 39.7
6mm = 40.4
4mm = 40.7
2mm = 41.0
0mm = 40.8

OD

03/29/11
12:36 PM
[TN]

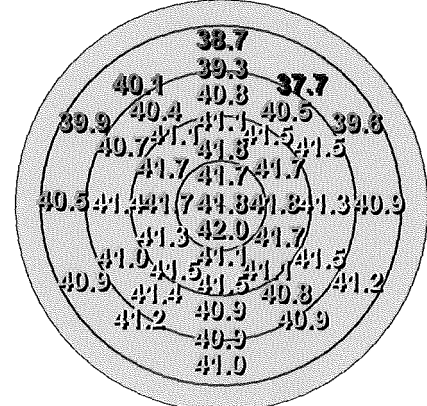


Numerical View

Avg Curvature
Overall = 40.7
10mm = 39.9
8mm = 39.8
6mm = 40.8
4mm = 41.2
2mm = 41.5
0mm = 41.8

OS

03/29/11
12:36 PM
[TN]



Numerical View

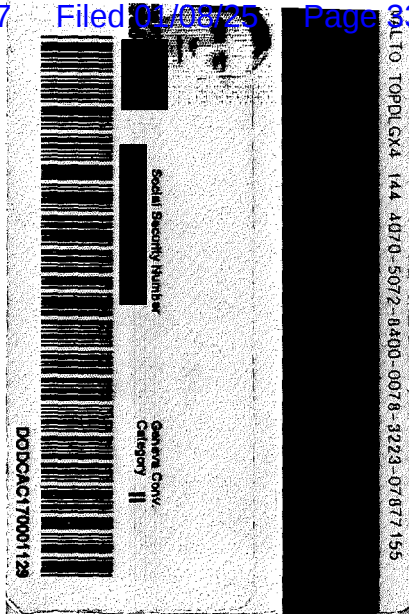
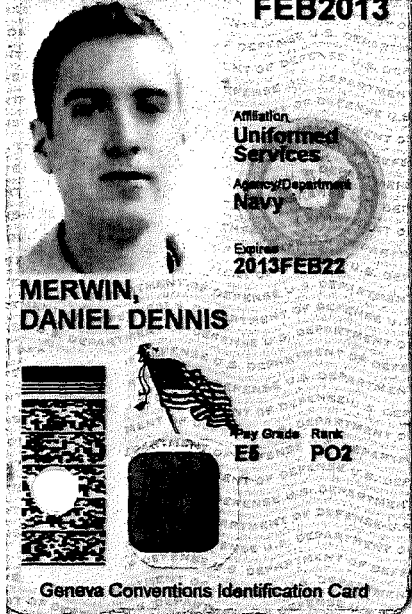
Options

ATLAS Version A12.2 (0001) Autosize

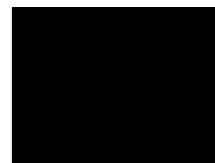
Extrapolated 1 mm

Wavefront Error		Physician: Ropp, Corby		Operator: HM2 Cordova		
Patient: Merwin, Daniel Patient ID: 20/ XXXXXXXXXX Notes:						
OD	-2.68 DS -0.55 DC x 105° @25.0 mm (4.00 Rx Calc) 29-Mar-2011 11:38:19 W.F. Diam (mm): 6.75 High Order: 4.9 % Eff. Blur (D): 2.81 Rms Err.(μ): 4.62 Quality: ✓✓✓✓			OS	-2.62 DS -0.24 DC x 58° @25.0 mm (4.00 Rx Calc) 29-Mar-2011 11:39:37 W.F. Diam (mm): 6.25 High Order: 11.3 % Eff. Blur (D): 2.57 Rms Err.(μ): 3.62 Quality: ✓✓✓✓	

<p>Acuity Map Rms Error (μ): 4.62</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p>microns</p> <table style="font-size: 0.8em;"> <tr><td>28.00</td><td>▶</td></tr> <tr><td>24.00</td><td>▶</td></tr> <tr><td>20.00</td><td>▶</td></tr> <tr><td>16.00</td><td>▶</td></tr> <tr><td>12.00</td><td>▶</td></tr> <tr><td>8.00</td><td>▶</td></tr> <tr><td>4.00</td><td>▶</td></tr> <tr><td>0.00</td><td>▶</td></tr> <tr><td>-4.00</td><td>▶</td></tr> <tr><td>-8.00</td><td>▶</td></tr> <tr><td>-12.00</td><td>▶</td></tr> <tr><td>-16.00</td><td>▶</td></tr> <tr><td>-20.00</td><td>▶</td></tr> <tr><td>-24.00</td><td>▶</td></tr> <tr><td>-28.00</td><td>▶</td></tr> </table> </div> <div style="margin-left: 10px;"> <p>Range: -0.0 to +18.1 microns</p> <p>Grid spacing: 1 mm.</p> </div> </div>	28.00	▶	24.00	▶	20.00	▶	16.00	▶	12.00	▶	8.00	▶	4.00	▶	0.00	▶	-4.00	▶	-8.00	▶	-12.00	▶	-16.00	▶	-20.00	▶	-24.00	▶	-28.00	▶	<p>Acuity Map Rms Error (μ): 3.62</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p>microns</p> <table style="font-size: 0.8em;"> <tr><td>14.00</td><td>▶</td></tr> <tr><td>12.00</td><td>▶</td></tr> <tr><td>10.00</td><td>▶</td></tr> <tr><td>8.00</td><td>▶</td></tr> <tr><td>6.00</td><td>▶</td></tr> <tr><td>4.00</td><td>▶</td></tr> <tr><td>2.00</td><td>▶</td></tr> <tr><td>0.00</td><td>▶</td></tr> <tr><td>-2.00</td><td>▶</td></tr> <tr><td>-4.00</td><td>▶</td></tr> <tr><td>-6.00</td><td>▶</td></tr> <tr><td>-8.00</td><td>▶</td></tr> <tr><td>-10.00</td><td>▶</td></tr> <tr><td>-12.00</td><td>▶</td></tr> <tr><td>-14.00</td><td>▶</td></tr> </table> </div> <div style="margin-left: 10px;"> <p>Range: -0.0 to +13.8 microns</p> <p>Grid spacing: 1 mm.</p> </div> </div>	14.00	▶	12.00	▶	10.00	▶	8.00	▶	6.00	▶	4.00	▶	2.00	▶	0.00	▶	-2.00	▶	-4.00	▶	-6.00	▶	-8.00	▶	-10.00	▶	-12.00	▶	-14.00	▶
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<p>Wavefront High Order Aberrations Rms Error (μ): 0.27</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p>microns</p> <table style="font-size: 0.8em;"> <tr><td>1.75</td><td>▶</td></tr> <tr><td>1.50</td><td>▶</td></tr> <tr><td>1.25</td><td>▶</td></tr> <tr><td>1.00</td><td>▶</td></tr> <tr><td>0.75</td><td>▶</td></tr> <tr><td>0.50</td><td>▶</td></tr> <tr><td>0.25</td><td>▶</td></tr> <tr><td>0.00</td><td>▶</td></tr> <tr><td>-0.25</td><td>▶</td></tr> <tr><td>-0.50</td><td>▶</td></tr> <tr><td>-0.75</td><td>▶</td></tr> <tr><td>-1.00</td><td>▶</td></tr> <tr><td>-1.25</td><td>▶</td></tr> <tr><td>-1.50</td><td>▶</td></tr> <tr><td>-1.75</td><td>▶</td></tr> </table> </div> <div style="margin-left: 10px;"> <p>Range: -0.9 to +0.9 microns</p> <p>Grid spacing: 1 mm.</p> </div> </div>	1.75	▶	1.50	▶	1.25	▶	1.00	▶	0.75	▶	0.50	▶	0.25	▶	0.00	▶	-0.25	▶	-0.50	▶	-0.75	▶	-1.00	▶	-1.25	▶	-1.50	▶	-1.75	▶	<p>Wavefront High Order Aberrations Rms Error (μ): 0.19</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p>microns</p> <table style="font-size: 0.8em;"> <tr><td>1.75</td><td>▶</td></tr> <tr><td>1.50</td><td>▶</td></tr> <tr><td>1.25</td><td>▶</td></tr> <tr><td>1.00</td><td>▶</td></tr> <tr><td>0.75</td><td>▶</td></tr> <tr><td>0.50</td><td>▶</td></tr> <tr><td>0.25</td><td>▶</td></tr> <tr><td>0.00</td><td>▶</td></tr> <tr><td>-0.25</td><td>▶</td></tr> <tr><td>-0.50</td><td>▶</td></tr> <tr><td>-0.75</td><td>▶</td></tr> <tr><td>-1.00</td><td>▶</td></tr> <tr><td>-1.25</td><td>▶</td></tr> <tr><td>-1.50</td><td>▶</td></tr> <tr><td>-1.75</td><td>▶</td></tr> </table> </div> <div style="margin-left: 10px;"> <p>Range: -0.5 to +0.9 microns</p> <p>Grid spacing: 1 mm.</p> </div> </div>	1.75	▶	1.50	▶	1.25	▶	1.00	▶	0.75	▶	0.50	▶	0.25	▶	0.00	▶	-0.25	▶	-0.50	▶	-0.75	▶	-1.00	▶	-1.25	▶	-1.50	▶	-1.75	▶
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REFRACTIVE SURGERY MEETING INFORMED CONSENT



Please read and initial each line. Sign where indicated.

DPM	1 I have read the Patient Information Booklet (downloaded from the website)
OPM	2 I understand the Surgery process and what will occur the day of surgery.
DPM	3 I understand what my responsibilities are the day of surgery. a Remember to bring Medications and dark sunglasses b No Mascara, perfumes, or colognes
DPM	4 I understand that I will need a driver on the day of surgery, my one day post op, and my five day post op appointments.
DPM	5 I understand my medication directions.
DPM	6 I have received a 2 page Pre & Post Op Instruction sheet.
DPM	7 I have read and signed my informed consents.
DPM	8 My questions have been answered to my satisfaction.
DPM	9 I understand I have an obligation and agree to meet my monthly follow-ups as required by my eye care provider. I also understand that I must book these exams myself; they are not booked for me.
DPM	10 I understand that if I am to PCS to any location at anytime prior to my 12 month post operative visit I must have an express written letter from a PRK/LASIK certified Optometrist or Ophthalmologist stating I will be accepted as a post PRK/LASIK patient at their clinic. I also understand I am not allowed to PCS nor do a TDY for 1 month after the procedure.
DPM	11 I affirm I do have proper retainability, and intend to remain active for the length required to have surgery, i.e. 6 months for Air Force, 12 months for Navy, Marines, and Coast Guard, and 18 months for Army. Date of Separation? <u>31 OCT '15</u>
DPM	12 I affirm that I have NOT received the smallpox vaccination with in the last 21 days. I will NOT receive a smallpox vaccination until the steroid taper is completed.

Patient Name (Print) DANIEL MERWIN Date 4/14/11

Patient Signature [Signature]

Where can we reach you during your surgery week? Home
And an emergency contact; name and number? Home

Comments to improve our service:

CORREY gcs

**INFORMED CONSENT FOR EXCIMER LASER
PHOTOREFRACTIVE KERATECTOMY**

I, DANIEL MERWIN, agree to have my surgeon, DR ROBO, M.D., perform the U.S. Food and Drug Administration (FDA) approved laser procedure called PHOTOREFRACTIVE KERATECTOMY (PRK). The excimer laser will be used to reshape the front of the cornea (the clear front part of the eye) to reduce or eliminate the need for glasses or contact lenses. I understand that this procedure is permanent and irreversible. I also understand that this is an elective procedure and that there is no government requirement for me to have this procedure done.

PROCEDURE (RIGHT - LEFT - BOTH)

My eye(s) being treated will receive topical anesthetic drops to reduce or eliminate discomfort associated with the procedure. I will be lying on my back under the laser and will be asked to look up into the operative microscope at the flashing red light. The laser will remove a calculated amount of tissue from the cornea in an attempt to reshape the cornea to reduce my dependence on glasses or contact lenses.

During the laser procedure, a popping or cracking sound will be heard. After the procedure, a bandage soft contact lens will be placed on my eye(s) along with antibiotic and anti-inflammatory drops. I realize that I may experience discomfort or pain in the hours following treatment as well as light sensitivity, tearing, irritation, and redness. Additional drops and instructions will be provided.

RISKS:

DDM (Initials) 1. I understand that, as with all surgical procedures, the results cannot be guaranteed. There is also no guarantee that I will eliminate my reliance on glasses or contact lenses. It is possible that the treatment could result in under-correction (residual nearsightedness or myopia), over-correction (farsightedness or hyperopia), or astigmatism, any of which may require glasses or contact lenses. It is also possible that this treatment may increase my dependence on reading glasses, or that I may require reading glasses at an earlier age. I understand that further treatment may be necessary, including the use of eyedrops, the wearing of glasses or contact lenses, or an additional laser treatment.

DDM (Initials) 2. I understand that if I currently wear reading glasses, I will likely still need them after this treatment. I also understand that if I currently do not need reading glasses, I will most likely need them at some point in time.

N/A (Initials) 3. (Female only) I am not pregnant nor have I been pregnant in the past 12 months. I am not nursing nor have I been nursing in the past 6 months. If it is possible that I am pregnant, I will obtain a pregnancy test to ascertain that I am not pregnant since pregnancy could adversely affect the treatment results. Also, I will notify my doctor immediately if I become pregnant within the six months following treatment. I understand that the use of oral contraceptive agents may increase certain risks associated with the procedure.

DDM (Initials) 4. I understand that I should make the doctor aware of any vascular or autoimmune disease I may have, or of any drug therapy that may suppress the immune system.

DDM (Initials) 5. I understand that the FDA has not specifically approved the use of a bandage soft contact lens immediately after the procedure. The contact lens is used to reduce postoperative pain or discomfort that can be severe. The contact lens however can increase the risk of corneal infection or inflammation. I will inform my doctor if I do not want a contact lens used after the procedure.

DDM (Initials) 6. I have been informed that complications can occur which, although usually temporary, may be permanent, and include:

- Decrease in best-corrected visual acuity.* A decrease in best-corrected visual acuity (vision with eyeglasses or contact lenses) may occur.
- Glare and halos.* Glare from bright lights or halos around lights may be experienced especially at night. The glare may be severe enough to cause difficulty driving at night or under low-light conditions.
- Decrease in contrast sensitivity.* A decrease in the *quality* of vision may occur even with excellent visual acuity as measured on a standard eye chart.
- Corneal scarring and haze.* A scar dense enough to affect vision may occur after the procedure.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

CTN² MERWIN, DANIEL
20/ [REDACTED]
DOB: [REDACTED] 1985

MEDICAL RECORD REPORT
Medical Record

OPTIONAL FORM 275

81 MDG/DREF-FORMS Approved Overprint 10/04 – PRK Consent

- e. *Elevated intraocular pressure.* High pressure in the eye, which may reduce vision, may occur while taking eye drops after the procedure. This condition is treated with additional drops, or rarely surgery.
- f. *Delayed healing.* Delayed healing of the skin on the surface of the cornea may extend the discomfort.

DM (Initials) 7. Other complications which have been reported include: cataract, corneal ulceration, infection, inflammation in the eye, corneal inflammation, double vision, drooping eyelid, shadow images, ghost images, and allergic reactions to the prescribed medications. Since it is impossible to state every complication of PRK, it is understandable that the above list is not complete or exhaustive. Fortunately, most complications are rare, temporary, or mild. Since each person is unique and responds differently to surgery and the healing process that follows, there can be no guarantee made to me regarding the results of PRK on my eye(s).

DDM (Initials) 8. I give permission for the medical data concerning my operation and any subsequent treatment to be submitted for outcome data analysis. I understand that my identity will be kept strictly confidential in any reports or journal articles.

DDM (Initials) 9. I understand that PRK treatment requires follow-up care at prescribed intervals for one year after treatment, and I agree to return for required examinations as requested.

DDM (Initials) 10. **SPECIAL MILITARY CONSIDERATIONS:** I understand that there is a risk of having complications such as loss of best corrected vision after the laser procedure which, in spite of additional treatment, may cause me to be no longer world wide qualified for continued active duty service, and may result in a change in my primary Air Force Specialty Code (AFSC), disqualification from flying duties, or in administrative separation from the U.S. Air Force.

Notes:

BENEFITS AND ALTERNATIVES TO TREATMENT:

The benefit of the procedure is to reduce my dependence on glasses or contact lenses and to reduce my blurriness when not wearing glasses or contact lenses (uncorrected visual acuity).

Non-surgical alternatives to treatment include continued wear of glasses or contact lenses. Surgical alternatives to PRK include, but are not limited to, radial keratotomy (RK), automated lamellar keratectomy (ALK), and laser in-situ keratomileusis (LASIK). RK uses a special knife to make incisions on the cornea and ALK uses a motorized blade to remove a small amount of tissue from the center of the cornea. LASIK combines the use of a motorized blade and a laser to reshape the cornea.

Notes:


ADVANCED DIRECTIVES:

DDM (Initials) I understand that by hospital policy, a **DO NOT RESUSICATE** order is temporarily suspended for the period surrounding conscious sedation or surgery. Any suspended advance directive may be re-instituted by me or my designated surrogate upon completion of the procedure.

AGREEMENT:

My signature indicates that I have read and understand the information provided and have discussed the risks, benefits, and alternatives of the procedure with an eye care provider. I have had an opportunity to ask my physician questions and would like to proceed with the treatment. I have received and read the FDA-mandated patient information booklet entitled "Facts You Need to Know about Photorefractive Keratectomy (PRK) Surgery". I agree that I will follow postoperative instructions and go to the required follow-up evaluations.

<u>DANIEL MERWIN</u>	<u>Daniel Merwin</u>	<u>4/14/11</u>
(Patient)	(Patient signature)	(Date)
<u>ROPP, CORBY D.</u>	<u>[Signature]</u>	<u>4/14/11</u>
(Physician)	(Physician signature)	(Date)
<u>HM2 YOUNG, RICHARD</u>	<u>[Signature]</u>	<u>14 APR 11</u>
(Witness)	(Witness signature)	(Date)

Exam Date		Last Name		First Name		Last 4	
SLIT LAMP EXAM							
OD		NL	ABNL	FINDINGS		OS	
Lids / Lashes / Lac		<input type="checkbox"/>	<input type="checkbox"/>			Lids / Lashes / Lac	
Conjunctiva		<input type="checkbox"/>	<input type="checkbox"/>			Conjunctiva	
Cornea		<input type="checkbox"/>	<input type="checkbox"/>			Cornea	
Haze <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4						Haze <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
A/C		<input type="checkbox"/>	<input type="checkbox"/>			A/C	
Iris		<input type="checkbox"/>	<input type="checkbox"/>			Iris	
Lens		<input type="checkbox"/>	<input type="checkbox"/>			Lens	
IOP <u>7</u> mmHg		Must be TA while on steroid eyedrops				IOP <u>-</u> mmHg	
TOPOGRAPHY		OD	OS	Comments		IMPRESSION / PLAN	
Not Performed		<input type="checkbox"/>	<input type="checkbox"/>			<p>A.) Healing abras. in (OS).</p> <p>B.) Vigamox QID (OS). 4m, mot. ev. TID, Flu 1 day.</p>	
Normal		<input type="checkbox"/>	<input type="checkbox"/>				
Abnormal		<input type="checkbox"/>	<input type="checkbox"/>				
FUNDUS		OD	OS	Comments			
Not Performed		<input type="checkbox"/>	<input type="checkbox"/>				
DFE		<input type="checkbox"/>	<input type="checkbox"/>				
Non-DFE		<input type="checkbox"/>	<input type="checkbox"/>				
Normal		<input type="checkbox"/>	<input type="checkbox"/>				
Abnormal		<input type="checkbox"/>	<input type="checkbox"/>				
Eye Care Provider		Aviator Meets AF Flight Vision Standards		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted	
RECOMMENDATION		Warfighter Meets AF Duty Vision Standards		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted	
Eye Care Provider		SR O'Connell, MD		Flight Surgeon Stamp/Signature			
Rank/Name		CAPT MC USN		 <p>C. R. Mc</p>			
Base		Naval Hospital Pensacola					
DSN		FAX					
E-mail		stephen.oconnell@med.navy.mil					

USAF-RS Post-Op, 20080603

2011 MAY 5 AM 8 08

MERWIN, DANIEL D
20/
4 May 2011, 0818

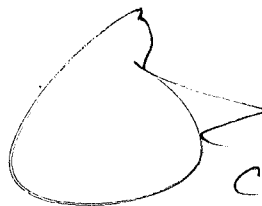
COPY

USAF REFRACTIVE SURGERY (USAF-RS) POST-OP FORM																																																																																																												
This form and other USAF Tools are available on AF Knowledge Exchange (DotMil, https://kx.afms.mil/USAF-RS) or Public Access http://airforcemedicine.afms.mil/USAF-RS																																																																																																												
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PATIENT INFORMATION																																																																																																												
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SUBJECTIVE INFORMATION																																																																																																												
Chief Complaint / Interval History <u>start strabismic by dog left eye</u> <u>scratched</u> <u>- last night 10 p.m.</u> <u>10/10 pain 5/10 now</u>					Post-Op Medication If currently using, indicate name and dosage <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Steroid <u>FML BID</u> <input type="checkbox"/> <input type="checkbox"/> IOP Control <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Artificial Tear <u>Refresh PRN</u> <input type="checkbox"/> <input type="checkbox"/> Other <u>Resch's BID, Nevanac PRN</u>																																																																																																							
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If aeromedical waiver is being considered, cycloplegic refraction and dilated fundus exam (DFE) are required. At least, one post-CRS evaluation must be included with the aeromedical summary requesting MAJCOM waiver.																																																																																																												
Cyclopentolate 1% Drop 1 @ hrs OD - X 20/ OS - X 20/ Drop 2 @																																																																																																												

MERWIN, DANIEL D

20/

4 May 2011, 0818

C.R.S.P
mc usd

HEALTH RECORD

CHRONOLOGICAL RECORD OF

MEDICAL CARE

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **16 Feb 2011 0830 CST**
 Clinic: **PULMONARY DISEASE CLINIC**

Appt Type: **SPEC**
 Provider: **LEWIS, CHRISTOPHER T**

Reason for Appointment: ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN
Appointment Comments:
 CAC-CN

Screening Written by LEE, BRANDON G @ 16 Feb 2011 0803 CST
Reason For Appointment: ASTHMA EXTRINSIC/CTD/MED/REC/15/PULMN

Allergen information verified by LEE, BRANDON G @ 16 Feb 2011 0803 CST

Vitals

Vitals Written by LEE, BRANDON G @ 16 Feb 2011 0803 CST

BP: 123/74, HR: 85, RR: 15, HT: 69 in, WT: 157 lbs, SpO₂: 98%, BMI: 23.18, BSA: 1.864 square meters,
 Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0905 CST

Chief complaint

The Chief Complaint is: Chest tightness.

History of present illness

The Patient is a 26 year old male.
 He reported: General overall feeling Good

No military duty-related information - (Not on PRP/SCI/PSP). No depression Screen: Negative PHQ-2 (Score < 3).
 Pt is a 26 yo male with a history of allergies and childhood asthma. He notes a history of asthma in childhood which was associated with allergic symptoms. He remarks on 1 hospitalization for his asthma as a child but none since. Since the age of 8 he has been doing well and was not maintained on any inhalers. He is very active and is an active marathoner. Recently he has noted increased symptoms of chest tightness associated with exposure to cats and dogs. He was briefly treated with Advair, but is currently being maintained on Zyrtec and Flonase as well as allergen avoidance with excellent control of his symptoms. He will have once weekly chest tightness and albuterol use, but is otherwise doing well, and recently completed a marathon. He presents for routine follow up.

Pain Severity 0 / 10.

Past medical/surgical history**Reported History:**

Past Medical History:
 1) childhood asthma
 2) allergies.
 Medical: Reported medical history N/A.
 Surgical / procedural: Surgical / procedural history 1) T&A.
 Reported medications: Medication history Zyrtec 1 tab po qd
 Flonase.

Personal history

-Tob: none
 -EtOH: none
 Originally from California. Lived in PA and NJ. USN for 5 years. Works as a cryptologist. Deployed to Japan recently, but no other travel or occupational exposure.
 Behavioral history: Never a smoker / Never Used Tobacco Products.
 Alcohol: No consumption of alcohol.
 Habits: Exercising regularly (Engaged in Routine / Regular Activity to Improve Your Health)

Family history

Family medical history N/A.

Review of systems

Military service: Visit is not deployment-related Location:

Date:

Systemic symptoms: Not feeling tired or poorly, not tiring easily, and no lethargy. No fever and no chills.

Pulmonary symptoms: No dyspnea, not coughing up sputum, no hemoptysis, and no wheezing.

Gastrointestinal symptoms: No heartburn, no nausea, and no vomiting.

Physical findings**Vital signs:**

° Current vital signs reviewed.

Name/SSN: MERWIN, DANIEL DENNIS/

Sex: M

Sponsor/SSN: MERWIN, DANIEL DENNIS/

FMP/SSN: 20/

Tel H:

Rank: PETTY OFFICER SECOND CLASS

DOB: 1985

Tel W:

Unit: N30922 (IA CNINTEL TRNG)

PCat: N11 USN ACTIVE DUTY

CS:

Outpt Rec. Rm: CORRY OUTPAT RECS

MC Status:

Status:

PCM:

Insurance: No

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS
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STANDARD FORM 600 (REV. 5)
 Prescribed by GSA and ICMR
 FIRM (41 CFR) 201-45.505

Page 1 of 3

AR 3344

HEALTH RECORD**CHRONOLOGICAL RECORD****MEDICAL CARE**

16 Feb 2011 0755

Facility: NH Pensacola FL

Clinic: PULMONARY DISEASE CLINIC

Provider: LEWIS, CHRISTOPHER T

General appearance:

° Well-appearing. ° Awake. ° Alert. ° In no acute distress.

Neck:

Palpation: ° Of the neck revealed no abnormalities.

Nose:

General/bilateral:

Nasal Discharge: ° No nasal discharge seen.

Sinus Tenderness: ° No sinus tenderness.

Pharynx:

Oropharynx: ° Uvula was not enlarged. ° Tonsils were not enlarged.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° No wheezing was heard. ° No rhonchi were heard. ° No prolonged expiratory time. ° No rales/crackles were heard.

Cardiovascular system:

Jugular Venous Pressure: ° JVP was normal.

Jugular Venous Distention: ° JVD not increased.

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° S1 normal. ° S2 normal. ° No S3 heard. ° No S4 heard. ° No pericardial friction rub heard.

Murmurs: ° No murmurs were heard.

Abdomen:

Palpation: ° Abdomen was not soft. ° No abdominal tenderness.

Skin:

° No generalized cyanosis.

A/P Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0930 CST

1. difficulty breathing (dyspnea): Pt is a 26 yo male with a history of childhood asthma and allergy type symptoms. His clinical history is suggestive of mild intermittent asthma, and his symptoms are under excellent control with control of his allergies with zyrtec and flonase. He will continue on these medications and prn albuterol for now, and will be referred for baseline PFTs and methacholine challenge study to definitive rule in/out asthma. Even with a positive study, his symptoms are under excellent control on his current therapy, and if needed he can be successfully controlled with an inhaled steroid. He is highly functional, and even if a diagnosis of asthma is established this in no way should impact upon his fitness for duty. He is currently fit for duty and fit for world wide deployment. He will follow up in 3-4 weeks to review the results of his PFTs.

Consult(s):

-Referred To: PULMONARY FUNCTION STUDIES (Routine) Specialty: PULMONARY DISEASE Clinic: PULMONARY FUNCTION LAB Primary Diagnosis: difficulty breathing (dyspnea)

Disposition Written by LEWIS, CHRISTOPHER T @ 16 Feb 2011 0931 CST**Released w/o Limitations**

Administrative Options: Consultation requested

Note Written by AEPPLI, CAROL @ 16 Feb 2011 0755 CST**Consult Order****Referring Provider:**

BROWN, TRAVIS S

Date of Request:

08 Feb 2011

Priority:

Routine

Provisional Diagnosis:

ASTHMA EXTRINSIC

Reason for Request:

LVM ON CELL PHONE 25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment. thank you. contact phone # 850 292 7149

Signed By LEWIS, CHRISTOPHER T (Physician, NH Pensacola FL) @ 16 Feb 2011 0931

Name/SSN: MERWIN, DANIEL DENNIS/

Sex: M

Sponsor/SSN: MERWIN, DANIEL DENNIS/

FMP/SSN: 20/

Tel H:

Rank: PETTY OFFICER SECOND CLASS

DOB: 1985

Tel W:

Unit: N30922 (IA CNINTEL TRNG)

PCat: N11 USN ACTIVE DUTY

CS:

Outpt Rec. Rm: CORY OUTPAT RECS

MC Status:

Status:

PCM:

Insurance: No

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

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Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

Page 2 of 3

AR 3345

CONSULTATION SHEET - Electronic Version of SF513

Lewis
16 Feb C 0830To: PULMONARY DISEASES CONSULT
Order/Date Time: 08 Feb 2011@0915From: DEPLOYMENT HEALTH CLINIC
Requested Date of Consult:

Reason for Request:

25 yo AD male has a history of childhood asthma, with improvement in symptoms as he reached adulthood. However he continues to have problems with tightness in his chest on occasion. States some things in the environment (dogs and cats for example) trigger his symptoms and may last for days. Denies any problems with routine exercise. He has been taking Zyrtec and Flonase daily however do not seem to be very effective. He was recently given Albuterol and Advair inhaler which he uses prn with good results. Please evaluate, treat and let me know his deployment status. Are there other environmental factors that could be an issue while on deployment. thank you. contact phone # 850 292 7149

Provisional Diagnosis: ASTHMA EXTRINSIC

Requesting HCP: BROWN, TRAVIS SCOTT
Entered By: BROWN, TRAVIS S

Priority: ROUTINE

CONSULTATION REPORT

Signature and Title:

Date/Time:

20/ [REDACTED] MERWIN, DANIEL DENNIS
[REDACTED] 1985 / Male
Loc:
Spon: MERWIN, DANIEL DENNIS
Unit: IA CNINTEL TRNG

USN ACTIVE DUTY
H: C [REDACTED]
W: not on file
Rank: NE5
RR: CORRY OUTPAT RECS

Addr: [REDACTED], PENSACOLA, FL [REDACTED]

Automated version of SF513

***** FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE *****

Any misuse or unauthorized disclosure of this information may
result in both criminal and civil penalties.

Date: 08-Feb-2011

Force IMR Report

Page: 1

Activity: N6288 - NIOC PENSACOLA

Cmd: 98 - Active Duty Navy

Name	Rate/ Rank	SSN	DOB	Gender	Age	Unit	Blood Type	IMR Status
MERWIN DANIEL DENNIS	CTN2			1985	M	25 41976	OPOS	Fully Medically Ready
USN	LOD: None	MRR: None	TNPQ: None	TNDQ: None	LIMDU: None	MEDBRD: None		

Waiver Type	Issue Date	Reason
Immunization	Series	Completed
Adenovirus		
Anthrax	5	09-Mar-2010
Cholera		
H1N1 Influenza		22-Dec-2009
HPV- Human Papilloma		
Hepatitis A	2	14-Dec-2005
Hepatitis B	2	14-Dec-2005
Influenza		15-Nov-2010
JEV		
MGC		
MMR	0	08-Nov-2005
Pneumococcal		
Polio	0	08-Nov-2005
Rabies		
Smallpox		
Smallpox Reading		
Tetanus/Diphtheria	0	08-Nov-2005
TwinRix	1	14-Dec-2005
Typhoid		
Varicella		
Yellow Fever	0	14-Dec-2005

Tests

Primary Physical:	Due:	Routine
PHA Exam Date: 17-Mar-2010	PHA Compl Date: 17-Mar-2010	Due: 17-Mar-2011
Short Flight Date:	Due:	
Dental Date: 15-Nov-2010	Class: 1	Type: Military Due: 01-Jan-2012
Biting Date:	Due: 08-Feb-2011	Panograph Date: Due: 08-Feb-2011
HIV Test Date: 09-Mar-2010	Results Date: 11-Mar-2010	Due: 09-Mar-2012
DNA Sent Date:	Date Reg: 15-Dec-2005	
Baseline DD2215: 07-Nov-2005		
Sickle Cell Test Date: 06-Nov-2005	Results: N	
G6PD Date: 06-Nov-2005	G6PD Code: N	
HBSAB Serology Titre:	Results:	
PAP Smear:	Mammogram:	
Eye Exam Date: 07-Nov-2005	Eye Exam Req: Y	Eye Exam Req: Y
Gas Mask Inserts Req: N	Issue Date:	Verified Date: 17-Mar-2010 Due: 17-Mar-2011
Pregnant:	Due Date:	Weeks Pregnant:
OCC Health Eval Date:	Eval Req: N	OCC Health:
TST Reading: 19-Mar-2010	TB Questionnaire:	PPD Reactor: N Due: 18-Mar-2013
NAMI Eval Date:	Specialty:	Annual Resubmit Req: Waiver:
Health Care Promotion: N	Health Enrollment Assessment: N	Health Risk Appraisal: N
Allergies (Y/N): Y	Warning Tag Required: 10-Nov-2008	Warning Tag Issued: 10-Aug-2009

Due - highlighted

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: **MERWIN, DANIEL DENNIS**
 Treatment Facility: **NH Pensacola**
 Patient Status: **Outpatient**

Date: **08 Feb 2011 0830 CST**
 Clinic: **DEPLOYMENT HEALTH CLINIC**

Appt Type: **WELL**
 Provider: **BROWN, TRAVIS SCOTT**

Reason for Appointment: **pha/jacc/15 min/rec/rx/ct**

Appointment Comments:
cac-cjm

AutoCites Refreshed by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Problems**Chronic:**

- Skin neoplasm of uncertain behavior
- Removal of sutures
- Extrinsic asthma
- Folliculitis
- Rosacea
- Lattice peripheral retinal degeneration
- Myopia
- Allergic rhinitis
- Visit for: occupational health/fitness exam
- Parent education about immunizations
- Visit for: military services physical
- Exposure to venereal disease
- Inquiry and counseling about contraceptive practices
- Visit for: administrative purposes

Family History

No Family History Found.

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications**Active Medications**

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	T1 TAB PO HS #30 RF5	5 of 5	24 Jan 2011
Fluticasone Propionate 0.05%, Spray, Nasal	Active	INHALE 2 SPRAYS IN EACH NOSTRIL ONCE A DAY #1 RF3	3 of 3	24 Jan 2011
Salmeterol Xinafoate 50mcg + Fluticasone Propionate 250mcg, Device, Inhalation	Active	INHALE 1 PUFF ORALLY BID #1 RF1	0 of 1	24 Jan 2011
KETOCONAZOLE, 2 %, SHAMPOO, TOPICAL	Active	USE ON TRUNK AND SCALP BID AS DIRECTED	4 of 4	13 Oct 2010
Non-Formulary Drug Request (NFDR) Device Not Specified Miscellaneous	Active	KETOCONAZOLE 2% SHAMPOO-- USE ON TRUNK AND SCALP TWICE DAILY AS DIRECTED #2 RF4	4 of 4	13 Oct 2010
Albuterol Sulfate 90mcg, Aerosol powder, Inhalation, HFA	Active	INH 2 PF PO Q4H FOR WHEEZING #1 RF1	1 of 1	01 Sep 2010
FEXOFENADINE HCL, 180 MG, TABLET, ORAL	Active	T1 TAB PO QD F ALLERGIES UD #30 RF2	2 of 2	25 Aug 2010
Cetaphil/Aquanil Cleanser Lotion Topical	Active	INSTEAD OF SOAP UD (BUT THE BEST SOAP IS NO SOAP) #2 RF6	6 of 6	20 Jul 2010

Screening Written by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Reason For Appointment: **pha/jacc/15 min/rec/rx/ct**

Allergen information verified by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0836 CST

Reason(s) For Visit (Chief Complaint): **visit for: occupational health / fitness exam (New) : pha;**

Vitals

Vitals Written by JOHNSONCRUTCHFIELD, ANDREA C @ 08 Feb 2011 0835 CST

BP: 120/74 Left Arm, Adult Cuff, HR: 58 Regular, Radial Artery, RR: 20, HT: 69 in Actual, With Shoes, WT: 156 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/25, Corr OS: 20/25, Corr OU: 20/25, BMI: 23.04, BSA: 1.859 square meters,

Name/SSN: **MERWIN, DANIEL DENNIS** [REDACTED]

Sex: **M**

Sponsor/SSN: **MERWIN, DANIEL DENNIS** [REDACTED]

FMP/SSN: **20** [REDACTED]

Tel H: [REDACTED]

Rank: **SEAMAN APPRENTICE**

DOB: [REDACTED] **1985**

Tel W: **252-3892**

Unit: **N4197660**

PCat: **N11 USN ACTIVE DUTY**

CS:

Outpt Rec. Rm: **CORRY OUTPAT RECS**

MC Status:

Status:

PCM:

Insurance: **No**

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
 Prescribed by GSA and ICMR
 FIRM (41 CFR) 201-45.505

Page 1 of 3

AR 3349

INTERIM TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT (Check the correct response)

1. Since your last tuberculosis risk assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ YES ☒ NO ☐ DON'T KNOW
2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; hospitalized patients, prisoners, or homeless shelter populations? ☐ YES ☒ NO
3. List any countries where you have traveled or deployed to since your last tuberculosis risk assessment.

NONE

4a. During this travel, did you have direct and prolonged contact with the local population? ☐ YES ☒ NO

4b. If yes, explain.

FOR THE PROVIDER

5. Tuberculosis risk assessment, based on above responses ☒ MINIMAL RISK ☐ INCREASED RISK
6. Recommend LTBI Testing ☐ YES ☒ NO
7. Provider Comments

TRAVIS BROWN NP-C
NAVHOSP PENSACOLA
DEPLOYMENT HEALTH

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE <i>Travis Brown NP-C</i>	DATE 08 Feb 2011
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)	HOSPITAL OR MEDICAL FACILITY	STATUS
MERWIN, DANIEL D [REDACTED] M [REDACTED] 85 E5	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. (Check all applicable boxes)

<input checked="" type="checkbox"/>	OPERATION OR PROCEDURE	SEDATION
<input checked="" type="checkbox"/>	ANESTHESIA	TRANSFUSION

1b. DESCRIBE

Punch biopsy

① Chest ② Back

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

After cleaning and local anesthesia, a plug of tissue will be removed using a punch

instrument and then stitched closed. A scar will form. Risks also include bleeding,

infection and damage to adjacent structures.

which is to be performed by or under the direction of Dr. Smith Brunwell

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are:

NONE

(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

x Daniel Merwin

(Signature of Patient)

28 Sep 10

(Date and Time)

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)

sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no.; SSN or other; hospital or medical facility)

REGISTER NO.

WARD NO.

MERWIN, DANIEL DENNIS

20/ [REDACTED]
28 Sep 2010, 0816

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES

Medical Record

OPTIONAL FORM 522 (REV. 7/2008)

Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)

DoD Exception to OF 522 approved by GSA

The timeout was conducted audibly verifying Antibiotics, Patient, Procedure, Laterality (Site Marked), Position, Implants, Exams (Studies/X Rays), Safety Precautions

Signature _____

Date: _____ Time: _____

Copy

AR 3351

PRE-PROCEDURE CHECKLIST UNIVERSAL PROTOCOL

I. PHYSICIAN'S PRE-PROCEDURE ASSESSMENT:

Procedure: Pancreas

II. UNIVERSAL PROTOCOL TIMEOUT: Verifying the Correct Patient - Correct Procedure - Correct Procedure Site Checklist.

- | | | |
|--|-------------------------------------|--------------------------|
| 1. Pre-procedural verification: Patient states name and DOB which is compared to the following (as appropriate): | YES | |
| <ul style="list-style-type: none"> ▪ Documents- History & Physical, Nursing Assessment ▪ Consent Form ▪ Diagnostic Test Results ▪ Blood Products, implants, devices, Special Equipment | <input checked="" type="checkbox"/> | |
| 2. Site Marking: (patient involvement if possible) | YES | N/A |
| <ul style="list-style-type: none"> ▪ By provider doing the procedure | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
-
- "TIME OUT" CONDUCTED AUDIBLY w/team**
- | | | |
|---|-------------------------------------|-------------------------------------|
| A ntibiotics/fluid for irrigation (if needed) | YES | N/A |
| | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| P atient- 2 identifiers (name and DOB) | <input checked="" type="checkbox"/> | |
| P rocedure- correct procedure documented on consent | <input checked="" type="checkbox"/> | |
| L aterality- Surgical site marked | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| E quipment- If needed | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| P osition- Verified | <input checked="" type="checkbox"/> | |
| I mplants- If needed | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| E xams- Diagnostic tests (radiographs etc.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| S afety Precautions- Based upon outpatient history and profile | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Comments (optional) _____

Provider Signature: _____

Date/Time: 9/28/10

Pat Info: _____

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES
-----------------------	--

A. IDENTIFICATION	
1a. (Check all applicable boxes)	1b. DESCRIBE
<input checked="" type="checkbox"/> OPERATION OR PROCEDURE <input checked="" type="checkbox"/> ANESTHESIA	SEDATION TRANSFUSION Shave biopsy

↓ mucosa Lip

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

After cleaning and local anesthesia, a piece fo tissue will be sliced off with a surgical blade, either scooped out below surface or shaved flush with skin surface. A scare will form. Risks also include bleeding, infection and recurrence.

which is to be performed by or under the direction of Dr. Smith

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are:

none

(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

- The name of the patient and his/her family is not used to identify said pictures.
- Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

AA CONLEY
(Signature of Witness, excluding members of operating team)

X [Signature]
(Signature of Patient)

24 NOV 10

(Date and Time)

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)

sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital

REGISTER NO.

WARD NO.

MERWIN, DANIEL DENNIS
20/ [Redacted]
24 Nov 2010, 0837

**REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES**

Medical Record

OPTIONAL FORM 522 (REV. 7/2008)

Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)

DoD Exception to OF 522 approved by GSA

Laterality (Site Marked), Position, Implants, Exam (Studies/X-Ray), Safety
Precautions
Signature
Date: _____ Time: _____

CORY

AR 3353

PRE-PROCEDURE CHECKLIST UNIVERSAL PROTOCOL

I. PHYSICIAN'S PRE-PROCEDURE ASSESSMENT:

Procedure: Shave

II. UNIVERSAL PROTOCOL TIMEOUT: Verifying the Correct Patient - Correct Procedure - Correct Procedure Site Checklist.

1. **Pre-procedural verification:** Patient states name and DOB which is compared to the following (as appropriate):

YES

☒

- Documents- History & Physical, Nursing Assessment
- Consent Form
- Diagnostic Test Results
- Blood Products, implants, devices, Special Equipment

2. **Site Marking:** (patient involvement if possible)

YES

☒

N/A

☐

- By provider doing the procedure

"TIME OUT" CONDUCTED AUDIBLY w/team

Antibiotics/fluid for irrigation (if needed)

YES

☐

N/A

☒

Patient- 2 identifiers (name and DOB)

☒

Procedure- correct procedure documented on consent

☒

Laterality- Surgical site marked

☒
☐

Equipment- if needed

☐
☒

Position- Verified

☒

Implants- If needed

☐
☒

Exams- Diagnostic tests (radiographs etc.)

☐
☒

Safety Precautions- Based upon outpatient history and profile

☒
☐

Comments (optional) _____

Provider Signature: _____

Date/Time: _____

11/24/11

Pat Info: _____

HEALTH RECORD

CHRONOLOGICAL RECORD OF

MEDICAL CARE

Patient: MERWIN, DANIEL DENNIS
Treatment Facility: NH Pensacola
Patient Status: Outpatient

Date: 17 Mar 2010 0730 CDT
Clinic: DEPLOYMENT HEALTH CLINIC

Appt Type: WELL
Provider: BROWN, TRAVIS SCOTT

Reason for Appointment: PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD

Appointment Comments:
cac-jab

AutoCites Refreshed by WHITE, PAMELA J @ 17 Mar 2010 0727 CDT

Allergies

• OTHER: Unknown (SEE MED RECORD)

Active Medications**Active Medications**

Sodium Fluoride, Cream, Dental

Status

Active

Sig

BRUSH FOR 5 MINUTES
BEFORE BEDTIME. DO
NOT RINSE. #2 RF3

Refills Left

3 of 3

Last Filled

18 Sep
2009

Screening Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT

Reason For Appointment: PHA PART 2/LABS DONE/JACC/UOD/RECORDS/20MIN/CTD

Allergen information verified by WHITE, PAMELA J. @ 17 Mar 2010 0730 CDT

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam (New) : PHA PART 2;

Vitals

Vitals Written by WHITE, PAMELA J @ 17 Mar 2010 0731 CDT

BP: 102/60, HR: 72, RR: 20, HT: 69.5 in Actual, With Shoes, WT: 150 lbs Upright Scale, Actual, With Shoes, Corr OD: 20/30, Corr OS: 20/20,

Corr OU: 20/20, BMI: 21.83, BSA: 1.838 square meters, Tobacco Use: No, Alcohol Use: Yes, Alcohol Comments: OCC., Pain Scale: 0 Pain Free

SO Note Written by BROWN, TRAVIS SCOTT @ 17 Mar 2010 0807 CDT

Chief complaint

The Chief Complaint is: PHA.

History of present illness

The Patient is a 25 year old male.

Barriers to learning were identified as: None

Barriers considered were, social, cultural, emotional, motivational, physical, religious, cognitive and language.

Problem list reviewed.

Head symptoms States he has a history of allergy to dogs and cats. Approximately 3 weeks ago he was at a friend's house who had a dog. since that time, he has had problems with head and nasal congestion and sneezing. Also reports one episode of shortness of breath when running approximately 2 weeks ago. States he has been using Primatene OTC. No other meds. On exam today the pharynx and nasal septum with mild erythema, no inflammation or drainage. Lungs clear to auscultation over all fields bilaterally. No wheezing noted.

Current medication

Primatene - OTC

Past medical/surgical history**Reported History:**

Past Medical History:

Fracture of right 5th phalanx - 2008 -Resolved

Surgical / procedural: Surgical / procedural history Past Surgical History:
noncontributory.

Review of systems

Neck symptoms: No neck symptoms.

Eye symptoms: No eye symptoms.

Otolaryngeal symptoms: No otolaryngeal symptoms.

Name/SSN: MERWIN, DANIEL DENNIS [REDACTED]

Sex: M

Sponsor/SSN: MERWIN, DANIEL DENNIS [REDACTED]

FMP/SSN: 20 [REDACTED]

Tel H:

Rank: PETTY OFFICER THIRD CLASS

DOB: [REDACTED] 1985

Tel W:

Unit: N4197660

PCat: N11 USN ACTIVE DUTY

CS:

Outpt Rec, Rm: CORY OUTPAT RECS

MC Status:

Status:

PCM:

Insurance: No

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

Page 1 of 2

AR 3355

HEALTH RECORD

CHRONOLOGICAL RECORD OF

MEDICAL CARE

17 Mar 2010 0727

Facility: NH Pensacola FL

Clinic: DEPLOYMENT HEALTH CLINIC

Provider: BROWN, TRAVIS SCOTT

Cardiovascular symptoms: No cardiovascular symptoms.**Pulmonary symptoms:** No pulmonary symptoms.**Gastrointestinal symptoms:** No gastrointestinal symptoms.**Genitourinary symptoms:** No genitourinary symptoms.**Musculoskeletal symptoms:** No musculoskeletal symptoms.**Psychological symptoms:** No psychological symptoms.A/P Written by BROWN, TRAVIS S @ 17 Mar 2010 0815 CDT

1. visit for: occupational health / fitness exam (PERIODIC PREVENTION EXAMINATION): Annual TB risk assessment completed. He has been in Asia over the past year. Recommend placing PPD today. See NAVMED 6224/8.

Counseled on lab results, triglycerides and discussed at length ways to improve through lifestyle changes; exercise, supplements and better nutrition. Teaching materials given.
Medically fit for full duty.

2. ALLERGIC RHINITIS: Place him on claratin and mucinex. f/u with PCM if symptoms not improved in 3-4 days. member states he was treated by an allergist as a child. Explained he could discuss this with his PCM if symptoms remain persistent.

Medication(s): -LORATADINE (CLARITIN)--PO 10MG TAB - T 1 TABLET PO QD PRN FOR ALLERGIES #100 RF0
Qt: 100 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT
-GUAIFENESIN PSE --PO 600MG-60MG TAB - TAKE ONE TABLET TWICE DAILY **MAX 50 TABS
PER FILL** #40 RF0 Qt: 40 Rf: 0 Ordered By: BROWN, TRAVIS S Ordering Provider: BROWN, TRAVIS SCOTT

Disposition Written by BROWN, TRAVIS S @ 17 Mar 2010 0817 CDT

Released w/o Limitations

Follow up: with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By BROWN, TRAVIS S (NP-C, NH Pensacola FL) @ 17 Mar 2010 0817

Name/SSN: MERWIN, DANIEL DENNIS [REDACTED]

Sex: M

Sponsor/SSN: MERWIN, DANIEL DENNIS [REDACTED]

FMP/SSN: 20 [REDACTED]

Tel H:

Rank: PETTY OFFICER THIRD CLASS

DOB: [REDACTED] 1985

Tel W:

Unit: N4197660

PCat: N11 USN ACTIVE DUTY

CS:

Outpt Rec. Rm: CORRY OUTPAT RECS

MC Status:

Status:

PCM:

Insurance: No

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

Page 2 of 2

AR 3356

INTERIM TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT (Check the correct response)

1. Since your last tuberculosis risk assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ YES ☒ NO ☐ DON'T KNOW
2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; hospitalized patients, prisoners, or homeless shelter populations? ☐ YES ☒ NO
3. List any countries where you have traveled or deployed to since your last tuberculosis risk assessment.

ASIA, SEVERAL COUNTRIES -

PHILIPPINES, KOREA, JAPAN, CHINA, THAILAND, CAMBODIA, AND AUSTRALIA

4a. During this travel, did you have direct and prolonged contact with the local population?

☒ YES ☐ NO

4b. If yes, explain.

LIVED IN JAPAN

FOR THE PROVIDER

5. Tuberculosis risk assessment, based on above responses ☐ MINIMAL RISK ☒ INCREASED RISK
6. Recommend LTBI Testing ☒ YES ☐ NO
7. Provider Comments

Recommend PPD since he has been to several locations in Asia over the past year.

TRAVIS BROWN NP-C
NAVHOSP PENSACOLA
DEPLOYMENT HEALTH

PRACTITIONER'S NAME

PRACTITIONER'S SIGNATURE

DATE

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPARTMENT / SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN

RELATIONSHIP TO SPONSOR

***** FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE *****

Any misuse or unauthorized disclosure of this information may
result in both criminal and civil penalties.

Date: 03-Sep-2009

Force IMR Report

Page: 1

Activity: N6288 - NIOC PENSACOLA

Cmd: 98 - Active Duty Navy

Name	Rate/ Rank	SSN	DOB	Gender	Age	Unit	Blood Type	IMR Status
MERWIN DANIEL DENNIS	CTN3	[REDACTED]	[REDACTED] 1985	M	24	41976	OPOS	Fully Medically Ready
USN	LOD: None	MRR: None	TNPQ: None	TNDQ: None	LIMDU: None	MEDBRD: None		

Waiver Type	Issue Date	Reason
Immunization	Series	Completed

Immunization	Series	Completed	Due	Lot Number	Req	Def	Date Deferred	Reaction
Adenovirus								
Anthrax	4	05-May-2008		UNK	Y	Y	10-Aug-09	
Cholera								
HPV- Human Papilloma								
Hepatitis A	2	14-Dec-2005		UNK	Y	Y	02-Apr-07	
Hepatitis B	2	14-Dec-2005		UNK		Y	02-Apr-07	
Influenza	0	16-Jan-2008	01-Sep-2009 *	UNK	Y			
JEV								
MGC								
MMR	0	08-Nov-2005		UNK	Y			
Pneumococcal								
Polio	0	08-Nov-2005		UNK	Y			
Rabies								
Smallpox								
Smallpox Reading								
Tetanus/Diphtheria	0	08-Nov-2005	06-Nov-2015	UNK	Y			
TwinRix	1	14-Dec-2005		UNK	Y			
Typhoid								
Varicella								
Yellow Fever	0	14-Dec-2005		UNK				

Tests

Primary Physical:	Due:	Routine
Short Flight Date:	Due:	PHA: 06-Feb-2009 Due: 06-Feb-2010
Dental Date:	02-Oct-2008	Class: 1 Type: Military Due: 01-Dec-2009
Bitewing Date:	Due: 03-Sep-2009 *	Panograph Date: Due: 03-Sep-2009 *
HIV Test Date:	02-Oct-2008	Results Date: 09-Dec-2008 Due: 02-Oct-2010
DNA Sent Date:		Date Reg: 15-Dec-2005
Baseline DD2215:	*	
Sickle Cell Test Date:	06-Nov-2005	Results: N
G6PD Date:	06-Nov-2005	G6PD Code: N
HBSAB Serology Titre:		Results:
PAP Smear:		Mammogram:
Eye Exam Date:	* Eye Exam Req: Y Eyeware Req: Verified Date: Due:	
Gas Mask Inserts Req:	Y Issue Date: 07-Nov-2005	
Pregnant:	Due Date: Weeks Pregnant:	
OCC Health Eval Date:	* Eval Req: N OCC Health:	
TST Reading:	15-Nov-2008 TB Questionnaire: PPD Reactor: N Due: 15-Nov-2009	
NAMI Eval Date:	Specialty: Annual Resubmit Req: Waiver:	
Health Care Promotion:	N Health Enrollment Assessment: N Health Risk Appraisal: N	
Allergies (Y/N):	Y Warning Tag Required: 10-Nov-2008 Warning Tag Issued: 10-Aug-2009	

* Due

**!!!! IF YOU WERE EVER A MILITARY DEPENDENT,
CIRCLE FORMER DEPENDENT !!!!!**

NAVAL HOSPITAL PENSACOLA
NBHC CORRY STATION
STAFF & STUDENT CHECK-IN SHEET

DATE: 07 MAY 09

NAME(LAST, FIRST, MI): MERWIN, DANIEL

SSN: [REDACTED] - [REDACTED] - [REDACTED] SEX: MALE FEMALE

DATE OF BIRTH: (DAY/MONTH/YEAR) [REDACTED] / [REDACTED] / 1988

RACE: ASIAN BLACK WHITE OTHER _____

ETHNIC ORIGIN _____ RELIGION: NO RELIGIOUS PREFERENCE

ADDRESS (IF STUDENT, BEQ AND ROOM NUMBER)

CID 1082-101A

CELL PHONE : [REDACTED]

HOME PHONE : _____

IMPORTANT EMERGENCY CONTACT NUMBER AND ADDRESS

[REDACTED]

[REDACTED]

LEXINGTON, SC [REDACTED]

Branch of Service: USA USN USAF USMC OTHER: _____ RANK E4

UIC: _____ Or School attending CTA CTN CTR CTT IT

Do you wish to be an organ donor? YES NO

Are you allergic to any medications? YES NO

If YES please list:

For corpsman use only!!! Sign and print name for personnel who are entering patient information into CHCS

!!!! IF YOU WERE EVER A MILITARY DEPENDENT,
CIRCLE FORMER DEPENDENT !!!!!

NAVAL HOSPITAL PENSACOLA
NBHC CORRY STATION
STAFF & STUDENT CHECK-IN SHEET

DATE: _____

NAME(LAST,FIRST,MI): _____

SSN: _____ - _____ - _____ **SEX**: MALE FEMALE

DATE OF BIRTH: (DAY/MONTH/YEAR) ____ / ____ / ____

RACE: ASIAN BLACK WHITE OTHER _____

ETHNIC ORIGIN _____ **RELIGION**: _____

ADDRESS (IF STUDENT, BEQ AND ROOM NUMBER)

CELL PHONE : _____

HOME PHONE : _____

IMPORTANT EMERGENCY CONTACT NUMBER AND ADDRESS

Branch of Service: USA USN USAF USMC OTHER: _____ RANK _____

UIC: _____ Or School attending CTA CTN CTR CTT IT

Do you wish to be an organ donor? YES NO

Are you allergic to any medications? YES NO

If YES please list:

For corpsman use only!!! Sign and print name for personnel who are entering patient information into CHCS

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
DATE: 16 SEP 09 1524	CORRY STATION BRANCH HEALTH CLINIC REENLISTMENT PHYSICAL
BP: 100/64	Per MANMED 15-12 a reenlistment evaluation must be conducted for the purpose of
P: 86	ensuring that no new medical conditions have developed or no previously diagnosed
R: 12	conditions have materialized or changed that might prevent the service member from
T: 98.4	Safely or effectively fulfilling the responsibility of their rank or rating. DD 2807-1
ALL: N/A	Must be completed and reviewed by a qualified examiner per MANMED 15-4.
MED: N/A	DENTAL:
	Dental class 1 2 <u>3</u> 4 Date of Last Exam 11 Sep 09
TOB: Y <u>N</u>	Member <u>IS</u> / IS NOT qualified for reenlistment per dental status.
/day	Signature of Dental Rep. [Signature] Date: 14 Sep 09
EOTH: Y	
VIT/SUP: Y / <u>N</u>	Review of medical history and any interval changes in the members medical history
	Since the last examination. Full PE
Pain Scale 0 / 10	
	Focused examination elements as needed.
	Member <u>IS</u> or IS NOT qualified for Reenlistment.
	Provider Signature [Signature] DATE: 16 SEP 09
HOSPITAL OR MEDICAL FACILITY NBHC CORRY	STATUS ACTIVE
SPONSOR'S NAME MERWIN DANIEL D	DEPART./SERVICE DOD NAVY
	RELATIONSHIP TO SPONSOR
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.
Merwin, Daniel [Redacted] Male [Redacted] 85 E-4	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-9.202-1

Apr 07 2005

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
Time 6 Feb 09	Annual Flight Deck Personnel Medical Screening Examination Reference - Manual of the Medical Department Chapter 15, Article 15-65
T -	Prospective Flight Deck Position: <input type="checkbox"/> Critical <input checked="" type="checkbox"/> Non Critical <input type="checkbox"/> Special
P - 76	<p>➤ Date of Last Physical Examination: _____ Date of Last Eye Examination: _____</p> <p>➤ Current Visual Acuity as transcribed from last Comprehensive Eye Examination:</p> <p>Uncorrected OS _____ OD _____ OU _____</p> <p>Corrected OS _____ OD _____ OU _____</p>
BP - 104/61	<p>➤ Critical: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye</p> <p>Uncorrected OS _____ OD _____ OU _____</p> <p>Corrected OS _____ OD _____ OU _____</p>
SMKR NONE	
ETOH SOMETIMES	<p>➤ Non Critical: Distant/near visual acuity - No limits uncorrected however must correct to 20/40 or better in one eye, 20/30 or better in the other</p> <p>Uncorrected OS _____ OD _____ OU _____</p> <p>Corrected OS <u>20/30</u> OD <u>20/30</u> OU <u>20/30</u></p>
Allergies	<p>➤ Special: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye</p> <p>Uncorrected OS _____ OD _____ OU _____</p> <p>Corrected OS _____ OD _____ OU _____</p>
NKDA	<p>➤ All: Field of Vision: OS _____ OD _____ OU _____</p> <p>➤ All: Depth Perception, did member pass Verhoeff or AFVBT <input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail</p> <p>➤ All: Color Vision, FALANT Results <u>9/9</u> <input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail</p>
Meds NONE	<p>Was member issued regular glasses? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes what is the date of issue: _____</p> <p>Members Acknowledgement. "I understand that I am required to maintain my current eyewear onboard at all times and that I am required to wear them during all flight deck evolutions."</p> <p>Based upon history, records review and physical examination the member is found to be:</p> <p><input checked="" type="checkbox"/> Qualified <input type="checkbox"/> Disqualified <input type="checkbox"/> Medically Deferred</p> <p>Member's Signature: <u>[Signature]</u> SMDR Signature: <u>Tom Hayes MD</u> USN MAIO ESSEX LHD-2</p>

Records Maintained At

Patient's Name (Last, First, Middle Initial) <u>MERWIN, DANIEL</u>		Sex <u>M</u>
Relationship to Sponsor Self	Status Active Duty	Rank/Grade <u>E4</u>
Sponsor's Name Self	Organization <u>V-3</u>	
Department/Service USN	SSN 20 [REDACTED]	Date of Birth [REDACTED] <u>85</u>

Enclosure (1)

PERIODIC HEALTH ASSESSMENT (PHA)

DATE:

6 Feb 09

SCREENING:

Height (inches)

63"

Weight (pounds)

135

BMI:

Temperature:

deferred

Pulse:

76

Respirations:

deferred

Blood Pressure:

104/61

MEDICAL EQUIPMENT:

Prescription Lenses (two pairs)

☒ Y ☐ N ☐ NA

Ballistic Eyewear

☐ Y ☒ N ☐ NA

Gas Mask Inserts

☒ Y ☐ N ☐ NA

Medical Alert Tags

☒ Y ☐ N ☐ NA

S: SUBJECTIVE

23 year old (☒ male (☐ female) reports for an annual PHA which includes record review/verification, assessment and counseling of health risk factors, clinical preventive services, deployment health history, and individual medical readiness (IMR) assessment.

Allergies (Medication and other): See Block 1 on DD 2766

Chronic Illnesses: See Block 2 on DD 2766

Medications (Rx / OTC / herbals / supplements / performance enhancers): See Block 3 on DD 2766

Hospitalizations/Surgeries since last PHA: See Block 4 on DD 2766

Family History: See Block 6 on DD 2766

Occupational History: See Block 8 on DD 2766

O: OBJECTIVE

Vital Signs noted. Remarkable for: ☐ None ☐ Other:

Visual Acuity: OD: 20/30 OS: 20/30 (Consult if worse than 10/40, no contacts)

Physical examination is otherwise deferred

Health Record	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> Remarkable for:
Dental Readiness	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Dental Classification	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4
Immunization Record	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input checked="" type="checkbox"/> See Plan
Lab/Path Results	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Clinical Prev. Services	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input type="checkbox"/> See Plan
Occupational Health	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input checked="" type="checkbox"/> See Plan
Hearing Assessment	<input checked="" type="checkbox"/> Reviewed	<input type="checkbox"/> Not Available	<input checked="" type="checkbox"/> See Plan

Deployment Health: See DD 2766

Deployed since previous PHA?

☐ Yes ☒ No

Post-Deployment Health Assessment (DD 2796) in record?

☐ Yes ☒ No

Post-Deployment Health Reassessment (DD 2900) in record?

☐ Yes ☒ No

Any unresolved deployment-related issues or health concerns?

☐ Yes ☒ No

Comments:

A: ASSESSMENT

Health Risk Assessment: Completed and reviewed? ☒ Yes ☐ No

Health Risk Assessment Level:

☐ High ☐ Med ☐ Low

Cardiovascular Screening (Framingham 10-year risk for Event/Death):

Pain Assessment (zero pain to severe): 0 1 2 3 4 5 6 7 8 9 10

Location:

Any other current health concerns?

PATIENT'S IDENTIFICATION

(Use this space for mechanical imprint telephone number and e-mail address for follow-up)

PATIENT'S NAME (Last, First, Middle Initial)

MERWIN, DANIEL

SEX

MALE

SSN / IDENTIFICATION NO.

STATUS

RANK/GRADE

20/

ACTIVE

E-4 / ADJ-3

USS ESSEX MEDICAL

DATE OF BIRTH

[REDACTED] 85

PERIODIC HEALTH ASSESSMENT (PHA) (Continued)

Duty Status Assessment

On Limited Duty (LIMDU) ☐ Yes ☒ No ☐ NA ☐ Comments _____
 Medical Board ☐ Yes ☒ No ☐ NA ☐ Comments _____
☐ TNPQ ☐ TNDQ ☐ NPQ ☐ LOD ☐ NA ☐ Comments _____

P: PLAN / P: PREVENTION

1. Updated DD 2766 Sections: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒ 9 ☒ 10 ☐ 11
2. Health counseling performed and documented on the DD 2766: ☒ Yes ☐ No
3. Labs ordered for the following: ☐ Blood Type and RH ☐ G6PD ☐ HIV ☐ DNA ☐ Lipids
☐ Others as required by geographic, occupation, or ISIC _____
 Electronic verification complete: ☒ Yes ☐ No
4. Immunizations ordered for the following: ☐ MMR ☐ Tdap (1 time booster) or ☐ Td ☐ IPV ☐ Influenza
☐ Hep A #1 #2 ☐ Hep B #1 #2 #3 (required for all new recruits) TWINRIX® may be used (3 shots required)
 Other immunizations: ☐ _____ ☐ _____ ☐ _____
 Electronic verification complete: ☒ Yes ☐ No
5. Tuberculosis Screening: ☒ PPD Placement: _____ Results: _____
6. Clinical Preventive Services recommended: ☐ Pap ☐ Chlamydia ☐ Mammogram ☐ Colorectal
☐ Clinical Breast Exam ☐ Testicular Exam ☐ Prostate ☐ Cholesterol
☐ Other: _____
7. Referred to Dental for: ☐ Annual T-2 Dental Exam ☐ Dental Class 3 ☐ Dental Class 4 ☐ Bitewings ☐ Panograph
8. Referred to PCM for: ☐ Physical Fitness Clearance ☐ Deployment-Related Condition
☐ Current Medications / Supplements ☐ Chronic Medical Conditions ☐ Current Illness / Injury
☐ Other: _____
9. Referred for Preventive / Healthy Lifestyle Counseling:
☐ Tobacco Use ☐ Physical Activity ☐ Safety ☐ Alcohol Use ☐ Dental Care ☐ Nutrition ☐ Mental Health
☐ Sexuality ☐ Other: _____
10. Other indicated referrals:
☐ Audiology ☒ Optometry ☐ Behavioral Health ☐ OB / GYN ☐ Dietician ☐ OCC Health
☐ Chaplain ☐ DAPA ☐ FFSC ☐ Semper Fit ☐ Weight Management
☐ Other: _____
11. Member readiness reviewed and updated in approved electronic data system. Member is fully medically ready and requires no follow-up at this time: ☒ Yes ☐ No
12. Additional Comments: _____

13. Member informed that completion of recommended tests / immunizations / screenings is to be performed within the next 30 days and he/she is personally responsible for maintaining IMR. Service Member received health risk prevention / healthy lifestyle counseling and voiced understanding

Member Signature

Date

6 FEB 09

HM / MDR Signature

Date

6 Feb 09

Provider Signature

Tom Hayes MD
 LT MC USN
 GMD ESSEX LHID-2

Date

06 Feb 09

RASH

USS Essex (LHD-2) Medical Department

F/U BOTH HANDS

1 OCT 08

S: 23 year/month old c/o RASH that started 1 1/2 yrs ago

Where did the rash begin? _____

How quickly has it spread? _____

Y / N Any medications used in the last 14 days, especially antibiotics.

If yes, which? _____

Y / N Ever had this type of rash before? If yes, explain: _____

Y / N Do you have a history of eczema? If yes, how do you to treat it: _____

Y / N Is rash itchy?

Y / N Is rash painful?

Y / N Any home treatments used for rash? If yes, explain: _____

Y / N Any new medicine, foods, soaps, lotion, detergent, fabric softener? (Circle any that apply)

Y / N Headache/sore throat/abdominal pain Other: _____

Y / N Fever? If yes, how high _____ Last fever _____

Y / N Any other recent illness?

Y / N Any recent travel? If yes, where: _____

P+ states skin not as dry as before, still notes pitting of skin & exposure to water - hands dry

O: General: _____

Skin: Single lesion Localized lesions

Diffuse rash Blanchable Non-blanchable

Hypopigmentation Hyperpigmentation

Erythema Macules Patches Papules

Plaques Nodules Tumors Pustules

Vesicles Bullae Petechiae Purpura

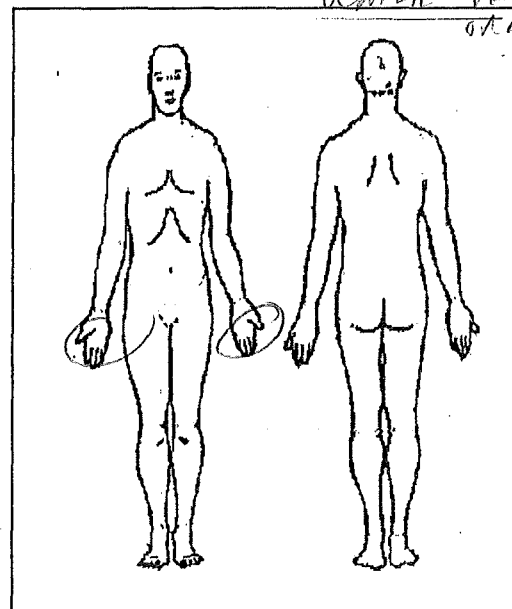
Ulcers Fissures Burrows Excoriations

Scale Crust Discharge

A: Hand Dermatitis, Impetigo

P: web assistance Bid.

Flu penic



PHA: _____

Tob Y ☒

Type _____

Qty _____

Freq _____

ETOH ☒

Type Socially

Qty _____

Freq _____

Allergies:

NKDA

Medications:

Triamcinolone Acetonide

PCO team:

Pr: Prevention topics: To A F N C S Rx Other: _____

Member DOES / DOES NOT verbalize understanding of prevention plan
Member ACCEPTS / DECLINES prevention plan

Provider: _____

STEVEN PRASKE
LCDR, MC/NAVY/7024
PAGER: _____☐ HISTORY & PHYSICAL
EXAMINATION
(SF 504, SF 505, & SF 506)☐ CONSULTATION SHEET
(SF-513)☒ CHRON RECORD OF
MEDICAL CARE - (SF 600)☐ PROGRESS NOTE
(SF 509)☐ OPERATION REPORT
(SF 510)☐ NARRATIVE SUMMARY
(SF 502)☐ AUTOPSY PROTOCOL
(SF 503)☐ EMG REPORT

NAME

MERKIN, DANIEL

REGISTER NO.

SSN

20/

STATUS

AO

DATE

TIME

MEDICAL RECORD REPORT

OPTIONAL FORM 275 (12 77)

Prescr
FPMI

AR 3365

RASH

USS Essex (LHD-2) Medical Department

BOTH HANDS

Date 15 OCT 08

Wt _____

Ht _____

T 98.8R 16BP 115/73P 87

PHA: _____

Tob Y/☒ N

Type _____

Qty _____

Freq _____

ETOH Y/N

Type _____

Qty _____

Freq Socially

Allergies:

Feathers(?)

Medications:

Ø

PCO team: _____

S: 23 year/month old c/o RASH that started 1 1/2 yearsWhere did the rash begin? Palms and tops of handsHow quickly has it spread? Been spreading for a timeY/☒ N Any medications used in the last 14 days, especially antibiotics.

If yes, which? _____

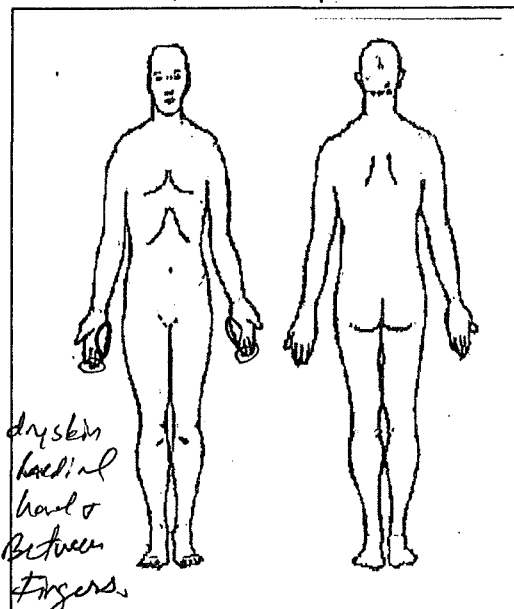
Y/☒ N Ever had this type of rash before? If yes, explain: _____Y/☒ N Do you have a history of eczema? If yes, how do you to treat it: _____Y/☒ N Is rash itchy?Y/☒ N Is rash painful? Has not been painful for last couple of monthsY/☒ N Any home treatments used for rash? If yes, explain: Nex hand lotion (No scent) + Baby lotionY/☒ N Any new medicine, foods, soaps, lotion, detergent, fabric softener? (Circle any that apply)Y/☒ N Headache/sore throat/abdominal pain Other: _____Y/☒ N Fever? If yes, how high _____ Last fever _____Y/☒ N Any other recent illness?Y/☒ N Any recent travel? If yes, where: _____O: General: It states that he gets a lot of dead skin rubbing off after showering
With strength insoles & dry, sloughing skin with minor skin later exposure.Skin: Single lesion Localized lesionsDiffuse rash Blanchable Non-blanchableHypopigmentation HyperpigmentationErythema Macules Patches Papules

Plaques Nodules Tumors Pustules

Vesicles Bullae Petechiae Purpura

Ulcers Fissures Burrows Excoriations

Scale Crust Discharge

A: Hand/Finger Rash characterized by
peeling skin & erythema within minutes of
water exposure, ?eczemaP: trial of Trimecaine 1% BPO x 2 wks
then Flu.
misbrz B i o

Pr: Prevention topics: To A F N C S Rx Other: _____

Member DOES / DOES NOT verbalize understanding of prevention plan

Member ACCEPTS / DECLINES prevention plan

Provider: _____

STEVEN PRASKE
LCDR, MC/NAVY/7024
PAGER: _____☐ HISTORY & PHYSICAL
EXAMINATION
(SF 504, SF 505, & SF 506)☐ CONSULTATION SHEET
(SF-513)☒ CHRON RECORD OF
MEDICAL CARE - (SF 600)☐ PROGRESS NOTE
(SF 509)☐ OPERATION REPORT
(SF 516)☐ NARRATIVE SUMMARY
(SF 502)☐ AUTOPSY PROTOCOL
(SF 503)☐ EMG REPORT

NAME

MERWIN DANIEL

REGISTER NO.

SSN

20

STATUS

DATE

TIME

0905

MEDICAL RECORD REPORT

OPTIONAL FORM 275 (12-77)

Prescr
FPMI

AR 3366

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Initial Note Page 2 of 2

This page may be completed by a healthcare provider

1. Provider Assessment Date (MM/DD/YYYY)

09/24/2008

If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

2. Reason for Vaccination (Indicate One):

- ☒ Pre-outbreak: disease prevention
☐ Post-outbreak: not exposed to virus
☐ Post-outbreak: exposed to virus
☐ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview
 (Check all that apply):

☒ No restriction

☐ Pregnancy
☐ Immune suppression
☐ Skin condition
☐ Relevant allergy
☐ Heart condition
☐ Unsure

Self

☒
☐
☐
☐
☐
☐
☐

Close Contact

☐
☐
☐
☐
☐
☐
☐

3+ RF ☐

☐ (Describe)

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevant diagnosis

5. Provider Decision and Plan (Check all that apply):

- ☐ Vaccinate: Primary (e.g. birth year >1972, military entry >1984)
☐ Vaccinate: Revaccination
☐ Medically immune: vaccinated within approp interval (MI)
☒ Vaccination deferred: Pending consult or lab test
☐ Vaccination deferred: Temporary contraindication (MT)
☐ Vaccination contraindicated unless exposed (MP)
☐ Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

☐ Reason for non-immunization explained

☒ Lab test requested

- ☐ Consult request written/sent
☐ Follow up appointment planned
☐ Other reason (specify below):

List labs or consults requested, and length of temp referrals

pending H1N1 lab result

VACCINE ADMINISTRATION

Vaccination Date (MM/DD/YYYY)

09/24/2008

7. Vaccination Action Taken:

Location: ☐ Left Arm ☐ Right Arm ☐ Other Location (Describe)

Number of jabs:

2

Lot #

000000-000000

Mfr #

000000

For QA use: local vial serial #

000000

8. IF IMMUNIZED, Check all that apply

- ☐ Information sheet given to recipient
☐ Recipient advised about post-vaccination reaction and site care
☐ Reasons for follow-up clinic visit described
☐ Patient understands information given
☐ Bandages provided if needed.

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Provider Signature and Printed Name/Stamp:

Michael Picio

Dr. Michael Picio, DO
 CDR, MC, USN 20/9765

Vaccine administered by: (Signature and Printed Name/Stamp)

Patient's identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
 RANK/GRADE
 SEX
 DATE OF BIRTH
 SPONSOR NAME
 (or Sponsor SSN)
 RELATIONSHIP TO SPONSOR
 (Or FMP)
 ORGANIZATION
 STATUS
 DEPT/SVC

Standard Form 600 (Rev.6-97) Electronic Copy SVP Overprint (4-08)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Initial Note Page 1 of 2
 This page may be completed by potential vaccine recipient

Shade Circles Like This--> ●
 Not Like This--> ○

1. Today's Date (MM/DD/YYYY) / / 2a. GENDER ☒ Male ☐ Female 2b. First day of last normal menstrual period: / /

2c. FEMALES: Was your last menstrual period normal and on time? ☐ Yes ☐ No ☐ Unsure
 2d. Are you currently breastfeeding? ☐ Yes ☐ No

3. Could someone you LIVE WITH or YOU be pregnant? ☐ Yes ☒ No ☐ Unsure

4. Did you ever receive smallpox vaccine? ☐ Yes ☐ No ☒ Unsure

4a. IF YES: Were you vaccinated within the last 10 years? ☐ Yes ☐ No ☒ Unsure

4b. IF UNSURE: Birth Year / / First Year in Military (if applicable) / /

5. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ☐ Yes ☒ No ☐ Unsure

6. Do you currently have an illness with fever? ☐ Yes ☒ No ☐ Unsure

7. Are you allergic to any of these products: polymyxin B, neomycin? *FEATHERS* ☐ Yes ☒ No ☐ Unsure

Before vaccinating against smallpox, we want to know if you or your household close contacts have any of several medical conditions.
 Please answer the following questions to the best of your knowledge.

	Myself	Close Contact
8. Do you OR someone you currently live with NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease or Other skin conditions (describe below)?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
9. Do you OR someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For example: have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; have or take medication for Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medication for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10. Have you OR someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) IF YES or UNSURE: for either you or your close contact, Answer 10a-10e	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10a. A doctor has made the diagnosis of eczema or atopic dermatitis.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10b. There have been itchy rashes that have lasted more than 2 weeks.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10c. At least once, there is a history of an itchy rash in the folds of the arms or legs.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10d. There is a history of eczema and food allergy during childhood.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
10e. A doctor has made the diagnosis of asthma or hayfever (including first-degree relatives).	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unsure
11. Are you being treated with steroid eye drops or ointment or have you had recent eye surgery?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Unsure
12. Do you have a heart or vessel condition, such as angina, earlier heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, stroke, "mini stroke", chest pain or trouble breathing on exertion?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Unsure
13. Check EACH of the following conditions that apply to you: <input type="radio"/> Heart Condition before age 50 in mother, father, brother, sister <input type="radio"/> Smoke cigarettes now <input type="radio"/> High blood pressure <input type="radio"/> High cholesterol <input type="radio"/> Diabetes or high blood sugar		
14. Do you have a child in home less one year of age?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
15. Do you have other questions or have other concerns you would like to discuss?	<input type="radio"/> Yes <input checked="" type="radio"/> No	

Explain "other," "unsure," or additional concerns (may use additional page). NOTE: If you might have a risk factor for HIV infection, we can arrange for HIV testing. FOR FEMALES: If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

Last Name

MERWIN

First Name

DANIEL

MI

D

Social Security Number

Patient's identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
 RANK/GRADE
 SEX
 DATE OF BIRTH
 SPONSOR NAME
 (or Sponsor SSN)
 RELATIONSHIP TO SPONSOR
 (or FMP)
 ORGANIZATION
 STATUS
 DEPT/SVC AIR

Apr 07 2005

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)		
<u>Time</u> 27 FEB 08	Annual Flight Deck Personnel Medical Screening Examination		
	Reference - Manual of the Medical Department Chapter 15, Article 15-65		
	Prospective Flight Deck Position: <input type="checkbox"/> Critical <input checked="" type="checkbox"/> Non Critical <input type="checkbox"/> Special		
<u>T-</u>	> Date of Last Physical Examination: 19 FEB 08 Date of Last Eye Examination: 07 NOV 05		
<u>P-</u>	> Current Visual Acuity as transcribed from last Comprehensive Eye Examination:		
<u>BP-</u>	Uncorrected OS 20/50 OD 20/40 OU		
	Corrected OS 20/20 OD 20/20 OU		
<u>SMKR</u>	> Critical: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye		
	Uncorrected OS OD OU		
	Corrected OS OD OU		
<u>ETOH</u>	> Non Critical: Distant/near visual acuity-No limits uncorrected however must correct to 20/40 or better in one eye, 20/30 or better in the other		
<u>SOCIAL</u>	Uncorrected OS OD OU		
	Corrected OS OD OU		
<u>Allergies</u>	> Special: Distant/near visual acuity - No limits uncorrected however must correct to 20/20 in each eye		
<u>NILDA</u>	Uncorrected OS OD OU		
	Corrected OS OD OU		
<u>Meds</u>	> All: Field of Vision: OS OD OU		
	> All: Depth Perception, did member pass Verhoeff or AFVBT <input type="checkbox"/> Pass <input type="checkbox"/> Fail		
	> All: Color Vision, FALANT Results <input type="checkbox"/> Pass <input type="checkbox"/> Fail		
	Was member issued regular glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes what is the date of issue:		
	Members Acknowledgement.		
	"I understand that I am required to maintain my current eyewear onboard at all times and that I am required to wear them during all flight deck evolutions."		
	Based upon history, records review and physical examination the member is found to be:		
	<input type="checkbox"/> Qualified <input type="checkbox"/> Disqualified <input type="checkbox"/> Medically Deferred		
	Member's Signature		SMDR Signature

Records Maintained At		
Patient's Name (Last, First, Middle Initial)		Sex
MERWIN DANIEL D		M
Relationship to Sponsor	Status	Rank/Grade
Self	Active Duty	AB43
Sponsor's Name	Organization	
Self	AIR V-3	
Department/Service	SSN	Date of Birth
USN	20 [REDACTED]	[REDACTED] 08

Enclosure (1)

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE/TIME

19K500

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

USS ESSEX LHD-2

Preventive Health Assessment (Circle all that apply):

- Sex: ☒ M ☐ F
 AGE: 23
 Wt: 130
 Ht: 68
 BP: 122/72
 P: 83
1. Do you have a history of ulcerative colitis or cancer? Y ☒ N
 2. Do your parents or grandparents have a h/o colon cancer? Y ☒ N
 3. Do you smoke? Number of packs per day ___ No of years ___ Y ☒ N
 4. Do you have diabetes? Y ☒ N
 5. Do your parents, siblings, or grandparents have a h/o heart attacks at a young age (<55 in male, <65 in female)? ☒ Y ☒ N
 6. Do you have a history of high blood pressure? Y ☒ N
 7. Do you have a history of high cholesterol? Y ☒ N
 8. Do your parents, siblings, or grandparents have a h/o high cholesterol? ☒ Y ☒ N
 9. Do you exercise more than 30 min 3 days per week? ☒ Y ☒ N
 10. Do you have any medical history that prevents deployment? Y ☒ N
What issues? _____
 11. Do you need help in dealing with stress? Y ☒ N
 12. Have you any admin issues that prevent deployment, i.e. EFMP, pregnancy, etc.? Y ☒ N
 13. Special Duties, ie. Rad Health, Flight, Explosive Handlers, Diving, SAR swimmer? other: _____ Y ☒ N
Hearing Conservation Program? ☒ Y ☒ N
Asbestos Surveillance? Y ☒ N

Women's Health:

14. History of abnormal Pap or dysplasia? When: _____ Y N
15. Do you need to be taught how to perform a self breast exam? Y N
16. Have you begun screening mammograms? Age began: _____ Y N
17. Do you need education on family planning, contraception, or STDs? Y N
18. On average, do you drink alcohol more than 7 drinks / week? Y N

Men's Health:

19. Do you have a history of undescended or abnormally small testes? Y ☒ N
20. Do you need to be taught how to do a self testicular exam? Y ☒ N
21. Do you have a family history of prostate cancer in a close relative? Y ☒ N
22. On average, do you drink alcohol more than 14 drinks / week? Y ☒ N

23. I am taking the following medicines or supplements:

NONE24. Allergies: XNone or NKA causes _____

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL PRINT)

RECORDS

MAINTAINED

AT:

USS ESSEX

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

Merwin, Daniel

SEX

MRELATIONSHIP TO SPONSOR
N/A

STATUS

AD

RANK/GRADE

ABH3SPONSOR'S NAME
N/A

ORGANIZATION

V-3DEPART./SERVICE
DOD/USN

SSN/IDENTIFICATION NO.

201

DATE OF BIRTH

85

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (REV. 5-84)

AR 3370

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

Clinic Review:

Labs documented:

Blood type A B 0+
 Sick Cell + 0
 G6PD nl abnl
 DNA on file Y N
 HIV w/in 2 Y N 07NOV06

Tests/Referrals/Education

___ BP checks x ___ days
 ___ fasting lipids
 ___ HIV within 1 year
 ___ Chem 7
 ___ Dental Appt >1 year
 ___ Optometry appt >2 yr
 ___ Nutritionist consult
 ___ Colon Ca Screening@
 ___ Mammograms @
 ___ Prostate screen @
 ___ Quit smoking (Ready for Referral?)
 ___ Drink responsibly or quit
 ___ Rec: aerobic exercises
 ___ SBE / STE Education

Immunizations current:

typhoid (2 yr) Y N 14APR06
 Hep A x 2 Y N 08NOV05/14DEC05
 Yellow Fever (10) Y N 14DEC05
 IPV Y N 08NOV05
 Td (10 y) Y N 08NOV05
 MMR Y N 08NOV05
 Influenza (q year) Y N 16JAN08
 Smallpox (10 y) Y N
 PPD (q year) Y N 20OCT07

Equipment on hand:

2 pair of glasses Y N N/A
 1 pair of mask inserts Y N N/A
 LAST EXAM NOV 2005

Follow up

T YR PHA.

Provider:

STEVEN PRASKE
LCDR. MC/NAVY/7024
 PAGER: A

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

PATIENT NEEDS TYPHOID
GIVEN 14 FEB 08

RECORDS MAINTAINED AT:			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)			SEX
<u>MERWIN DANIEL</u>			<u>MALE</u>
RELATIONSHIP TO SPONSOR N/A	STATUS <u>ACTIVE</u>	RANK/GRADE <u>E-4/ABH-3</u>	
SPONSOR'S NAME N/A		ORGANIZATION <u>AIR/V-3</u>	
DEPART./SERVICE DOD/	SSN/IDENTIFICATION NO. <u>201</u> <u>[REDACTED]</u>	DATE OF BIRTH <u>[REDACTED]</u> <u>85</u>	

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev.5-84)

AR 3371

HEALTH RECORD

CHRO

OFFICIAL RECORD OF MEDICAL CARE

DATE/TIME

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

USS ESSEX LHD-2

DATE:

MEDICAL DEPARTMENT

USS ESSEX (LHD-2) FPO AP 96643-1661

CHECK-IN / CHECK OUT ANNUAL / CLOSE OUT VERIFICATION

PMT REVIEW

PART ONE: PREVENTIVE MEDICINE Completed by: Hm2 Grace☒ Medical Surveillance Questionnaire completely filled out?REQUIRED SURVEILLANCE PROGRAM: Hearing

() Asbestos Questionnaire Asbestos Physical Frequency: _____

Last Asbestos Physical: _____

() Special PMT physical (for all CSSs, SHs, HTs, All R div. All AIMD Painters, or other special physical)

() Respirator Questionnaire (E1-E6 Only) () PPD Converter? Y/N

If no: Last screening: _____

☒ LAST PPD: 20 OCT 07 PPD Converters: INH Complete? Y/N.

LAST MONTHLY/ANNUAL EVAL: _____

() Immunizations:

ANTHRAX: 1 01 NOV 07 2 20 OCT 07 3 13 NOV 07 4 _____ 5 _____
6 _____ B _____

SMALLPOX: _____

INFLUENZA: 16 Jan 08TETANUS: 08 Nov 05TYPHOID: 14 APR 06 TYPE: _____HEPATIS-A: #1 08 Nov 05 #2 14 DEC 05HEPATIS-B: #1 08 Nov 05 #2 14 DEC 05 #3 _____MMR: 08 Nov 05POLIO: 08 Nov 05YELLOW FEVER: 14 DEC 05

LABORATORY REVIEW

PART TWO: LABORATORY

Completed by: Hm2 Grace

() Last annual PAP Smear _____ F/u for PAP Smear due on _____

☒ Sick Cell Pos/Neg Neg Counseling complete? Yes/No/N/A☒ G6PD Norm/Deficient Norm Counseling complete? Yes/No/N/A☒ HIV Date: 07 Nov 06☒ Blood type: OT☒ DNA DRAW DATE: 6 DEC 05 VERIFIED? ☒ N DATE: 27 APR 06

PHYSICAL REVIEW

PART THREE: PHYSICAL

Complete by: Hm2 Grace☒ Last Preventative Health Assessment (PHA): 27 Mar 07☒ Special Physicals required? Y / N Last conducted: _____☒ Wears Glasses? Last exam: 07 Nov 05 # of Glasses/GMI: 2/0

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:		PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)		SEX
		<u>Merwin, Daniel D</u>		<u>male</u>
RELATIONSHIP TO SPONSOR N/A		STATUS <u>AD</u>	RANK/GRADE <u>ABP3</u>	
SPONSOR'S NAME N/A			ORGANIZATION <u>Air/V3</u>	
DEPART./SERVICE DOD/ <u>USN</u>	SSN/IDENTIFICATION NO. <u>20/</u> [REDACTED]	DATE OF BIRTH [REDACTED] <u>85</u>		

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev. 5-84)

HEALTH RECORD	C I	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)	

Issued/Ordered/If/A Date Issued: _____

() Flight Deck screening (for personnel in V-1 and V-4 Div) member in V-3

() Ear Plug size: L: XL R: XL TYPE: T-F

() Hearing Conservation screening for personnel in ACU-1, AIR, DECK, ENG, AIMD.

Date of last 2215 8 Nov 05 Date of last 2216: 11 Nov 07 Next 2216 due: 11 Nov 08

() Sight Conservation Screening for personnel in ACU-1, AIR, AIMD DECK, ENG, LAB, X-RAY, PMT.

() AMMO Driver/Explosive Ordinance Physical for WEPS division and some AIMD personnel (given annually)

MEDICAL ADMIN

PART FOUR: HEALTH RECORDS

Completed by: Knobloch

() Year Blackened on Jacket? () Pencil entries on inside cover?

() Current rate in pencil on jacket?

() Privacy Act entries/signature inside back cover?

() Pink card complete? () Line out blank SF 600s

() Update Problem Summary list () 6150/4? _____

() Allergy Dog tag required? Y/N/NA

Patient Signature: _____ HM Signature: _____ Date: _____

() Health Record in Good Repair? Replace/Repair if not: _____

Ensure that forms are in the right location.

() SAMS data entry complete? Y / N

() Enrolled in TRICARE? Y / N

CLINICAL REVIEW

() Operational Duty Screening conducted as required? Y / N

() Any presence of CHRONIC OR SIGNIFICANT ILLNESS? Y / N

DIAGNOSIS: _____

LAST FOLLOW-UP: _____

() On maintenance medication? Y / N

MEDICATION: _____

ENROLLED ON MAIL ORDER PHARMACY? Y / N

() DRUG ALLERGIES: NKDA (Feathers)

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)			SEX
RELATIONSHIP TO SPONSOR N/A	STATUS	RANK/GRADE	
SPONSOR'S NAME N/A		ORGANIZATION	
DEPART./SERVICE DOD/	SSN/IDENTIFICATION NO.	DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev. 5-84)

AR 3373

NSN 7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643-1661			
TIME IN: 1424	HM NAME: HM3 BOLDE	MO or IDC:	
TIME OUT:	<p>11: @ knee pain</p> <p>5: 22 yo ♂ c/o @ knee pain @ Rem. noted incident</p> <p>T- 92.2 since beginning of MAY. Pt states</p> <p>P- 80 Pain located lateral knee. Pt states</p> <p>Resp- 14 pain started @ after marathon in APRIL.</p> <p>B/P- 117/76 Pt taken time off to rest but pain persistent.</p> <p>MEDS: @ Pain worse @ long standing / exercise. Pt</p> <p>@ will Rem to @ knee.</p>		
ALLERGIES:	<p>General: NAD, pleasant & distress</p> <p>HEBENT: PERRUA, BOUT & CAD</p> <p>NKDA Ext" & Lachman's</p> <p>@ effusion</p> <p>@ swelling</p> <p>@ apprehension</p> <p>AIR Tendinitis (mild)</p> <p>① Pt elevated on PT exercises</p> <p>② Motm 40mg PRN up to ASD</p> <p>③ RTC if symptoms worsen or do not improve</p> <p>④ monitor PRN</p>		
LMP:			
SMOKE:			
DRINK:			

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (Last, First, Middle Initial)			SEX
MERNIA, DANIEL D.			M.
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	
- NA -	AD	E-4	
SPONSOR'S NAME		ORGANIZATION	
- NA -		A.R.N-3	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH	
USN	201 [REDACTED]	[REDACTED] 85	

CHRONOLOGICAL RECORD OF MEDICAL CARE

 STANDARD FORM 600 (Rev. 5-84)
 Prescribed by GSA and ICMR
 FIRM (41 CFR) 201-45.505

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME 27mar07	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

USS ESSEX LHD-2

Preventive Health Assessment (Circle all that apply):

Sex: M F 1. Do you have a history of ulcerative colitis or cancer? Y N
 AGE: 22 2. Do your parents or grandparents have a h/o colon cancer? Y N
 Wt: 137 3. Do you smoke? Number of packs per day ___ No of years ___ Y N
 Ht: 68in 4. Do you have diabetes? Y N
 BP: 111/59 5. Do your parents, siblings, or grandparents have a h/o heart attacks at a young age (<55 in male, <65 in female)? Y N
 P: 89 6. Do you have a history of high blood pressure? Y N
 7. Do you have a history of high cholesterol? Y N
 8. Do your parents, siblings, or grandparents have a h/o high cholesterol? Y N
 9. Do you exercise more than 30 min 3 days per week? Y N
 10. Do you have any medical history that prevents deployment? Y N
 What issues? _____
 11. Do you need help in dealing with stress? Y N
 12. Have you any admin issues that prevent deployment, i.e. EFMP, pregnancy, etc.? Y N
 13. Special Duties, ie. Rad Health, Flight, Explosive Handlers, Diving, SAR swimmer? other: _____ Y N
 Hearing Conservation Program? Y N
 Asbestos Surveillance? Y N

~~Women's Health:~~

~~14. History of abnormal Pap or dysplasia? When: _____ Y N~~
~~15. Do you need to be taught how to perform a self-breast exam? Y N~~
~~16. Have you begun screening mammograms? Age began: _____ Y N~~
~~17. Do you need education on family planning, contraception, or STDs? Y N~~
~~18. On average, do you drink alcohol more than 7 drinks / week? Y N~~

Men's Health:

19. Do you have a history of undescended or abnormally small testes? Y N
 20. Do you need to be taught how to do a self testicular exam? Y N
 21. Do you have a family history of prostate cancer in a close relative? Y N
 22. On average, do you drink alcohol more than 14 drinks / week? Y N

23. I am taking the following medicines or supplements:

24. Allergies: Y None or FEATHERS causes BREATHING DIFFICULTY

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:		
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) <u>MERWIN DANIEL D</u>	SEX <u>M</u>	
RELATIONSHIP TO SPONSOR N/A	STATUS <u>ACTIVE DUTY</u>	RANK/GRADE <u>E3</u>
SPONSOR'S NAME N/A		ORGANIZATION <u>USS ESSEX</u>
DEPART./SERVICE DOD/ <u>Navy</u>	SSN/IDENTIFICATION NO. [REDACTED]	DATE OF BIRTH [REDACTED] <u>85</u>

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev.5-84)

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME 27 Nov 07 CSC	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

Clinic Review:

Labs documented:

Tests/Referrals/Education

Blood type A B 0+
 Sickle Cell +
 G6PD (nl) abnl
 DNA on file (Y) N
 HIV w/in 1yr (Y) N CTN0006
NO results -

___ BP checks x ___ days
 ___ fasting lipids
 ___ HIV within 1 year
 ___ Chem 7
 ___ Dental Appt >1 year
 ___ Optometry appt >2 yr
 ___ Nutritionist consult
 ___ Colon Ca Screening@___
 ___ Mammograms @ ___
 ___ Prostate screen @ ___
 ___ Quit smoking (Ready for Referral?)
 ___ Drink responsibly or quit
 ___ Rec: aerobic exercises
 ___ SBE / STE Education

Immunizations current:

typhoid (2 yr) (Y) N 14 APR 06
 Hep A x 2 (Y) N 08 NOV 05; 14 DEC 05
 Yellow Fever (10) (Y) N 14 DEC 05
 IPV (Y) N 08 NOV 05
 Td (10 y) (Y) N 08 NOV 05
 MMR (Y) N 08 NOV 05
 Influenza (q year) (Y) N 12 NOV 06
 Smallpox (10 y) (Y) (N) NEEDS
 PPD (q year) (Y) N 13 OCT 06 ZERO MM

Equipment on hand:

2 pair of glasses (Y) N N/A
 1 pair of mask inserts (Y) (N) N/A

Follow up

Provider:

[Signature]
 Daniel Caradana, J.G.
 CPC

- ① Patient exercises regularly
- ② NO significant family hx
- ③ Practices safe sex
- ④ ETOH: moderation

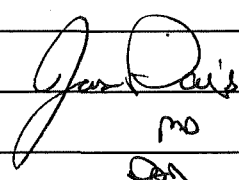
PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL IMPRINT)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) <u>Merritt, Daniel</u>			SEX <u>male</u>
RELATIONSHIP TO SPONSOR N/A	STATUS <u>AD</u>	RANK/GRADE <u>AB43</u>	
SPONSOR'S NAME N/A		ORGANIZATION <u>AB43 US3</u>	
DEPART./SERVICE DOD/ <u>USN</u>	SSN/IDENTIFICATION NO. <u>20/</u> [REDACTED]	DATE OF BIRTH [REDACTED] <u>85</u>	

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev. 5-84)

NSN 7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
21 MAR 07	MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643 -1661		
TIME IN: 0740	HM NAME: Hn2Bn	MO or IDC:	
TIME OUT:	CC: // wound check		
T: 97.8	Pt presents for f/u of abscess abscess @ the back		
P:	of his neck. Looks good & zero signs of infection		
Resp: 16	Discharge/drainage		
B/P:	PE Flw on hand. PE has Full ROM of neck & movement of		
MEDS:	56h Metoprolol		
	OI: vs noted		
	Gen: A+ Cx 3rd NDD		
	Spch well healed Abscess a back of neck		
ALLERGIES:	Rt hand All exten + flex of pseudotumor		
further	well healed		
	A/P (3) Abscess. S/P tx to eradicate MRSA		
LMP:	PE Flw PRN		
	(3) Boxes for no pain Flw Full ROM.		
	Flw PRN.		
SMOKE:	<div style="text-align: right;">  James D. Davis MD CAPT </div>		
ETOH:			

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT: LHD-2			
PATIENT'S NAME (Last, First, Middle Initial) Merwin, Daniel		SEX M	
RELATIONSHIP TO SPONSOR	STATUS AD	RANK/GRADE ABNAN	
SPONSOR'S NAME		ORGANIZATION Apr / 03	
DEPART./SERVICE USN	SSN/IDENTIFICATION NO. 201 [REDACTED]	DATE OF BIRTH [REDACTED]	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
01 MAR 07	MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643-1661
TIME IN:	HM NAME: 1M3 Coronado MO or IDC:
0810	cc: wound check
TIME OUT:	⑤ 22 410 or presented to medical for
T - 96.8	flu of abscess in back of neck. Pt
P - 14	has no complaints at this time.
HR - 68	less swelling at redress packing removed as expected
B/P - 118/61	5/6 in AM
MEDS:	
Motrin	
Septin DS	
Rapin	
ALLERGIES:	
peachers	
LMP:	
N/A	
SMOKE:	
✓	
DRINK:	

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	USS ESSEX
PATIENT'S NAME (Last, First, Middle Initial)	MERWIN DANIEL
RELATIONSHIP TO SPONSOR	N/A
SPONSOR'S NAME	N/A
DEPART./SERVICE	USN
SSN/IDENTIFICATION	[REDACTED]
STATUS	AD
ORGANIZATION	AIR 2
RANK/GRADE	WBHAN
DATE OF BIRTH	03
SEX	M

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
03 MAR 07	MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643-1661
TIME IN: 0805	HM NAME: Claus MO or IDC: Daily
	cc: f/u @ 5 th metacarpal FX + abscess on back of neck
TIME OUT:	2240 ♂ presents to SC for f/u FX that occurred 10 FEB 07.
T - 98.5	PT states ♂ pain in hand and feels much better. PT
P -	states he has an abscess on back of neck x 4 days. States
HR - 101	it is very painful + has had 2 other abscesses in the
B/P - 131/88	recent months, one on scalp + 1 on face. PT has been
MEDS: ♂	applying neosporin + showering 2 times a day. PT states
	that he uses anti bacterial soap + takes many other
	precautions to prevent them.
ALLERGIES:	
feathers	0- ♂ swelling, edema, or deformation in hand
	♂ pain or tenderness ± palpation or manipulation, FROM
LMP:	neck - abscess is round ± erythematous borders, 2x2 cm,
	± purulent discharge, warm to touch.
	ATP Agac & abas
SMOKE: ♂	ⓐ Boxer fracture no pain & grip. Will D/c splint. Will have
	pt f/u repeat x-ray in approx 2-3 weeks
DRINK:	ⓑ Abscess
	- I + D see procedure notes
	- Se Culture

continue

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

USS Essex

PATIENT'S NAME (Last, First, Middle Initial)

Merwin, Daniel

SEX

M

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

ADMAN

SPONSOR'S NAME

ORGANIZATION

Air/V3

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

85

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

AR 3379

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	<p>Suspect pt is carrier of MRSA</p> <ul style="list-style-type: none"> • Septin DS & tab PO BID - Rifampin 600mg PO BID for 7 days • Bactroban to nose TID for 5 days - Bactroban to finger nails - Hibiclens showers <p style="text-align: right;"><i>James [Signature]</i></p>
	<p>Procedure Note I+D</p> <p>The area was antiseptically cleaned with Lidocaine & Epi. Using #11 blade a 0.5 cm incision was made. Abscess was obtained.</p> <p>The abscess was packed with Iodoform. PG F/U in AM.</p> <p style="text-align: right;"><i>[Signature] MD</i></p>
<p>T 979</p> <p>P 85</p> <p>BP 127/60</p>	<p>3-4-07 MD note</p> <p>PG has dressing change. PG states possibly sore out last night</p> <p>PG having less pain. The cavity irrigated & then out packed with Iodoform. PG will F/U AM.</p> <p style="text-align: right;"><i>James [Signature]</i></p>
	<p>3-5-07</p> <p>PG presents for dressing change. Site looks improved. & induration and redness. Packing was pulled & irrigated & then</p> <p>PG F/U in AM.</p> <p style="text-align: right;"><i>[Signature]</i></p>

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE/TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

Issued/Ordered/N/A Date Issued: _____

- () Flight Deck screening (for personnel in V-1 and V-4 Div) 14 APR06
- (✓) Ear Plug size: L: NL R: NL TYPE: TRIPLE FLANGE
- (✓) Hearing Conservation screening for personnel in ACU-1, AIR, DECK, ENG, AIMD. 07 NOV05 03 NOV06 03 NOV07
- Date of last 2215: 1 Date of last 2216: 1 Next 2216 due: 1
- () Sight Conservation Screening for personnel in ACU-1, AIR, AIMD DECK, ENG, LAB, X-RAY, PMT.
- () AMMO Driver/Explosive Ordinance Physical for WEPS division and some AIMD personnel (given annually)

NEXT DUE:
14 APR07

MEDICAL ADMIN

PART FOUR: HEALTH RECORDS

Completed by: _____

- (✓) Year Blackened on Jacket? (✓) Pencil entries on inside cover?
- (✓) Current rate in pencil on jacket?
- (✓) Privacy Act entries/signature inside back cover?
- (✓) Pink card complete? (✓) Line out blank SF 600s
- (✓) Update Problem Summary list (✓) 6150/4?
- (✓) Allergy Dog tag required? Y/N N/A FEATHERS !!!
- Patient Signature: _____ HM Signature: _____ Date: _____
- (✓) Health Record in Good Repair Replace/Repair if not: _____
- Ensure that forms are in the right location.
- (✓) SAMS data entry complete? Y N
- (✓) Enrolled in TRICARE? Y N

CLINICAL REVIEW

- (✓) Operational Duty Screening conducted as required? Y N
- (✓) Any presence of CHRONIC OR SIGNIFICANT ILLNESS? Y N
- DIAGNOSIS: _____
- LAST FOLLOW-UP: _____
- (✓) On maintenance medication? Y N
- MEDICATION: _____
- ENROLLED ON MAIL ORDER PHARMACY? Y / N
- (✓) DRUG ALLERGIES: N/A

Cristina Calderon
CALDERON, CRISTINA
HM3

PATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL PRINT)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)			SEX
RELATIONSHIP TO SPONSOR N/A	STATUS	RANK/GRADE	
SPONSOR'S NAME N/A		ORGANIZATION	
DEPART./SERVICE DOD/	SSN/IDENTIFICATION NO.	DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE Standard Form 600 (Rev.5-84)

NSN 7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
17 Feb 07	MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643-1661		
TIME IN: 0805	HM NAME: Claus/Desantiago MO or IDC: Daily		
	cc: f/u @ 5 th metacarpal FX + abscess of crown of head		
TIME OUT:	22yo ♂ presents to SC for f/u of 5 th metacarpal FX.		
T- 97	PX states pain is 1-2/10 throbbing pain. PT states only		
P-	bothers him when getting ready in AM. PT also has 1cm		
BP 116/70	abscess on crown of his head. PT states pain is very		
HR-	minimal. States he changes his pillow case daily. PT		
HR- 81	denies wearing cap or covering of any kind.		
MEDS: X			
	O- Hand- yellowish bruising @ FX site, & swelling.		
ALLERGIES:	Head- abscess is erythematous & purulent discharge.		
Feathers	scaly borders		
	X-ray distal fm of 5 th digit & angulation		
LMP:	A/P ① Bone FX		
	- continue splint for 3 more weeks		
	② Continue daily castre warm compress.		
SMOKE: X			
DRINK:			
occasion			

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	USS ESSEX		
PATIENT'S NAME (Last, First, Middle Initial)	Merwin Daniel		SEX M
RELATIONSHIP TO SPONSOR	N/A	STATUS AD	RANK/GRADE ABHAD
SPONSOR'S NAME	N/A	ORGANIZATION A121V-3	
DEPART./SERVICE	USN	SSN/IDENTIFICATION NO.	DATE OF BIRTH
		207 [REDACTED]	[REDACTED] 185

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 6-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 FEB 2007	MEDICAL DEPARTMENT: USS ESSEX LHD 2 FPO AP 96643-1661
TIME IN: 1530	HM NAME: HM2 Arnold MO or IDC:
TIME OUT:	CC: F/U on broken hand (R). Now patient is have swelling on scalp.
T- 929	S: 22yr old ♂ experiencing swelling and redness on crown of his head. Very painful 3 out 10
R- 16	Patient has history of abscess. last on 24 JAN 07
HR- 80	treated with antibiotic only.
B/P- 123/82	
MEDS: None	O: vs noted
	Scalp 0.5cm x 0.5cm nodular & fluctuant
	A/P O. Fine Cobble.
ALLERGIES:	- Warm compresses
feather	- Bacitracin ADP 2-3 times a day
LMP: N/A	
SMOKE: NO	
DRINK: occasionally	

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	USS Essex LHD-2		
PATIENT'S NAME (Last, First, Middle Initial)	Merwin, Daniel D	SEX	Male
RELATIONSHIP TO SPONSOR	Self	STATUS	Active Duty
SPONSOR'S NAME	Self	RANK/GRADE	ABHAN/E3
DEPART./SERVICE	USN	ORGANIZATION	
SSN/IDENTIFICATION NO.	20/ [REDACTED]	DATE OF BIRTH	[REDACTED] 985

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Cloned Reductu

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____

(Description of operation or procedure in layman's language)

Risk Infectio Bleeding

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

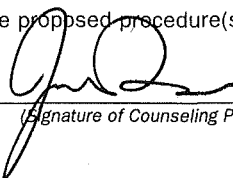
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

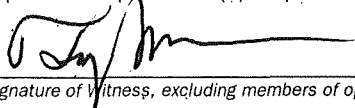
(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

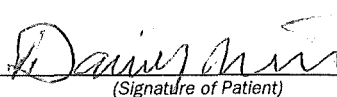


(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.



(Signature of Witness, excluding members of operating team)



(Signature of Patient)

10 FEB 07

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR
PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

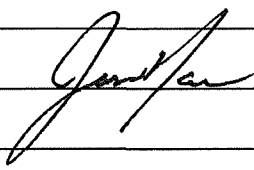
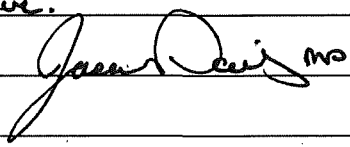
STANDARD FORM 522 (REV. 7-91)

Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1


☆ U.S. GOVERNMENT PRINTING OFFICE: 1993-342-199/50210

NSN 7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
10 FEB 07	CC: Contusion Rt hand		
TIME IN: 0812	SI: 21 y/o ♂ presents to medical after banging		
TIME OUT:	his Rt hand yesterday on PE Pouch the wall		
	PE complains of pain Rt hand worse w/ movement.		
BP- 127/75	O: VS noted		
P- 89	Gen A+ O x 3 in NAO		
T- 983	Rt hand		
R-	Swelling to 5th Metacarpal TTP		
	X-ray distal dir 5th metacarpal 5 Ant angulation		
Meds	A Borne's Fracture		
φ	P: ① Closed Reduction see procedure note		
Sup	② Ultra gutter splint 4 weeks		
	③ Motrin PRN per		
Surgeries	 Procedure Note		
Allergies	Informed consent was obtained. A hematoma block was done		
NKAs	5 Gcc Lidoc 5 Epi. Closed reduction was done		
	A ultra gutter splint applied. PE to procedure.		
	Repeat lateral shows less angulation		
			

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT: 			
PATIENT'S NAME (Last, First, Middle Initial)		SEX	
Merwin Daniel		M	
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	
		ABFAN	
SPONSOR'S NAME		ORGANIZATION	
		Air Div-3	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH	
USA	20 [REDACTED]	[REDACTED] 85	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

OPNAVINST 5100.19D

05 October 2000

Appendix B6-A

Enclosure (1)

Appendix B6-A

MEDICAL CLEARANCE REQUEST

FOR OFFICIAL USE ONLY (when filled in)

From: _____ Division Officer

To: Medical Department Representative

Subj: REQUEST FOR MEDICAL CLEARANCE FOR RESPIRATOR USE

1. The following individual is referred to you for subject clearance:

Name MERWIN, DANIEL D SSN [REDACTED]Supervisor ABHI WIKES Date of Birth 1/4/85

Circle type(s) of respirator(s) to be used:

Air-purifying (non-powered) Air-purifying (powered)

Hose mask (with blower) Hose mask (without blower)

Air-line (demand) Air-line (pressure-demand)

Air-line (continuous flow) SCBA (closed circuit)

SCBA (open-circuit, demand) SCBA (open-circuit, pressure-demand)

Level of Work Effort (Circle one): Light Moderate Heavy Strenuous

Extent of usage (Circle one):

Daily Occasionally but more than once a week Rarely or emergency only

Length of time of anticipated effort (hours per day) _____

Special work considerations (e.g., high places, elevated temperatures, hazardous

material, protective clothing required, etc.)

for [Signature] ABAC (N/SW) 7 MAY 06

Division Officer Signature and Date

FOR OFFICIAL USE ONLY (when filled in)

OPNAVINST 5100.19D

05 October 2000

Appendix B6-D

Enclosure (1)

Appendix B6-D

MEDICAL QUESTIONNAIRE FOR POTENTIAL RESPIRATOR USERS

Part 1

1. Today's date:

05/07/06

2. Your name:

MERWIN, DANIEL D

3. Your age (to nearest year):

21

4. Your sex (circle one): ☒ Male ☐ Female

5. Your height (Feet and Inches):

5'8"

6. Your weight (Pounds):

136

7. Your job title/rate:

ABHAN

8. A phone number where you can be reached by the health care professional

who reviews this questionnaire (include the Area Code):

9. Circle the type of respirator you will use (you can check more than one category):

a. N, R, or P disposable respirator (filter-mask, non-cartridge type only)

b. N, R, or P non-disposable respirator (filter-mask, with cartridges)

☒ c. Other type of cartridge respirators (for example, dust, fume, mist, or organic vapor respirators)

d. Other types of respirators (for example, powered-air purifying, supplied-

air, or self-contained breathing apparatus).

10. Have you ever/previously worn a respirator (circle one): Yes ☐ No ☒

If yes, what type(s):

Part 2

Questions 1 through 9 below must be answered by every person who has been selected

to use any type of respirator (please circle yes or no).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last

month: Yes ☐ No ☒

2. Have you ever had any of the following conditions?

a. Seizures (fits): Yes ☐ No ☒b. Diabetes (sugar disease): Yes ☐ No ☒c. Allergic reactions that interfere with your breathing: Yes ☐ No ☒ PETS HAIR AL AS REL PTd. Claustrophobia (fear of closed-in places): Yes ☐ No ☒e. Trouble smelling odors: Yes ☐ No ☒

OPNAVINST 5100.19D

05 October 2000

B6-D-7 Appendix B6-D

Enclosure (1)

b. Moderate: Yes/No Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs..) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs..) on a level surface.
If yes, how long does this period last during the average shift (number of hours):

c. Heavy: Yes/No Examples of heavy work are lifting a heavy load (about 50 lbs..) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs..).
If yes, how long does this period last during the average shift (number of hours):

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 90 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

OPNAVINST 5100.19D

05 October 2000

Appendix B6-D B6-D-8

Enclosure (1)

Name of the first toxic substance: PAINT

Estimated maximum exposure level per shift: VARIOUS

Duration of exposure per shift

Name of the second toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

Name of the third toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

The name of any other toxic substances that you'll be exposed to while using

your respirator:

18. Describe any special or hazardous conditions you might encounter when

you're using your respirator(s) (for example, confined spaces, lifethreatening gases): NONE

19. Describe any special responsibilities you'll have while using your respirator(NONE

s) that may affect the safety and well-being of others (for example, rescue, security): NONE

OPNAVINST 5100.19D

05 October 2000

Appendix B6-D B6-D-6

Enclosure (1)

5. List any second jobs or side businesses you have: *NONE*

6. List your previous occupations: *CUSTOMER SERVICE REP*

7. List your current and previous hobbies: *NONE*

8. Have you been in other military services? Yes/*NO*

Do you suspect that you were you exposed to biological or chemical agents

while in the military or in a military operation: Yes/*NO*

9. Other than medications for breathing and lung problems, heart trouble,

blood pressure, and seizures mentioned earlier in this questionnaire, are you

taking any other medications for any reason (including over-the-counter medications):

Yes/*NO*

If yes, name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/*NO*

b. Canisters (for example, gas masks): Yes/*NO*

c. Cartridges: Yes/*NO*

11. How often are you expected to use the respirator(s) (circle yes or no for

all answers that apply to you)?:

a. Escape only (no rescue): Yes/*NO*

b. Emergency rescue only: Yes/*NO*

c. Less than 5 hours per week: Yes/*NO*

d. Less than 2 hours per day: Yes/*NO*

e. 2 to 4 hours per day: Yes/*NO*

f. Over 4 hours per day: Yes/*NO*

12. During the period you are using the respirator(s), is your work effort

(circle):

a. Light: Yes/*NO* Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing

while operating a drill press (1-3 lbs..) or controlling machines.

If yes, how long does this period last during the average shift (number of hours):

OPNAVINST 5100.19D

05 October 2000

Appendix B6-D B6-D-4

Enclosure (1)

e. Any other problem that interferes with your use of a respirator:
Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Part 3

Questions 10 to 15 below must be answered by every employee who has been selected

to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of

respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently):

Yes/No

11. Do you currently have any of the following vision problems?

a. Wear contact lenses: Yes/No

b. Wear glasses: Yes/No

c. Color blind: Yes/No

d. Any other eye or vision problem: Yes/No

e. Any other eye or vision problem: Yes/No

12. Have you ever had an injury to your ears, including a broken ear drum:

Yes/No

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing: Yes/No

b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/No

14. Have you ever had a back injury: Yes/No

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist:

Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f. Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/No

OPNAVINST 5100.19D

05 October 2000

B6-D-5 Appendix B6-D

Enclosure (1)

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.:

Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part 4

(Any of the following questions, and other questions not listed, may be added

to the questionnaire at the discretion of the health care professional who

will review the questionnaire)

1. In your present job, are you working at high altitudes (over 5,000 feet)

or in a place that has lower than normal amounts of oxygen: Yes/No

If yes, do you have feelings of dizziness, shortness of breath, pounding in

your chest, or other symptoms when you're working under these conditions:

Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous

airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If yes, name the chemicals if you know them:

3. Have you ever been a member of a HAZMAT spill response team, or a member

of a HAZMINCEN: Yes/No

4. Have you ever worked with any of the materials, or under any of the conditions,

listed below:

a. Asbestos: Yes/No

b. Silica (e.g., in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material):

Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No

g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If yes, describe these exposures:

N/A

OPNAVINST 5100.19D

05 October 2000

Appendix B6-D B6-D-2

Enclosure (1)

3. Have you ever had any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

c. Chronic bronchitis: Yes/No

d. Emphysema: Yes/No

e. Pneumonia: Yes/No

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

j. Broken ribs: Yes/No

k. Any chest injuries or surgeries: Yes/No

l. Any other lung problem that you've been told about: Yes/No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No

b. Shortness of breath when walking fast on level ground or walking up a

slight hill or incline: Yes/No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

e. Shortness of breath when washing or dressing yourself: Yes/No

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

h. Coughing that wakes you early in the morning: Yes/No

i. Coughing that occurs mostly when you are lying down: Yes/No

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

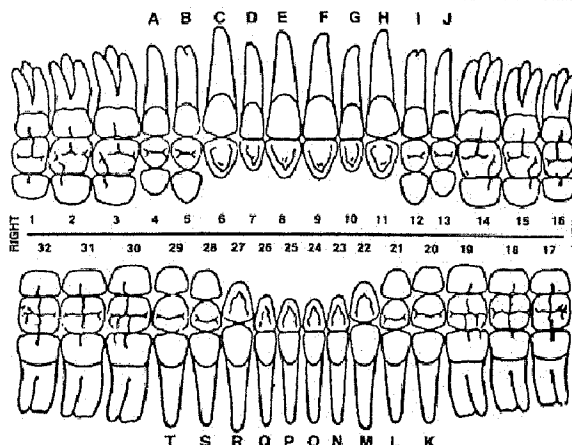
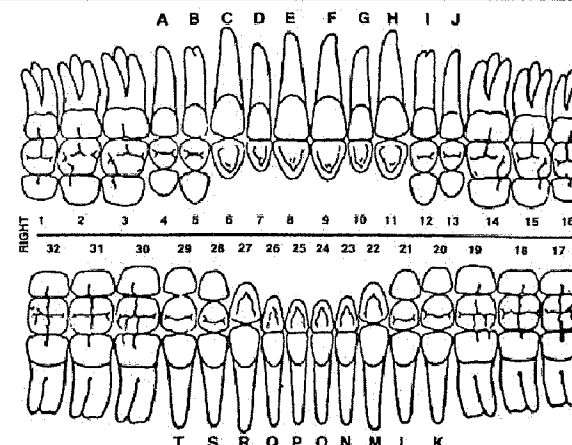
Standard Form 603-A

HEALTH RECORD	DENTAL - Continuation
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SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

PAGE: 1

8. RESTORATIONS AND TREATMENTS (Completed during service)**9. SUBSEQUENT DISEASES AND ABNORMALITIES**

	
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REMARKS

REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
26 Oct 2015	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)] Periodic ortho tx, Time out, retied both arches 19 X 25 SS lower aw, 17 X 25 SS upper aw with PC to rotated #11. NV Check #11. PROCEDURES: A9999(x1), D8670(x1) PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495 [Signed by TERP ALFRED JEROME: 26 Oct 2015 09:56:00 AM CST]	2
24 Nov 2015	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)] Periodic ortho tx, Time out, retied 17 X 25 SS upper aw with PC for rotation #11, retied lower aw. NV Check #11. PROCEDURES: A9999(x1), D8670(x1) PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495 [Signed by TERP ALFRED JEROME: 24 Nov 2015 11:36:00 AM CST]	2
07 Jan 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)] Periodic ortho tx, Time out, retied PC #11-12 for rotation, pt can't tolerate PC #3-11, retied lower aw. NV Bond Bracket #11. PROCEDURES: A9999(x1), D8670(x1) PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495 [Signed by TERP ALFRED JEROME: 07 Jan 2016 09:55:00 AM CST]	2
08 Feb 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)] Periodic ortho tx, time out, pain 0/10, updated Med hx, retied both arches 19 X 25 SS, placed PC #11-13-14 and #11 to AW distal #10. NV Eval rotation #11 and consider bonding bracket. PROCEDURES: A9999(x1), D8670(x1) PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	

PATIENT'S IDENTIFICATION (Use this Space for Mechanical Imprint)

PATIENT'S NAME (Last, First, Middle Initial)

MERWIN DANIEL DENNIS

SEX

DATE OF BIRTH

1985

RELATIONSHIP TO SPONSOR

COMPONENT STATUS

DEPART SERVICE

SPONSOR'S NAME

MERWIN DANIEL DENNIS

RANK/GRADE

SSN OR IDENTIFICATION NO.

ORGANIZATION

EXCEPTION TO SF 603A

APPROVED BY GSA/IRMS 1-91

Standard Form 603A (10-75)

GSA/ICMR

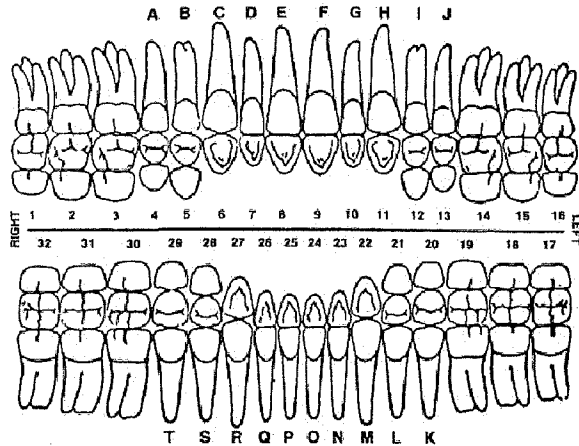
FIRM (41 CFR) 201-45.505

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SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

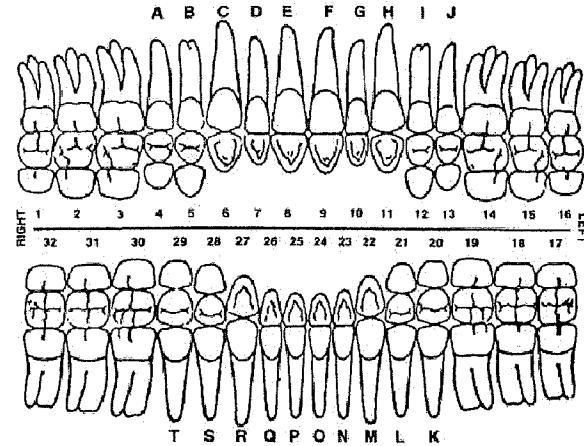
PAGE: 2

8. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
	[Signed by TERP ALFRED JEROME: 08 Feb 2016 07:40:00 AM CST]	2
07 Mar 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, bonded bracket #11, used 14 niti with 17 X 25 SS overlay, PC #14-11, retied lower aw. NV	
	Check rotation #11.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 07 Mar 2016 08:23:00 AM CST]	2
05 Apr 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, placed 18 Niti upper aw with 17 X 25 SS overlay, retied lower 19 X 25 SS. NV Pano, consider rebonding #11 also #7,10 for tip.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 05 Apr 2016 07:19:00 AM CST]	2
05 May 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, Pano, placed 20 niti upper aw with PC #11-14 for rotation, retied lower arch. NV Rebond #11 for rotation.	
	PROCEDURES: A9999(x1), D0330(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 05 May 2016 08:27:00 AM CST]	2
07 Jun 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, rebonded #11, retied 20 Niti upper aw, retied lower 19 X 25 SS. NV Dx casts.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 07 Jun 2016 02:02:00 PM CST]	2
11 Aug 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, reviewed medical history - no changes, told patient to update dental exam at home clinic (record kept at Fort Meade), 2 dx casts for pre-surgical coordination, rebonded #11 for mesial rotation and tip, retied 20 Niti upper aw, retied lower 19 X 25 SS with PC 6-6. NV Check #11 and discuss set up.	
	PROCEDURES: A9999(x1), D0470(x1), D8670(x1), L0001(x1)	
	(Continued)	

PATIENT'S NAME: MERWIN DANIEL DENNIS

SSN: [REDACTED]

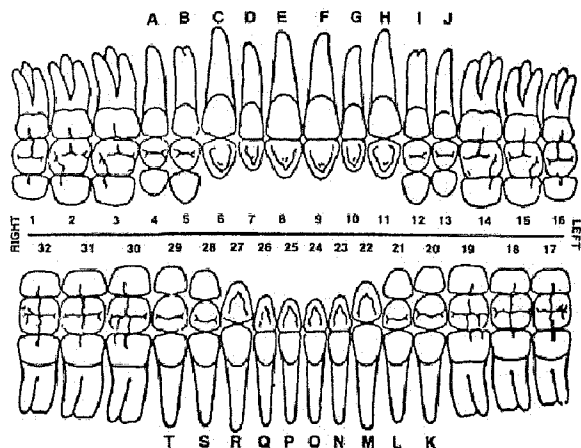
SF 603A (SIDE 2)

AR 3396

SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

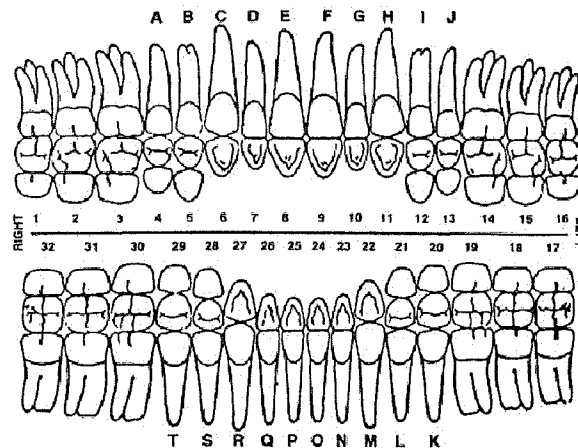
PAGE: 3

8. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
11 Aug 2016	(Continued)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 11 Aug 2016 08:27:00 AM CST]	2
13 Sep 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history -no changes, placed 18 X 25 niti upper aw, retied lower 19 X 25 SS. NV Check #11,15.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 13 Sep 2016 10:00:00 AM CST]	2
24 Oct 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, retied 19 X 25 SS lower aw, placed 19 X 25 SS with PC 6-6 lower /7-7 upper. NV Check space distal #11.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 24 Oct 2016 09:07:00 AM CST]	2
05 Dec 2016	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, retied both arches with PC 7-7. NV Dx casts for surgical planning.	
	PROCEDURES: A9999(x1), D8670(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 05 Dec 2016 08:59:00 AM CST]	2
04 Jan 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, 2 dx casts, retied both arches (19 X 25 SS) with PC 6-6. NV Discuss set up.	
	PROCEDURES: D0470(x1), D8670(x1), U0001(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 04 Jan 2017 11:39:00 AM CST]	2
01 Feb 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, discussed set up for Lefort adv, models show adequate transverse although compensated, retied both arches, referred to OS for 2nd look eval. NV Retie / possible surgical lugs.	
	PROCEDURES: D8670(x1), W9999(x1)	
	(Continued)	

PATIENT'S NAME: MERWIN DANIEL DENNIS

SSN: [REDACTED]

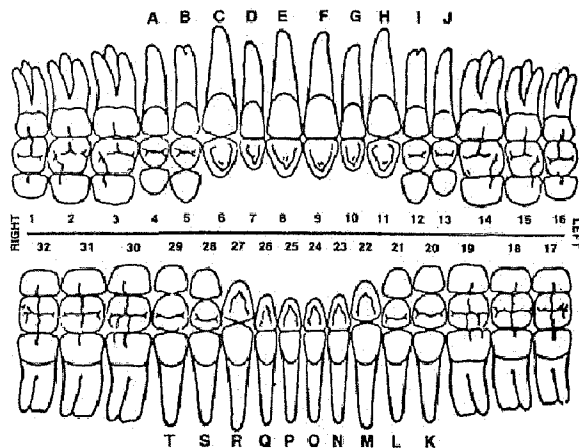
SF 603A (SIDE 2)

AR 3397

SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

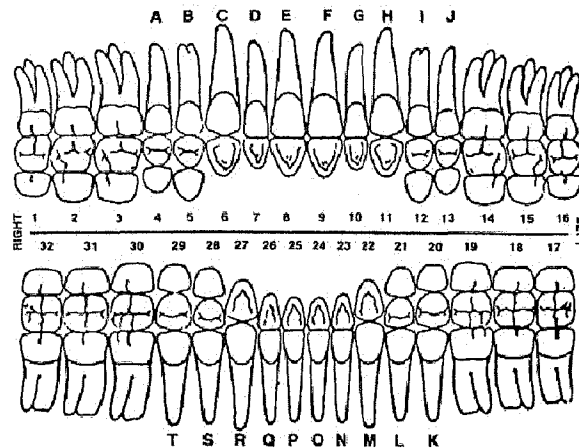
PAGE: 4

8. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
01 Feb 2017	(Continued)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 01 Feb 2017 01:30:00 PM CST]	2
07 Mar 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, retied both arches with PC lower 6-6. NV surgical lugs - for 20 APR surgery.	
	PROCEDURES: D8670(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 07 Mar 2017 09:56:00 AM CST]	2
05 Apr 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, 4 dx casts for OS, soldered surgical lugs for Lefort adv (27 APR). NV Pre-op with OS.	
	PROCEDURES: D0470(x1), D8670(x1), U0014(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 05 Apr 2017 09:09:00 AM CST]	1
07 Jun 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Oral Maxillofacial Surgery)]	
	6 weeks s/p lefort 1 single piece advancement presenting for routine follow-up. 0/10 pain. Has been following post-operative hygiene and diet. Pain well controlled. Good nutrition and normal bowel movements. Sensation has continued to improved at midface. Patient has finished with endo tx of tooth #12 in interim. PMH reviewed no changes. AFSVSS. EOE: Mild midface edema bilaterally consistent with surgery. V2 with hypoesthesia bilaterally, intact to level A. Nares patent without rhinorrhea. IOE: Patient biting in stable and repeatable occlusion without splint. No evidence of open bite. Max midline coincident with MSP. Incisions are well healed. No erythema, edema, hyperemia, or discharge. No pain on percussion at #12. Healthy appearing soft tissue environment. Overall good hygiene. A/P: 6 week sp lefort 1 advancement with stable and uneventful post-operative course. Patient has progressed well and finished with RCT by endo for tooth #12. Big 3 imaging taken today and revealed adequate fixation and occlusion. Jaw relation in good position. No concerning abnormalities. POI provided. Patient to return to normal diet and activity. Patient to see COL Terp next week to start orthodontic phase of treatment. He will visit med photo for post-op pictures. He was also provided copies of records for tx. Left in good spirits and pleased with result. FU prn. Peters R3 SDW Dr Jensen	
	PROCEDURES: D0140(x1), D0330(x1), D0340(x1), W9999(x1)	
	(Continued)	

PATIENT'S NAME: MERWIN DANIEL DENNIS

SSN: [REDACTED]

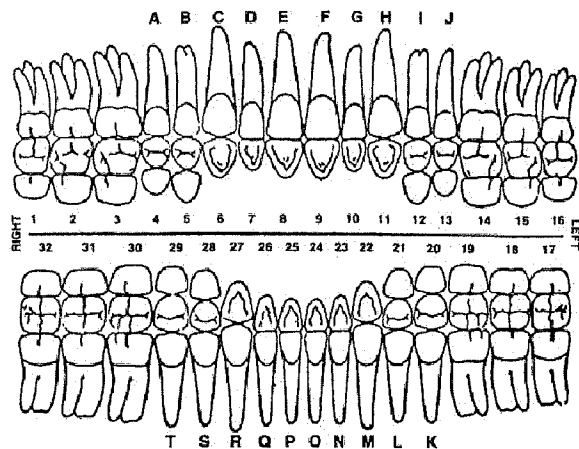
SF 603A (SIDE 2)

AR 3398

SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

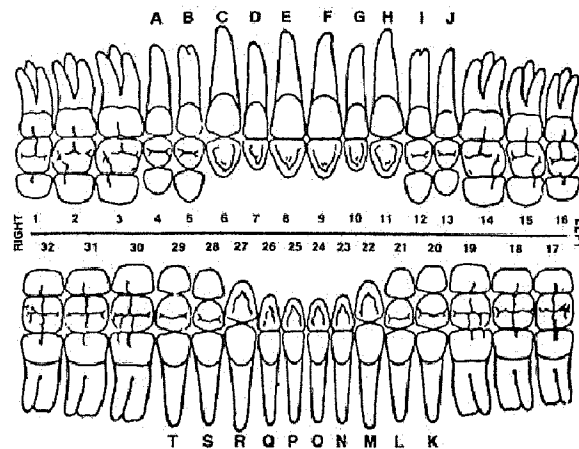
PAGE: 5

8. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
07 Jun 2017	(Continued)	
	PROVIDER: JENSEN DAMON TY, LCDR, USN, DC, NPI ID: 1851598437	
	[Signed by JENSEN DAMON TY: 08 Jun 2017 06:59:00 AM CST]	1
14 Jun 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, patient presents 6 weeks post Lefort adv, removed surgical aw's, placed 17 X 25 TMA both arches with PC 7-7, TTB elastics #2/31, class I impalas 4-5's. NV Check settling and #2.	
	PROCEDURES: D8670(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 14 Jun 2017 10:13:00 AM CST]	2
12 Jul 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, retied both arches with PC lower 7-7, upper 6-6, LCT lower posteriors, TTB elastics #2/31, continue impalas. NV Check 7's and space distal to #11.	
	PROCEDURES: D8670(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 12 Jul 2017 08:19:00 AM CST]	2
08 Aug 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Periodic ortho tx, time out, pain 0/10, reviewed medical history - no changes, patient noticed palatal tissue "peeling off" for the past week, upon examination, marginal palatal gingiva #6-11 extremely inflamed and erythematous, consulted oral path - possible desquamative gingivitis, recommend prophy with RDH, Rx for peridex 473 ml written rinse 1 time per day for 14 days, re-eval in 10-14 days. Retied both arches, elastics nights only. 2 dx photos. NV Check settling.	
	PROCEDURES: D8670(x1), W9999(x1)	
	PROVIDER: COL TERP ALFRED JEROME, NPI ID: 1093790495	
	[Signed by TERP ALFRED JEROME: 08 Aug 2017 02:37:00 PM CST]	2
07 Sep 2017	[TREATMENT LOCATION: Walter Reed National Military Medical Center - Clinic (Hospital Dentistry)]	
	Comp adult orthodontic debond, time out, pain 0/10, reviewed medical history - no changes noted, patient requests appliance removal - is happy with occlusion / esthetics, 4 dx casts, 8 dx photos, pano, lat cep, anterior PA's, BTW's utilized ultrasonic scaler, orthodontic retention, inserted Essix retainers with written POI's. NV Hawley insert.	
	(Continued)	

PATIENT'S NAME: MERWIN DANIEL DENNIS

SSN: [REDACTED]

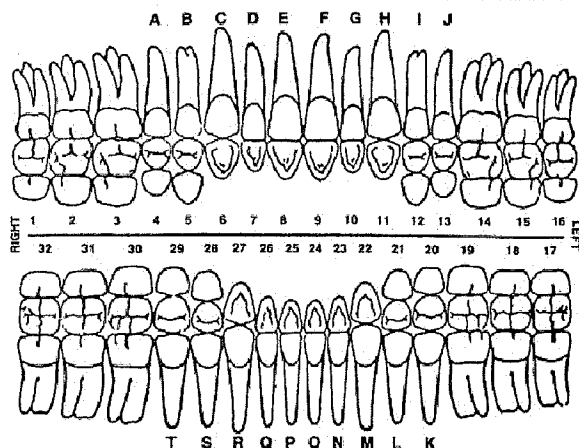
SF 603A (SIDE 2)

AR 3399

SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

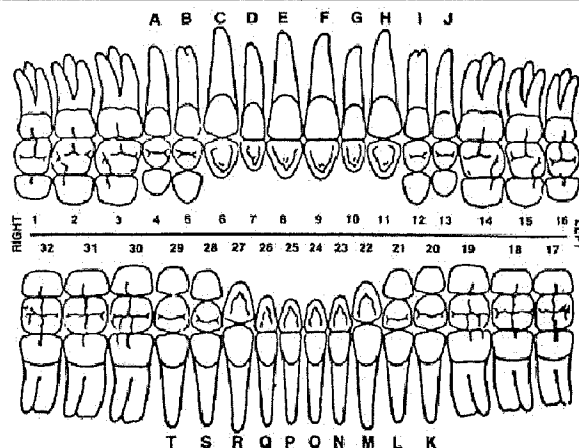
PAGE: 6

8. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

[illegible]

PATIENT'S NAME: MERWIN DANIEL DENNIS

SF 603A (SIDE 2)

SSN:

AR 3400



General Internal Medicine Service

Medical Home Team Fox River (301) 295-0196 office ; (301) 295-4630 fax

08 August 2017

From: Martin R. Linker, MD, Medical Home Fox River, WRNMMC
To: Command for Petty Officer Third Class Daniel D. Merwin
Subj: Clarification of/ Addendum to NAVMED 6100/5 dated 13 June 2017
PO3 Daniel D. Merwin
Ref: Participation in PT

1. I am the Primary Care Manager at WRNMMC for this SM. I saw him on 27 July 2017 and again on 07 August 2017. His diagnoses include Generalized Anxiety Disorder, Major Depressive Disorder, and Irritable Bowel Syndrome with Diarrhea.
2. PO3 Merwin should be excused from and not participate in Company Level PT, marching, or standing. He should participate in PT at his own pace. He may stand for up to 30 minutes. He must be excused to use sanitary bathroom facilities if necessary.

If you have any questions, please contact me directly at martin.r.linker.ctr@mail.mil.

**Walter Reed National Military Medical Center Bethesda
8901 Wisconsin Avenue Bethesda, MD 20889**



DEFENSE HEALTH AGENCY
WALTER REED NATIONAL MILITARY MEDICAL CENTER
GASTROENTEROLOGY SERVICE
8901 WISCONSIN AVENUE
BETHESDA, MD 20889-5600

Service Chief

LTC Dawn Torres, MD

Clinical Services & Research
MAJ(P) Fouad Moawad, MD
Director - Fellowship Program
CDR Patrick Young, MD
Director - Endoscopic Services
MAJ(P) Jeffrey Laczek, MD

Staff Providers

Anita Bhushan, MD
Lawrence Goldkind, MD
Maria Sjogren, MD, COL USA RET
Roy Wong, MD, COL USA RET
MAJ Michael Asike, MD
CDR John Bassett, MD USN
MAJ Ryan Kwok, MD
LCDR Manish Singla, MD
Helen Copsey, PA-C
Marylyn Ezenyi, CRNP
Jose Balinas, PA-C, LT USN RET

October 11th, 2016

To Whom It May Concern,

PO1 Daniel Merwin (██████1985) is followed in our clinic for a chronic medical condition that can impact his day to day functioning. Please take this under consideration if/when PO1 Merwin requests reasonable accomodations to his work schedule.

Please feel free to contact me directly with any questions or concerns.

Sincerely,

**COPSEY.HELE
N.CHRISTINA.
1393890351**

Digitally signed by
COPSEY.HELEN.CHRISTINA.13938903
51
DN: c=US, o=U.S. Government,
ou=DoD, ou=PKI, ou=CONTRACTOR,
cn=COPSEY.HELEN.CHRISTINA.13938
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Helen Copsey, PA-C
301-400-0552
Helen.C.Copsey.ctr@mail.mil

RECORD OF MILITARY PROCESSING - ARMED FORCES OF THE UNITED STATES															Form Approved OMB No. 0704-0173 Expires Oct 31, 2006																																																																																																																																																																																																																																																											
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20. NAME (Last, First, Middle Initial) MERWIN DANIEL DENNIS				21. SOCIAL SECURITY NUMBER [REDACTED]	
SECTION III - OTHER PERSONAL DATA					
22. EDUCATION					
a. List all high schools and colleges attended. (List dates in YYYYMM format.)					(5) GRADUATE
(1) FROM	(2) TO	(3) NAME OF SCHOOL	(4) LOCATION	YES	NO
199909	200306	HACKETTSTOWN HIGH SCHOOL	HACKETTSTOWN, NJ	X	
b. Have you ever been enrolled in ROTC, Junior ROTC, Sea Cadet Program or Civil Air Patrol?				YES	NO
					DDM
23. MARITAL/DEPENDENCY STATUS AND FAMILY DATA					
(If "Yes," explain in Section VI, "Remarks.")					
a. Is anyone dependent upon you for support?					DDM
b. Is there any court order or judgment in effect that directs you to provide alimony or support for children?					DDM
c. Do you have an immediate relative (father, mother, brother, or sister) who: (1) is now a prisoner of war or is missing in action (MIA); or (2) died or became 100% permanently disabled while serving in the Armed Services?					DDM
d. Are you the only living child in your immediate family?					DDM
24. PREVIOUS MILITARY SERVICE OR EMPLOYMENT WITH THE U.S. GOVERNMENT					
(If "Yes," explain in Section VI, "Remarks.")					
a. Are you now or have you ever been in any regular or reserve branch of the Armed Forces or in the Army National Guard or Air National Guard?					DDM
b. Have you ever been rejected for enlistment, reenlistment, or induction by any branch of the Armed Forces of the United States?					DDM
c. Are you now or have you ever been a deserter from any branch of the Armed Forces of the United States?					DDM
d. Have you ever been employed by the United States Government?					DDM
e. Are you now drawing, or do you have an application pending, or approval for: retired pay, disability allowance, severance pay, or a pension from any agency of the government of the United States?					DDM
25. ABILITY TO PERFORM MILITARY DUTIES					
(If "Yes," explain in Section VI, "Remarks.")					
a. Are you now or have you ever been a conscientious objector? (That is, do you have, or have you ever had, a firm, fixed, and sincere objection to participation in war in any form or to the bearing of arms because of religious belief or training?)					DDM
b. Have you ever been discharged by any branch of the Armed Forces of the United States for reasons pertaining to being a conscientious objector?					DDM
c. Is there anything which would preclude you from performing military duties or participating in military activities whenever necessary (i.e., do you have any personal restrictions or religious practices which would restrict your availability)?					DDM
26. DRUG USE AND ABUSE (If "Yes," explain in Section VI, "Remarks.")					
Have you ever tried, used, sold, supplied, or possessed any narcotic (to include heroin or cocaine), depressant (to include quaaludes), stimulant, hallucinogen (to include LSD or PCP), or cannabis (to include marijuana or hashish), or any mind-altering substance (to include glue or paint), or anabolic steroid, except as prescribed by a licensed physician?					
					DDM

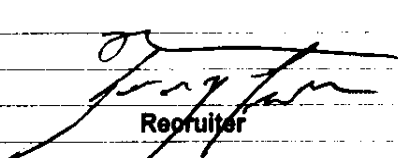
27. NAME (Last, First, Middle Initial) MERWIN DANIEL DENNIS		28. SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px;"></div>	
SECTION IV - CERTIFICATION			
29. CERTIFICATION OF APPLICANT (Your signature in this block must be witnessed by your recruiter.)			
a. I certify that the information given by me in this document is true, complete, and correct to the best of my knowledge and belief. I understand that I am being accepted for enlistment based on the information provided by me in this document; that if any of the information is knowingly false or incorrect, I could be tried in a civilian or military court and could receive a less than honorable discharge which could affect my future employment opportunities.			
b. TYPED OR PRINTED NAME (Last, First, Middle Initial) MERWIN DANIEL DENNIS		c. SIGNATURE 	
		d. DATE SIGNED (YYYYMMDD) 20051012	
30. DATA VERIFICATION BY RECRUITER (Enter description of the actual documents used to verify the following items.)			
a. NAME (X one) <input checked="" type="checkbox"/> (1) BIRTH CERTIFICATE <input type="checkbox"/> (2) OTHER (Explain)		b. AGE (X one) <input checked="" type="checkbox"/> (1) BIRTH CERTIFICATE <input type="checkbox"/> (2) OTHER (Explain)	
d. SOCIAL SECURITY NUMBER (SSN) (X one) <input checked="" type="checkbox"/> (1) SSN CARD <input type="checkbox"/> (2) OTHER (Explain)		e. EDUCATION (X one) <input checked="" type="checkbox"/> (1) DIPLOMA <input type="checkbox"/> (2) OTHER (Explain)	
		c. CITIZENSHIP (X one) <input checked="" type="checkbox"/> (1) BIRTH CERTIFICATE <input type="checkbox"/> (2) OTHER (Explain)	
		f. OTHER DOCUMENTS USED SEE SECTION VI	
31. CERTIFICATION OF WITNESS			
a. I certify that I have witnessed the applicant's signature above and that I have verified the data in the documents required as prescribed by my directives. I further certify that I have not made any promises or guarantees other than those listed and signed by me. I understand my liability to trial by courts-martial under the Uniform Code of Military Justice should I effect or cause to be effected the enlistment of anyone known by me to be ineligible for enlistment.			
b. TYPED OR PRINTED NAME (Last, First, Middle Initial) LEVAN, TERRY W.		c. PAY GRADE E-6	
		d. RECRUITER I.D. <div style="background-color: black; width: 100px; height: 20px;"></div>	
		e. SIGNATURE 	
		f. DATE SIGNED (YYYYMMDD) 20051012	
32. SPECIFIC OPTION/PROGRAM ENLISTED FOR, MILITARY SKILL, OR ASSIGNMENT TO A GEOGRAPHICAL AREA GUARANTEES			
a. SPECIFIC OPTION/PROGRAM ENLISTED FOR (Completed by Guidance Counselor, MEPS Liaison NCO, etc., as specified by sponsoring service.) (Use clear text English) FOUR YEAR OBLIGATOR AVIATION BOATSWAINMATE (HANDLING) CLASS "A" SCHOOL GUARANTEE (4YO/SG-ABH); ACTIVE DUTY DATE: 2005NOV01			
b. I fully understand that I will not be guaranteed any specific military skill or assignment to a geographic area except as shown in item 32.a. above and annexes attached to my Enlistment/Reenlistment Document (DD Form 4).			c. APPLICANT'S INITIALS DDM
33. CERTIFICATION OF RECRUITER OR ACCEPTOR			
a. I certify that I have reviewed all information contained in this document and, to the best of my judgment and belief, the applicant fulfills all legal policy requirements for enlistment. I accept him/her for enlistment on behalf of the United States (Enter Branch of Service) NAVY and certify that I have not made any promises or guarantees other than those listed in item 32.a. above. I further certify that service regulations governing such enlistments have been strictly complied with and any waivers required to effect applicant's enlistment have been secured and are attached to this document.			
b. TYPED OR PRINTED NAME (Last, First, Middle Initial) BROWN, BRYAN C.		c. PAY GRADE E-6	
		d. RECRUITER I.D. OR ORGANIZATION <div style="background-color: black; width: 100px; height: 20px;"></div>	
		e. SIGNATURE 	
		f. DATE SIGNED (YYYYMMDD) 20051012	
SECTION V - RECERTIFICATION			
34. RECERTIFICATION BY APPLICANT AND CORRECTION OF DATA AT THE TIME OF ACTIVE DUTY ENTRY			
a. I have reviewed all information contained in this document this date. That information is still correct and true to the best of my knowledge and belief. If changes were required, the original entry has been marked "See Item 34" and the correct information is provided below.			
b. ITEM NUMBER		c. CHANGE REQUIRED	
		<div style="font-size: 2em; transform: rotate(-15deg); opacity: 0.5;">NO CHANGES</div>	
d. APPLICANT (1) SIGNATURE 		e. WITNESS (1) TYPED OR PRINTED NAME (Last, First, Middle Initial) WILLIAMSON, John	
(2) DATE SIGNED (YYYYMMDD) 20051012		(2) RANK/ GRADE GS-09	
		(3) SIGNATURE 	

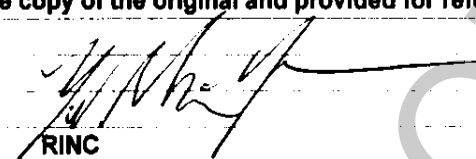
35. NAME (Last, First, Middle Initial) MERWIN DANIEL DENNIS	36. SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px;"></div>
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SECTION VI - REMARKS

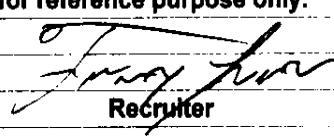
(Specify items(s) being continued by item number. Continue on separate pages if necessary.)

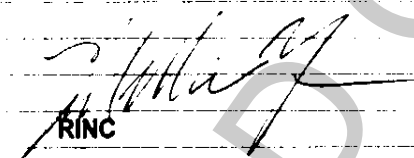
12OCT2005: I have personally sighted Daniel Dennis Merwin's original birth certificate issued by the State of California. I certify the reproduced document is a true copy of the original and provided for reference purpose only.


 Recruiter

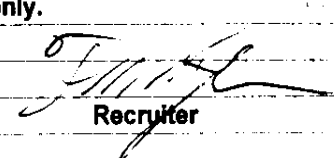

 RINC

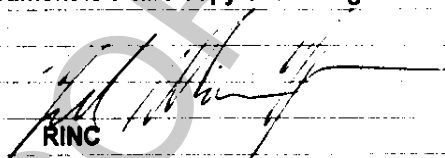
12OCT2005: I have personally sighted Daniel Dennis Merwin's original Social Security Number Card issued by the Social Security Administration. I certify the reproduced document is a true copy of the original and provided for reference purpose only.


 Recruiter


 RINC

12OCT2005: I have personally sighted Daniel Dennis Merwin's original High School Diploma issued by Hackettstown High School. I certify the reproduced document is a true copy of the original and provided for reference purpose only.


 Recruiter


 RINC

DD FORM 1966/5	YES	
ATTACHED? (X one)	NO	

SECTION VII - STATEMENT OF NAME FOR OFFICIAL MILITARY RECORDS

37. NAME CHANGE

If the preferred enlistment name (name given in Item 2) is not the same as on your birth certificate, and it has not been changed by legal procedure prescribed by state law, and it is the same as on your social security number card, complete the following:

a. NAME AS SHOWN ON BIRTH CERTIFICATE	b. NAME AS SHOWN ON SOCIAL SECURITY NUMBER CARD

c. I hereby state that I have not changed my name through any court or other legal procedure; that I prefer to use the name of _____ by which I am known in the community as a matter of convenience and with no criminal intent. I further state that I am the same person as the person whose name is shown in Item 2.

d. APPLICANT

(1) SIGNATURE	(2) DATE SIGNED (YYYYMMDD)

e. WITNESS

(1) TYPED OR PRINTED NAME (Last, First, Middle Initial)	(2) PAY GRADE	(3) SIGNATURE

Page 4

REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD) 20051013		2. SOCIAL SECURITY NUMBER [REDACTED]	
PRIVACY ACT STATEMENT						
<p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>						
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN DANIEL DENNIS			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code) [REDACTED] BETHLEHEM, PA [REDACTED]		5. HOME TELEPHONE NUMBER [REDACTED]	
6. GRADE CIVILIAN	7. DATE OF BIRTH (YYYYMMDD) 1985 [REDACTED]	8. AGE (20)	9. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White		b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input checked="" type="checkbox"/> Not Hispanic/Latino
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY <input type="checkbox"/> b. CIVILIAN <input type="checkbox"/>		12. AGENCY (Non-Service Members Only) DN		13. ORGANIZATION UNIT AND UIC/CODE		
14.a. RATING OR SPECIALTY (Aviators Only)		b. TOTAL FLYING TIME		c. LAST SIX MONTHS		
15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input checked="" type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) HARRISBURG MEPS 4641 Westport Drive Mechanicsburg, PA 17055-4843
CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)						
				44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)		
17. Head, face, neck, and scalp						
18. Nose						
19. Sinuses						
20. Mouth and throat						
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)						
22. Drums (Perforation)						
23. Eyes - General (Visual acuity and refraction under items 61 - 63)						
24. Ophthalmoscopic						
25. Pupils (Equality and reaction)						
26. Ocular motility (Associated parallel movements, nystagmus)						
27. Heart (Thrust, size, rhythm, sounds)						
28. Lungs and chest (Include breasts)						
29. Vascular system (Varicosities, etc.)						
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)						
31. Abdomen and viscera (Include hernia)						
32. External genitalia (Genitourinary)						
33. Upper extremities						
34. Lower extremities (Except feet)						
35. Feet (See Item 35 Continued)						
36. Spine, other musculoskeletal						
37. Identifying body marks, scars, tattoos						
38. Skin, lymphatics						
39. Neurologic						
40. Psychiatric (Specify any personality deviation)						
41. Pelvic (Females only)						
42. Endocrine						
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in item 44.)				35. FEET (Continued) (Circle category)		
<input checked="" type="checkbox"/> Acceptable				N - Normal Arch		
<input type="checkbox"/> Not Acceptable Class				C - Pes Cavus		
				P - Pes Planus		
				1 - Mild		
				2 - Moderate		
				3 - Severe		
				A - Asymptomatic		
				S - Symptomatic		



LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS						DNR		SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 1.2em;"></div>																	
LABORATORY FINDINGS																									
45. URINALYSIS		a. Albumin NEG		46. URINE HCG		47. H/H		48. BLOOD TYPE																	
		b. Sugar NEG																							
TESTS		RESULTS				 615122489 06095320 20051013 (YYYYMMDD)		SECOND SPECIMEN ID LABEL																	
		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>FIRST TEST</th> <th>CODE</th> <th>SECOND TEST</th> <th>CODE</th> </tr> <tr> <td>49. HIV</td> <td>NEG</td> <td>50. DRUGS</td> <td>NEG</td> </tr> <tr> <td>51. ALCOHOL</td> <td>NEG</td> <td>52. OTHER</td> <td></td> </tr> <tr> <td>a. PAP SMEAR</td> <td></td> <td>b. EKG</td> <td></td> </tr> <tr> <td>c. CXR</td> <td></td> <td></td> <td></td> </tr> </table>								FIRST TEST	CODE	SECOND TEST	CODE	49. HIV	NEG	50. DRUGS	NEG	51. ALCOHOL	NEG	52. OTHER		a. PAP SMEAR		b. EKG	
FIRST TEST	CODE	SECOND TEST	CODE																						
49. HIV	NEG	50. DRUGS	NEG																						
51. ALCOHOL	NEG	52. OTHER																							
a. PAP SMEAR		b. EKG																							
c. CXR																									
MEASUREMENTS AND OTHER FINDINGS																									
53. HEIGHT 6800		54. WEIGHT 170 lbs.		55.a. MIN WGT - MAX WGT 181		55.b. ACTUAL BF % - MAX BF %		56. TEMPERATURE																	
58. BLOOD PRESSURE				59. RED/GREEN (Army Only)		60. OTHER VISION TEST:		57. PULSE 96																	
a. 1ST		b. 2ND		c. 3RD		a. COLOR HAIR		b. COLOR EYES																	
SYS. 131		SYS.		SYS.		Red		Right: Other																	
DIAS. 74		DIAS.		DIAS.				Left:																	
61. DISTANT VISION				62. REFRACTION BY <u>AUTOREFRACTION</u> OR MANIFEST				63. NEAR VISION																	
Right 20/ 40 Corr. to 20/ 20				By -1.00 S. +0.50 CX 180				Right 20/ 20 Corr. to 20/ by																	
Left 20/ 50 Corr. to 20/ 20				By -0.75 S. +0.50 CX 180				Left 20/ 20 Corr. to 20/ by																	
64. HETEROPHORIA (Specify distance)																									
ES °		EX °		R.H.		L.H.		Prism div. Prism Conv CT NPR PD																	
65. ACCOMMODATION				66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT																	
Right Left				PIP Passed /14				Uncorrected Corrected																	
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION																	
								O.D. O.S.																	
71a. AUDIOMETER		Unit Serial Number 11042539				71b. Unit Serial Number		72a. READING ALOUD TEST																	
Date Calibrated (YYYYMMDD)		20041111				Date Calibrated (YYYYMMDD)																			
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	SAT	UNSAT										
Right	05	10	15	15	15	05	Right																		
Left	10	15	15	20	10	15	Left																		
72b. VALSALVA																									
SAT UNSAT																									
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																									

AR 3409



REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate of Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no persons shall be subject to any penalty for failing to comply with a collection of information if it does not display a current valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.**PRIVACY ACT STATEMENT****AUTHORITY:** 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.**PRINCIPAL PURPOSE(S):** To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members for the Armed Forces.**ROUTINE USE(S):** None.**DISCLOSURE:** Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.**WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.**1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)**MERWIN
DANIEL DENNIS**2. SOCIAL SECURITY NUMBER**

[REDACTED]

3. TODAY'S DATE (YYYYMMDD)

20051013

4. HOME ADDRESS (Street, Apartment No., City, State, ZIP Code)

BETHLEHEM, PA

5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)Harrisburg Meps
4641 Westport Drive
Mechanicsburg, PA 17055-4843**b. HOME TELEPHONE (Include Area Code)****X ALL APPLICABLE BOXES:****6.a. SERVICE**
☐ Army ☐ Coast Guard
☒ Navy
☐ Marine Corps
☐ Air Force
b. COMPONENT
☒ Active Duty
☐ Reserve
☐ National Guard
c. PURPOSE OF EXAMINATION
☒ Enlistment
☐ Commission
☐ Retention
☐ Separation

☐ Medical Board ☐ Other (Specify)
☐ Retirement
☐ U.S. Service Academy
☐ ROTC Scholarship Program
7.a. POSITION (Title, Grade, Component)**CIVILIAN****b. USUAL OCCUPATION**Technical Care
Representative**8. CURRENT MEDICATIONS (Prescription and Over-the-counter)**

None

9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)

None

Mark each item "YES" or "NO".

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

YES NO

10. a. Tuberculosis ☐ YES ☒ NO
 b. Lived with someone who had tuberculosis ☐ YES ☒ NO
 c. Coughed up blood ☐ YES ☒ NO
 d. Asthma or any breathing problems related to exercise, weather, pollens, etc. ☐ YES ☒ NO
 e. Shortness of breath ☐ YES ☒ NO
 f. Bronchitis ☐ YES ☒ NO
 g. Wheezing or problems with wheezing ☐ YES ☒ NO
 h. Been prescribed or used an inhaler ☐ YES ☒ NO
 i. A chronic cough or cough at night ☐ YES ☒ NO
 j. Sinusitis ☐ YES ☒ NO
 k. Hay fever ☐ YES ☒ NO
 l. Chronic or frequent colds ☐ YES ☒ NO
 11. a. Severe tooth or gum trouble ☐ YES ☒ NO
 b. Thyroid trouble or goiter ☐ YES ☒ NO
 c. Eye disorder or trouble ☐ YES ☒ NO
 d. Ear, nose, or throat trouble ☐ YES ☒ NO
 e. Loss of vision in either eye ☐ YES ☒ NO
 f. Worn contact lenses or glasses ☐ YES ☒ NO
 g. A hearing loss or wear a hearing aid ☐ YES ☒ NO
 h. Surgery to correct vision (RK, PRK, LASIK, etc.) ☐ YES ☒ NO
 12. a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) ☐ YES ☒ NO
 b. Arthritis, rheumatism, or bursitis ☐ YES ☒ NO
 c. Recurrent back pain or any back problem ☐ YES ☒ NO
 d. Numbness or tingling ☐ YES ☒ NO
 e. Loss of finger or toe ☐ YES ☒ NO

12. (Continued)

f. Foot trouble (e.g., pain, corns, bunions, etc.) ☐ YES ☒ NO
 g. Impaired use of arms, legs, hands, or feet ☐ YES ☒ NO
 h. Swollen or painful joint(s) ☐ YES ☒ NO
 i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) ☐ YES ☒ NO
 j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint ☐ YES ☒ NO
 k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. ☐ YES ☒ NO
 l. Bone, joint, or other deformity ☐ YES ☒ NO
 m. Plate(s), screw(s), rod(s) or pin(s) in any bone ☐ YES ☒ NO
 n. Broken bone(s) (cracked or fractured) ☐ YES ☒ NO
 13. a. Frequent indigestion or heartburn ☐ YES ☒ NO
 b. Stomach, liver, intestinal trouble, or ulcer ☐ YES ☒ NO
 c. Gall bladder trouble or gallstones ☐ YES ☒ NO
 d. Jaundice or hepatitis (liver disease) ☐ YES ☒ NO
 e. Rupture/hernia ☐ YES ☒ NO
 f. Rectal disease, hemorrhoids or blood from the rectum ☐ YES ☒ NO
 g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) ☐ YES ☒ NO
 h. Frequent or painful urination ☐ YES ☒ NO
 i. High or low blood sugar ☐ YES ☒ NO
 j. Kidney stone or blood in urine ☐ YES ☒ NO
 k. Sugar or protein in urine ☐ YES ☒ NO
 l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) ☐ YES ☒ NO
 14. a. Adverse reaction to serum, food, insect stings or medicine ☐ YES ☒ NO
 b. Recent unexplained gain or loss of weight ☐ YES ☒ NO
 c. Currently in good health (If no, explain in Item 29 on page 2) ☒ YES ☐ NO
 d. Tumor, growth, cyst, or cancer ☐ YES ☒ NO

DoD exception to SF 93 approved by ICMR, August 3, 2000.

Page 1 of 4 Pages

DD FORM 2807-1, OCT 2003

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001

AR 3411



LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

SOCIAL SECURITY NUMBER

MERWIN, DANIEL DENNIS

Mark each item "YES" or "NO".

Mark each item "YES" or "NO". For items 19 - 28, every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

YES

NO

15. a. Dizziness or fainting spells ☐ YES ☒ NO
 b. Frequent or severe headache ☐ YES ☒ NO
 c. A head injury, memory loss or amnesia ☐ YES ☒ NO
 d. Paralysis ☐ YES ☒ NO
 e. Seizures, convulsions, epilepsy or fits ☐ YES ☒ NO
 f. Car, train, sea, or air sickness ☐ YES ☒ NO
 g. A period of unconsciousness or concussion ☐ YES ☒ NO
 h. Meningitis, encephalitis, or other neurological problems ☐ YES ☒ NO

16. a. Rheumatic fever ☐ YES ☒ NO
 b. Prolonged bleeding (as after an injury or tooth extraction, etc.) ☐ YES ☒ NO
 c. Pain or pressure in the chest ☐ YES ☒ NO
 d. Palpitation, pounding heart or abnormal heartbeat ☐ YES ☒ NO
 e. Heart trouble or murmur ☐ YES ☒ NO
 f. High or low blood pressure ☐ YES ☒ NO

17. a. Nervous trouble of any sort (anxiety or panic attacks) ☐ YES ☒ NO
 b. Habitual stammering or stuttering ☐ YES ☒ NO
 c. Loss of memory or amnesia, or neurological symptoms ☐ YES ☒ NO
 d. Frequent trouble sleeping ☐ YES ☒ NO
 e. Received counseling of any type ☐ YES ☒ NO
 f. Depression or excessive worry ☐ YES ☒ NO
 g. Been evaluated or treated for a mental condition (If yes, fully explain in Item 29 below.) ☐ YES ☒ NO
 h. Attempted suicide ☐ YES ☒ NO
 i. Used illegal drugs or abused prescription drugs ☐ YES ☒ NO

18. FEMALES ONLY, Have you ever had or do you now have:

- a. Treatment for a gynecological (female) disorder ☐ YES ☒ NO
 b. A change of menstrual pattern ☐ YES ☒ NO
 c. Any abnormal PAP smears ☐ YES ☒ NO
 d. First day of last menstrual period (YYYYMMDD). ☐ YES ☒ NO
 e. Date of last PAP smear (YYYYMM). ☐ YES ☒ NO

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

YES

NO

19. Have you been refused employment or been unable to hold a job or stay in school because of:

- a. Sensitivity to chemicals, dust, sunlight, etc. ☐ YES ☒ NO
 b. Inability to perform certain motions ☐ YES ☒ NO
 c. Inability to stand, sit, kneel, lie down, etc. ☐ YES ☒ NO
 d. Other medical reasons (If yes, give reasons.) ☐ YES ☒ NO

20. Have you ever been treated in an Emergency Room? (If yes, for what?) ☐ YES ☒ NO

21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) ☐ YES ☒ NO

22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) ☒ YES ☐ NO

23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) ☒ YES ☐ NO

24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) ☐ YES ☒ NO

25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) ☐ YES ☒ NO

26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) ☐ YES ☒ NO

27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) ☐ YES ☒ NO

28. Have you ever been denied life insurance? ☐ YES ☒ NO

29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

② Tonsillectomies, Had it Done, 200409

②34CD Chicken Pox

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED, MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

DD FORM 2807-1, OCT 2003

DoD exception to SF 93 approved by ICMR, August 3, 2000.

AR 3412 Page 2 of 4 Pages

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) MERWIN, DANIEL DENNIS	SOCIAL SECURITY NUMBER [REDACTED]
---	---

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 8 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)

a. COMMENTS

22 Tonsille ctomy - 2004, Sept
age 19.

23 UCD churchipx -

QUESTIONING REVEALS	YES	NO	DETAILS
MARIJUANA USE		<input checked="" type="checkbox"/>	
OTHER DRUG ABUSE		<input checked="" type="checkbox"/>	
ALCOHOL ABUSE		<input checked="" type="checkbox"/>	

EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.

Daniel Dennis Merwin
EXAMINEE SIGNATURE

20051013
DATE

b. TYPED OR PRINTED NAME OF EXAMINEE
DANIEL S. MERWIN, D.O.

c. SIGNATURE

D S E L y o o

d. DATE SIGNED
(YY/MM/DD)

20051013



PROCESSEE/ENLISTEE RECORD

DATE: 2005-11-01
TIME: 0741
MEPS: A06



*** PRIVACY ACT PL93-579 APPLIES ***

PERSONAL

SSN [REDACTED]	SPF DNR	PMS: N SSN: R	DAYS: 0000 ARN: [REDACTED]	DMDC: N ENTNAC: F	P V	A P	M P	D A	E B	H * O B	SSC: SS#:
NAME (Last, First, Middle, Suffix) MERWIN DANIEL DENNIS		HIV: R		DRUG: R	PROJ FOR: WKID RPTD:		7 7		1 1		
P-SSN: P-LNAME:		P-MEPS: A06		L-TRANS: 8001B		USER: LEITZEL		RID: 6		PROCESSING DATE 2005-11-01	
L-DOA: 2005-11-01		L-SYNC: 20051101/073949									
ADDRESS B	TYPE STREET, CITY, COUNTY, STATE, COUNTRY, ZIP CODE [REDACTED] BETHLEHEM 42077 PA US [REDACTED]										
CTZN CA	ARN A	SEX M	RACIAL E	ETHNIC B	MARITAL S	#DEP 0	DOB 1985-[REDACTED]	REL 01	EDUC 12L	F LANGUAGE 1 - 2 -	NONE
DRV LIC	FLAG Y	ST NJ	# M27861536402855		EXP DATE 2007-01-31		CITY, STATE, COUNTRY RIVERSIDE CA US		RECRUITER ID/SSN-STATION ID [REDACTED] / 20015		

INS

CURRENT MEDICAL INSURER NAME NONE	CURRENT MEDICAL PROVIDER NAME NONE
MEDICAL INSURER ADDRESS (Street, City, State, Country, ZIP Code)	MEDICAL PROVIDER ADDRESS (Street, City, State, Country, ZIP Code)

TESTING

AFQT TID 55 01E	DOT 2005-10-12	ST M-SITE P 061992	TYPE SCORE DOT CS 10000033 2005-10-12	GS 61	AR 51	WK 51	PC 50	MK 56	EI 56	AS 56	MC 56	AO 52	VE 50
COMPOSITES: GT EL BEE ENG MEC ME2 NUC OPS HM ADM 101 224 224 112 163 159 213 209 167 106				ELIGIBLE DATE: 2005-11-12									
ADMINISTRATOR: [REDACTED]				MANUAL - AUTHORIZATION:									

MEDICAL

SF88: PRESscreen:	PHYSICAL: 2005-10-13	INSP: 2005-11-01	SPECIMEN DOT RSLT RSLT-DATE 06095320 2005-10-13 5B 2005-10-17
RBJ: ELIGIBILITY:	AUDIO: 05 10 20 30 40 60 RIGHT: 05 10 15 15 15 05 LEFT: 10 15 15 20 10 15	HIV DRUG ALCO	06095320 2005-10-13 N N 2005-10-18
X-RAY NXT EQP N HGT 68.5 WGT 116 FAT HAIR RED EYES OTHER/OTHER BP 131/074	PIP P FLNT X AFVT X DISTANT NEAR R: 020/020 020/020 L: 020/020 020/020 REFRAC M	P U L H E S X 1 1 1 1 1 1 0 WVR N CNSLT N HCG M	2005-10-13 N
FAIL		ICDCODE	

DEP

DEP DOE 2005-10-13	PADD 2005-11-01	ES 3	RECRUITER INFO 012000000 / 00000	PEF C4A29	T-E MOS/AFS AR	WAIVER CODE YYY	PAY GRADE E01	DEP DISCHARGE DATE
SERVICE REQUIRED CODES:								REASON
								SPF
								DATE
								REASON
								SPF

ACCESSION

ACC DOE 2005-11-01	ADSD 2005-11-01	PED 2005-11-01	TOE 4	YYY	WAIVER CODE	PAY GRADE E01	DOG 2005-11-01	REASON	
ES 1	EDUC 12L	RECRUITER INFO [REDACTED] 00000	PEF A4A29	T-E MOS/AFS AR	PMOS/AFS 000000	YOUTH YY0	OA WY	TRANSFER TO (UIC) N30646	368 N
SERVICE REQUIRED CODES:									
1 1 1 2 0 0 6 0 5 1 0 3 1 3 2 1 7 1 1 7 0 6 0 1 0 0 0 0 0 0 0 0 0 0 0 0									
1 2 3 4 5 6 7 8 9 50 1 2 3 4 5 6 7 8 9 60 1 2 3 4 5 6 7 8 9 70 1 2 3 4 5 6 7 8 9 80 1 2 3 4 5 6 7 8 9 90									
0 0 0 0 0 0 0 0 0 Y Y Y Y Y Y 0 X 0 0 0 0 0 C 6 9 1 1 6 R E D O T H									
1 2 3 4 5 6 7 8 9 00 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 20 1 2 3 4 5 6 7 8 9 30 1 2 3 4 5 6 7 8 9 40									
Y									



O BACKGROUND

O DISCREPANCIES

PMS	PMS INFO		P-SPF		DATE RCVD			
	DATE SUB	RSLT	DATE RCVD	FOREIGN BORN	DATE DEATH	DEATH SOURCE		
SSN	2005-10-12	R	2005-10-14	A				
ARN	DATE SUB	CASE #	DATE CASE #	RSLT	DATE CLSD	DOB	POB-CTRY	STATUS
	L-NAME:	USCIS INFO				CTZN	WORK	
PEI/PAI	F-NAME:							
	PATH	DATE SUB	CASE #	DATE CASE #	RSLT	AGY	DATE CLSD	ALIAS
ENTNAC	M	2005-10-13	60010467		F		2005-10-20	TYPE NAME
ENTNAC	TYPE APPLY TO	DATE INTVWD	DATE CLRD	REMARKS				

REMARKS

REASON

WORK HISTORY

REJ	WKID	DOA/TIME	SYNC	MEPS	OWN	SPF	USERNAME	REJ	WKID	DOA/TIME	SYNC	MEPS	OWN	SPF	USERNAME
B001B	20051101/074111	N	A06	P	DNR	LEITZEL									
B070P	20051101/070521	Y	A06	P	DNR	TAYLOR									
B006F	20051021/051241	Y	A06	P	DNR	USMIRSDB									
B0D0P	20051018/051215	Y	A06	P	DNR	USMIRSDB									
B050P	20051017/051319	Y	A06	P	DNR	USMIRSDB									
B006S	20051014/051056	Y	A06	P	DNR	USMIRSDB									
V000S	20051014/050528	Y	A06	P	DNR	USMIRSDB									
B006M	20051013/123338	Y	A06	P	DNR	REED									
B002A	20051013/123335	Y	A06	P	DNR	REED									
J000V	20051013/122750	Y	A06	P	DNR	REED									
B010P	20051013/105257	Y	A06	P	DNR	TAYLOR									
B800P	20051012/183440	Y	A06	P	DNR	LOLAS									
B100P	20051012/183440	Y	A06	P	DNR	LOLAS									
A000V	20051012/124457	Y	A06	P	DNR	BROWN									

DATE: 2005-11-01

TIME: 0741



1. Name (Last, First, Middle) MERWIN DANIEL DENNIS		2a. SSN [REDACTED]	2b. Initial (To indicate valid SSN) [REDACTED]	3a. SVC DNR	3b. Reporting Unit Code Duty Station
4. Spouse's Name/Address		SINGLE			
5. Children's Names/Relationship/ Date of Birth (YYMMDD)/ Address		None			
6. Father's Name/Address		[REDACTED] BELVIDERE NJ			
7. Mother's Name/Address		[REDACTED] LEXINGTON SC			
8. Do Not Notify Due to Ill Health		a.		b. Notify Instead	
9. Beneficiary(ies) for DG - If No Surviving Spouse or Child / Address / Percentage		[REDACTED] 100 % BELVIDERE, NJ FATHER			
10. Beneficiary(ies) for Unpaid Pay/ Allowances/Address/Percentage		[REDACTED] 100 % BELVIDERE, NJ FATHER			
11. Allotment Designee/Percentage if Missing*		* Subject to Secretarial Determination			
12. Insurance (SGLI & Other Insurance Companies/Policy Nos.)		a. SGLI (Optional Service Use) <input type="checkbox"/> Maximum <input type="checkbox"/> No <input type="checkbox"/> Other (Amount)		b. Insurance Companies/Policy Numbers	
13. Continuation/Remarks					
14. Signature of Servicemember (Include Rank/Grade/Rate) <i>Daniel Dennis Merritt FI</i>		15. Signature of Witness (Include Rank/Grade/Rate) <i>Sally J. Merritt MS-4</i>		16. Date Signed (YYMMDD) <i>05/00/01</i>	

Privacy Act Statement

AUTHORITY:

10 USC 1475 to 1480 and 2771, 38 USC 770, 44 USC 3101, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSES:

This form is used to designate beneficiaries for certain benefits in the event of the servicemember's death. It is a guide for the disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the servicemember desires to be notified in case of emergency or death. The purpose of soliciting the SSN is to provide positive identification.

ROUTINE USES:

This form is a component in the Casualty Notification file series appropriate to each branch of the Military Services. It is to be used by casualty offices to notify a servicemember's next of kin of that member's injury, illness, or death. The member designates the person(s) to receive any unreceived pay and allowances and death gratuity benefits. Additional information concerning wills, insurance policies, and other personal data to be used in settling personal affairs in the event of the member's death may be included on this form. Release of personal identifier information to the member's finance office is required for appropriate distribution of pay and allowance benefits to designated beneficiaries of missing or interned servicemembers. This form is strictly for internal Service record purposes.

DISCLOSURE:

Voluntary; however, failure to provide personal identifier information may delay notification of the servicemember's status or may handicap processing of benefits to designated beneficiaries.

INSTRUCTIONS TO SERVICEMEMBER:

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty, and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other dependents listed; for example, as a result of marriage, civil court action, death, or address change. Regarding your designation in Item 11, "Allotment if Missing" (if used by your Service), please read the following statement carefully, and sign on the line provided.

I fully understand that, if I am captured, missing, or interned, my designation of allotments to dependents from my pay and allowances serves only as a guide to the Secretary of my Service. The Secretary may alter my designated allotment in the best interests of myself, my dependents, or the United States Government.

Daniel Dennis Merritt
SIGNATURE OF SERVICEMEMBER

ENLISTMENT/REENLISTMENT DOCUMENT ARMED FORCES OF THE UNITED STATES

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 3331; 32 USC 708; 44 USC 708 and 3101; 10 USC 133, 265, 275, 504, 508, 510, 591, 672(d), 678, 837, 1007, 1071 through 1087, 1168, 1169, 1475 through 1480, 1553, 2107, 2122, 3012, 5031, 8012, 8033, 8496, and 9411; 14 USC 351 and 632; and Executive Order 9397, November 1943 (SSN).

PRINCIPAL PURPOSE(S): To record enlistment or reenlistment into the U.S. Armed Forces. This information becomes a part of the subject's military personnel records which are used to document promotion, reassignment, training, medical support, and other personnel management actions. The purpose of soliciting the SSN is for positive identification.

ROUTINE USE(S): This form becomes a part of the Service's Enlisted Master File and Field Personnel File. All uses of the form are internal to the relevant Service.

DISCLOSURE: Voluntary; however, failure to furnish personal identification information may negate the enlistment/reenlistment application.

A. ENLISTEE/REENLISTEE IDENTIFICATION DATA

1. NAME (Last, First, Middle) MERWIN DANIEL DENNIS		2. SOCIAL SECURITY NUMBER [REDACTED]	
3. HOME OF RECORD (Street, City, State, ZIP Code) [REDACTED] BETHLEHEM, PA [REDACTED]		4. PLACE OF ENLISTMENT/REENLISTMENT (Mil. Installation, City, State) HARRISBURG MEPS MECHANICSBURG, PA 17055-4843	
5. DATE OF ENLISTMENT/ REENLISTMENT (YYYYMMDD) 20051013	6. DATE OF BIRTH (YYYYMMDD) 1985 [REDACTED]	7. PREV MIL SVC UPON ENL/REENLIST	YEARS MONTHS DAYS
		a. TOTAL ACTIVE MILITARY SERVICE	
		b. TOTAL INACTIVE MILITARY SERVICE	

B. AGREEMENTS

8. I am enlisting/reenlisting in the United States (list branch of service) NAVAL RESERVE
this date for 8 years and 00 weeks beginning in pay grade E-1.
The additional details of my enlistment/reenlistment are in Section C and Annex(es)
A

a. FOR ENLISTMENT IN A DELAYED ENTRY/ENLISTMENT PROGRAM (DEP):

I understand that I will be ordered to active duty as a Reservist unless I report to the place shown in item 4 above by (list date (YYYYMMDD)) 0600 20051101 for enlistment in the Regular component of the United States (list branch of service) NAVY for not less than 4 years and 00 weeks. My enlistment in the DEP is in a nonpay status. I understand my period of time in the DEP is **NOT** creditable for pay purposes upon entry into a pay status. However, I also understand that this time is counted toward fulfillment of my military service obligation or commitment. I must maintain my current qualifications and keep my recruiter informed of any changes in my physical or dependency status, moral qualifications, and mailing address.

b. REMARKS: (If none, so state.) **NONE**

c. The agreements in this section and attached annex(es) are all the promises made to me by the Government.
ANYTHING ELSE ANYONE HAS PROMISED ME IS NOT VALID AND WILL NOT BE HONORED.

(Initials of Enlistee/Reenlistee) JDM

(Continued on reverse side.)

C. PARTIAL STATEMENT OF EXISTING UNITED STATES LAWS

9. FOR ALL ENLISTEES OR REENLISTEES: Many laws, regulations, and military customs will govern my conduct and require me to do things a civilian does not have to do. The following statements are not promises or guarantees of any kind. They explain some of the present laws affecting the Armed Forces which I cannot change but which Congress can change at any time.

a. My enlistment is more than an employment agreement. As a member of the Armed Forces of the United States, I will be:

(1) Required to obey all lawful orders and perform all assigned duties.

(2) Subject to separation during or at the end of my enlistment. If my behavior fails to meet acceptable military standards, I may be discharged and given a certificate for less than honorable service, which may hurt my future job opportunities and my claim for veteran's benefits.

(3) Subject to the military justice system, which means, among other things, that I may be tried by military courts-martial.

(4) Required upon order to serve in combat or other hazardous situations.

(5) Entitled to receive pay, allowances, and other benefits as provided by law and regulation.

b. Laws and regulations that govern military personnel may change without notice to me. Such changes may affect my status, pay, allowances, benefits, and responsibilities as a member of the Armed Forces **REGARDLESS** of the provisions of this enlistment/reenlistment document.

c. In the event of war, my enlistment in the Armed Forces continues until six (6) months after the war ends, unless my enlistment is ended sooner by the President of the United States.

10. MILITARY SERVICE OBLIGATION FOR ALL MEMBERS OF THE ACTIVE AND RESERVE COMPONENTS, INCLUDING THE NATIONAL GUARD.

a. **FOR ALL ENLISTEES:** If this is my initial enlistment, I must serve a total of eight (8) years. Any part of that service not served on active duty must be served in a Reserve Component unless I am sooner discharged.

b. If I am a member of a Reserve Component of an Armed Force at the beginning of a period of war or national emergency declared by Congress, or if I become a member during that period, my military service may be extended without my consent until six (6) months after the end of that period of war.

c. As a member of a Reserve Component, in time of war or national emergency declared by the Congress, I may be required to serve on active duty (other than for training) for the entire period of the war or emergency and for six (6) months after its end.

d. As a member of the Ready Reserve I may be required to perform active duty or active duty for training without my consent (other than as provided in item 8 of this document) as follows:

(1) In time of national emergency declared by the President of the United States, I may be ordered to active duty (other than for training) for not more than 24 consecutive months.

(2) I may be ordered to active duty for 24 months, and my enlistment may be extended so I can complete 24 months of active duty, if:

(a) I am not assigned to, or participating satisfactorily in, a unit of the Ready Reserve; and

(b) I have not met my Reserve obligation; and

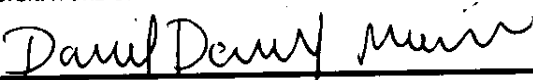

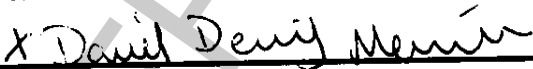

(c) I have not served on active duty for a total of 24 months.

(3) I may be ordered to perform additional active duty training for not more than 45 days if I have not fulfilled my military service obligation and fail in any year to perform the required training duty satisfactorily. If the failure occurs during the last year of my required membership in the Ready Reserve, my enlistment may be extended until I perform that additional duty, but not for more than six months.


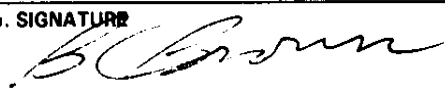

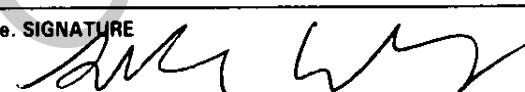
(4) When determined by the President that it is necessary to support any operational mission, I may be ordered to active duty as prescribed by law, if I am a member of the Selected Reserve.

11. FOR ENLISTEES/REENLISTEES IN THE NAVY, MARINE CORPS, OR COAST GUARD: I understand that if I am serving on a naval vessel in foreign waters, and my enlistment expires, I will be returned to the United States for discharge as soon as possible consistent with my desires. However, if essential to the public interest, I understand that I may be retained on active duty until the vessel returns to the United States. If I am retained under these circumstances, I understand I will be discharged not later than 30 days after my return to the United States; and, that except in time of war, I will be entitled to an increase in basic pay of 25 percent from the date my enlistment expires to the date of my discharge.

12. FOR ALL MALE APPLICANTS: Completion of this form constitutes registration with the Selective Service System in accordance with the Military Selective Service Act. Incident thereto the Department of Defense may transmit my name, permanent address, military address, Social Security Number, and birthdate to the Selective Service System for recording as evidence of the registration.

NAME OF ENLISTEE/REENLISTEE (Last, First, Middle) MERWIN DANIEL DENNIS		SOCIAL SECURITY NO OF ENLISTEE/REENLISTEE [REDACTED]	
D. CERTIFICATION AND ACCEPTANCE			
<p>13a. My acceptance for enlistment is based on the information I have given in my application for enlistment. If any of that information is false or incorrect, this enlistment may be voided or terminated administratively by the Government or I may be tried by a Federal, civilian, or military court and, if found guilty, may be punished.</p> <p>I CERTIFY THAT I HAVE CAREFULLY READ THIS DOCUMENT. ANY QUESTIONS I HAD WERE EXPLAINED TO MY SATISFACTION. I FULLY UNDERSTAND THAT ONLY THOSE AGREEMENTS IN SECTION B OF THIS DOCUMENT OR RECORDED ON THE ATTACHED ANNEX(ES) WILL BE HONORED. ANY OTHER PROMISES OR GUARANTEES MADE TO ME BY ANYONE ARE WRITTEN BELOW: (If none, X "NONE" and initial.)</p> <p style="text-align: right;"><input checked="" type="checkbox"/> NONE <u>DDM</u> (Initials of enlistee/reenlistee)</p>			
b. SIGNATURE OF ENLISTEE/REENLISTEE 		c. DATE SIGNED (YYYYMMDD) 20051013	
14. SERVICE REPRESENTATIVE CERTIFICATION			
<p>a. On behalf of the United States (list branch of service) <u>NAVY</u>, I accept this applicant for enlistment. I have witnessed the signature in item 13b to this document. I certify that I have explained that only those agreements in Section B of this form and in the attached Annex(es) will be honored, and any other promises made by any person are not effective and will not be honored.</p>			
b. NAME (Last, First, Middle) BROWN BRYAN C	c. PAY GRADE E-6	d. UNIT/COMMAND NAME USN RECRUITING DISTRICT	
e. SIGNATURE 	f. DATE SIGNED (YYYYMMDD) 20051013	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) PITTSBURGH PA 15222	
E. CONFIRMATION OF ENLISTMENT OR REENLISTMENT			
<p>15. IN THE ARMED FORCES EXCEPT THE NATIONAL GUARD (ARMY OR AIR): I, <u>DANIEL DENNIS MERWIN</u>, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.</p>			
<p>16. IN THE NATIONAL GUARD (ARMY OR AIR): I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the State of _____ against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the Governor of _____ and the orders of the officers appointed over me, according to law and regulations. So help me God.</p>			
<p>17. IN THE NATIONAL GUARD (ARMY OR AIR): I do hereby acknowledge to have voluntarily enlisted/reenlisted this _____ day of _____, in the _____ National Guard and as a Reserve of the United States (list branch of service) _____ with membership in the _____ National Guard of the United States for a period of _____ years, _____ months, _____ days, under the conditions prescribed by law, unless sooner discharged by proper authority.a</p>			
18a. SIGNATURE OF ENLISTEE/REENLISTEE 		b. DATE SIGNED (YYYYMMDD) 20051013	
19. ENLISTMENT/REENLISTMENT OFFICER CERTIFICATION			
a. The above oath was administered, subscribed, and duly sworn to (or affirmed) before me this date.			
b. NAME (Last, First, Middle) FEIGHT WESLEY L	c. PAY GRADE O-4	d. UNIT/COMMAND NAME HARRISBURG MEPS	
e. SIGNATURE 	f. DATE SIGNED (YYYYMMDD) 20051013	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) MECHANICSBURG PA 17055-4843	



NAME OF ENLISTEE/REENLISTEE (Last, First, Middle) MERWIN DANIEL DENNIS		SOCIAL SECURITY NO OF ENLISTEE/REENLISTEE <div style="background-color: black; width: 100px; height: 20px;"></div>	
F. DISCHARGE FROM DELAYED ENTRY/ENLISTMENT PROGRAM			
<p>20a. I request to be discharged from the Delayed Entry/Enlistment Program (DEP) and enlisted in the Regular Component of the United States (list branch of service) <u>NAVY</u> for a period of <u>4</u> years and <u>00</u> weeks. No changes have been made to my enlistment options OR if changes were made they are recorded on Annex(es) <u>NA</u> which replace(s) Annex(es) <u>NA</u>.</p>			
b. SIGNATURE OF DELAYED ENTRY/ENLISTMENT PROGRAM ENLISTEE 		c. DATE SIGNED (YYYYMMDD) 20051101	
G. APPROVAL AND ACCEPTANCE BY SERVICE REPRESENTATIVE			
<p>21. SERVICE REPRESENTATIVE CERTIFICATION</p> <p>a. This enlistee is discharged from the Reserve Component shown in item 8 and is accepted for enlistment in the Regular Component of the United States (list branch of service) <u>NAVY</u> in pay grade <u>E-1</u>.</p>			
b. NAME (Last, First, Middle) BROWN BRYAN C	c. PAY GRADE E-6	d. UNIT/COMMAND NAME USN RECRUITING DISTRICT	
e. SIGNATURE 	f. DATE SIGNED (YYYYMMDD) 20051101	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) PITTSBURGH PA 15222	
H. CONFIRMATION OF ENLISTMENT OR REENLISTMENT			
<p>22a. IN A REGULAR COMPONENT OF THE ARMED FORCES:</p> <p>I, <u>DANIEL DENNIS MERWIN</u>, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.</p>			
b. SIGNATURE OF ENLISTEE/REENLISTEE 		c. DATE SIGNED (YYYYMMDD) 20051101	
<p>23. ENLISTMENT OFFICER CERTIFICATION</p> <p>a. The above oath was administered, subscribed, and duly sworn to (or affirmed) before me this date.</p>			
b. NAME (Last, First, Middle) WILLIAMS THEODORE	c. PAY GRADE O-3	d. UNIT/COMMAND NAME HARRISBURG MEPS	
e. SIGNATURE 	f. DATE SIGNED (YYYYMMDD) 20051101	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) MECHANICSBURG PA 17055-4843	



ENLISTMENT GUARANTEES

MERWIN DANIEL DENNIS

NAME (LAST, FIRST, MIDDLE JR.ETC)

SSN

1. **ACKNOWLEDGEMENT:** In connection with my enlistment into the United States Navy, I hereby acknowledge that:

a. I am enlisting into the U.S. Navy for an active duty period of four years and, at the same time, I agree to extend my enlistment for N/A months to meet the obligations of the N/A program.

I am enlisting with the following guarantees and understandings:

b. Upon enlistment, I will be enlisting under the provisions of Commander, Navy Recruiting Command Instruction 1130.8 option or options as indicated below:

Option (1) AVIATION BOATSWAIN'S MATE (HANDLING) CLASS "A" SCHOOL GUARANTEE (4YO/SG-ABH)

Option (2) N/A

Option (3) N/A

Option (4) N/A

2. I understand that I must be fully qualified at all times throughout my obligated service for all security, professional, military, physical, psychological and academic requirements of the options guaranteed in section 1b and that my eligibility will be rechecked during recruit training and periodically throughout my enlistment.

3. The Navy will enroll me in the training specified above. If during the periodic reviews of my eligibility, I am found no longer eligible for the options listed in 1b above because of information I provided in my enlistment application; because of a physical or psychological disqualification, or because of some reason that is not due to my fault, negligence, or conduct, I may only choose one of the following options:

- a. Reassignment to an "A" school for which I am qualified and a vacancy exists, or
- b. Navy apprentice training for which I am qualified and a vacancy exists.

In any event, the Navy may, at its option, choose to discharge me.

4. If I am not enrolled in the training guarantee specified in section 1b above because of some reason that is due to my own fault, negligence or conduct or if I am disenrolled from it for and other reason not specified in paragraph 3, then I lose that guarantee and at the Navy's option remain subject to continued naval service. I also understand:

- a. If I am retained, I may be required to serve the rest of my enlistment. If given accelerated advancement, post-apprentice training, or an enlistment/reenlistment bonus, I may incur additional service as required by regulation.
- b. The Navy may, at its option, discharge me in accordance with law and regulation.

5. I certify that I have read and received a copy of the Classifier Rating/Program Fact Sheet for the Rating/Program for which I am enlisting, and the Statement of Understand required for Option(s) (1). I understand the obligations for the Options and training that I will receive DDM.

(applicant's initials)

R. E. CARR, ECI(SW), USN, BYDIRCO 2005-10-13

(Signature of Enlisting Officer)/Date

Daniel Dennis Merwin 2005-10-13

(Signature of Enlistee)/Date

Service members' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)
☐ Name or update your beneficiary
☐ Reduce the amount of your insurance coverage
☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name NEBWIN	First name DANIEL	Middle name DENNIS	Rank, title or grade E-1	Social Security Number [REDACTED]
Branch of Service (Do not abbreviate) UNITED STATES NAVY			Current Duty Location RECRUIT TRAINING COMMAND, GREAT LAKES, IL 60088	

Amount of Insurance

By law, you are automatically insured for \$250,000. If you want \$250,000 of insurance, skip to Beneficiary(ies) and Payment Options. If you want less than \$250,000 of insurance, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. If you do not want any insurance*, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage under the SGLI program.

☒ I want coverage in the amount of \$ 400,000 Your initials DDM
☐ _____

(Write "I do not want insurance at this time.")

*Note: Reduced or refused insurance can only be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of VGLI you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fraction)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1. [REDACTED] BETHLEHEM, PA		STEP MOTHER	100%	LUMP SUM
2.				
3.				
4.				

☐ Additional Principals on page 5 (check if applicable)

Contingent

1. NO CONTINGENT				
2.				
3.				
4.				

☐ Additional Contingents on page 5 (check if applicable)

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- This form cancels any prior beneficiary or payment instructions.
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$250,000.

SIGN HERE IN INK Daniel Dennis Martin
 (Your signature. Do not print.)

Date: 10 NOV 05

Do not write in space below. For official use only.

WITNESSED AND RECEIVED BY: <u>[Signature]</u>	RANK, TITLE OR GRADE <u>CAV</u>	ORGANIZATION	DATE RECEIVED <u>10 NOV 05</u>
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MONTGOMERY GI BILL ACT OF 1984 (MGIB)

(Chapter 30, Title 38, U.S. Code)

BASIC ENROLLMENT

DIV: 041

SHIP: 06

PRIVACY ACT STATEMENT**AUTHORITY:** Chapter 30, Title 38, U.S. Code, Sections 3011, 3012, 3018A, and 3018B; and EO 9397.**PRINCIPAL PURPOSE(S):** To document the understanding of members about their eligibility or lack of eligibility for benefits under the Montgomery GI Bill Act of 1984 (MGIB) and document a member's election to decline enrollment for benefits under the MGIB.**ROUTINE USE(S):** To the Department of Veterans' Affairs to ascertain an individual's eligibility to claim benefits under the MGIB.**DISCLOSURE:** Voluntary; however, failure to provide the requested information will result in the individual being automatically enrolled in the MGIB program.**1. SERVICE MEMBER DATA****a. NAME (LAST, First, Middle Initial)**

MERWIN, DANIEL D

b. SOCIAL SECURITY NUMBER (SSN)

[REDACTED]

2. STATEMENT OF UNDERSTANDING FOR INELIGIBLE MEMBERS

I am **NOT** eligible for the MGIB because (a) I am a service academy graduate, or (b) I am an ROTC scholarship graduate who received more than the current minimum amount allowed for enrollment in MGIB, or (c) I am a prior service member who disenrolled during my previous term of active duty.

a. SERVICE MEMBER SIGNATURE**b. RANK/GRADE****c. DATE SIGNED (YYYYMMDD)****3. STATEMENT OF UNDERSTANDING FOR ALL ELIGIBLE MEMBERS**

- (1) I am automatically enrolled unless I exercise the option to **DISENROLL** by signing item 5 below.
- (2) **UNLESS I DISENROLL** from the MGIB, my basic pay will be reduced \$100 per month, or the current monthly rate until \$1,200 has been deducted; this basic pay reduction **CANNOT** be **REFUNDED, SUSPENDED OR STOPPED**, this is an **IRREVOCABLE DECISION**.
- (3) I must complete 36 months of active duty service (24 months if my enlistment is for less than 36 months) before I am entitled to the current rate of monthly benefits. The MGIB provides benefits for a period of 36 months.
- (4) I understand I am eligible for an increased monthly benefit by contributing an additional amount, not to exceed \$800 while on active duty. Once I separate, I cannot contribute.
- (5) I must receive an **HONORABLE** discharge for service establishing entitlement to the MGIB. This **DOES NOT** include "under honorable conditions".
- (6) I must complete the requirements of a secondary school diploma or equivalency certification, or successfully complete the equivalent of 12 semester hours in a program of education leading to a standard college degree before applying for benefits with the Department of Veterans' Affairs.
- (7) I have 10 years from date of last discharge from active duty to use MGIB benefits.
- (8) If I die while on active duty, or within one year after discharge or release from active duty if service related, my designated beneficiary(ies) will receive the unused balance of the money reduced from my basic pay for the MGIB. This death benefit will be paid by the Department of Veterans' Affairs (DVA).
- (9) I cannot receive any combination of DVA educational benefits in excess of 48 months.
- (10) I must complete at least 24 months of a 3 year active duty service obligation and if my obligation is 2 years I may join and serve honorably in the Selected Reserve for a minimum of 48 months to qualify for the current active duty benefit rate. A (one) period of service **CANNOT** qualify me for both active and reserve MGIB benefits.

a. SERVICE MEMBER SIGNATURE

Daniel Davis Merwin

b. RANK/GRADE

SR/E1

c. DATE SIGNED (YYYYMMDD)

2005 11 08

4. SERVICE UNIQUE EDUCATION ASSISTANCE OPTIONS

MGIB

5. STATEMENT OF DISENROLLMENTI **DO NOT** desire to participate in MGIB. I understand the benefits of the MGIB program and that I **WILL NOT** be able to enroll at a later date.**a. DATE SIGNED (YYYYMMDD)****b. RANK/GRADE****c. SERVICE MEMBER SIGNATURE****6. CERTIFYING OFFICIAL****a. TYPED OR PRINTED NAME (LAST, First, Middle Initial)**

HOLLAND, VICTOR, U

b. RANK/GRADE

05278 2004

052/E5

c. SIGNATURE

[Signature]

d. DATE SIGNED (YYYYMMDD)

2005 11 08

HIV ANTIBODY TESTING ACKNOWLEDGMENT FORM

For use of this form, see USMEPCOM Reg 40-8

FOR OFFICIAL USE ONLY

1. I acknowledge I have been informed by verbal briefing and this document that all statements apply to my medical processing.
2. Medical examinations include blood tests for the presence of antibodies to the Human Immunodeficiency Virus (HIV).
3. This virus causes Acquired Immune Deficiency Syndrome (AIDS).
4. This is not a test for AIDS. Positive tests mean persons have contracted the virus and built antibodies in their blood. Positive tests do not mean those persons have AIDS.
5. HIV tests are conducted by serum testing at contract laboratories.
6. Negative tests mean there are no detectable antibodies, but do not guarantee against future positive tests.
7. Positive tests are rechecked by different laboratory tests to confirm results.
8. Confirmed positive HIV tests are permanently disqualifying for entry into the Armed Forces.
9. MEPS physician will tell me personally if my test is positive and offer a second test to double check the accuracy of the first test.
10. MEPS physician will also tell my parents or legal guardians if my test is positive and I am a minor.
11. MEPS commander will notify my chain of command of all test results if I am a member of the Armed Forces.
12. All tests results are recorded on my medical examination and in MEPS computer records. MEPS will not remove either positive or negative results from computer records or medical forms, regardless of circumstances.
13. As part of my processing, I must give a current, correct address for notification.
14. Some states require by-name reporting of positive HIV results by the MEPS' higher headquarters. Those states are Alabama, Arizona, Colorado, Florida, Idaho, Illinois, Indiana, Minnesota, Nevada, Oklahoma, South Carolina, Tennessee, Virginia, West Virginia, and Wisconsin.
15. If a needlestick (or needlestick injury) occurs while my blood is being drawn, I understand that I will be required to provide a second blood specimen to continue processing.
16. My signature in this block indicates that I understand the HIV testing requirement, consequences of positive results, and use of all results.

DANIEL DENNIS MERWIN

Print first, middle, and last name

 Social security number


Signature

 20051013
 Date


1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABHAN		3. Desig		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/>		TAR <input type="checkbox"/>		INACT <input type="checkbox"/>		AT/ADSW/ 265 <input type="checkbox"/>		6. UIC 21533		
7. Ship/Station LHD 2 ESSEX				8. Promotion Status REGULAR		9. Date Reported 06APR11				
Occasion for Report 10. Periodic <input checked="" type="checkbox"/>			Detachment 11. of Individual <input type="checkbox"/>			Promotion/ 12. Frocking <input type="checkbox"/>			13. Special <input type="checkbox"/>	
Period of Report 14. From: 06JAN04			15. To: 06JUL15			20. Physical Readiness P/WS			21. Billet Subcategory (if any) NA	
16. Not Observed Report <input type="checkbox"/>			Type of Report 17. Regular <input checked="" type="checkbox"/>			18. Concurrent <input type="checkbox"/>			22. Reporting Senior (Last, FI MI) ST. LOUIS, K P	
23. Grade LT			24. Desig 1310			25. Title DIVO			26. UIC 21533	
27. SSN [REDACTED]			28. Command employment and command achievements. Forward deployed Western Pacific-3. COBRA GOLD '06. PVSTS: Thailand.							
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) PLANE HANDLER Chock and Chain Handler-3. Responsible for the safe and expeditious movement and securing of embarked aircraft in the Hangar Bay. Performs general maintenance and upkeep of 29 divisional spaces. WATCH: Baggage checker-3, CONFLAG-1. LV/TT: 06JAN04-06APR11										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>Daniel Merwin</i>		

PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.

PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	- <input type="checkbox"/>	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	- <input checked="" type="checkbox"/>	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	- <input type="checkbox"/>	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	- <input checked="" type="checkbox"/>	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	- <input type="checkbox"/>	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	- <input checked="" type="checkbox"/>	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input type="checkbox"/>	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input checked="" type="checkbox"/>	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	- <input type="checkbox"/>	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	- <input checked="" type="checkbox"/>	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate ABHAN		3. Desig		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	<input type="checkbox"/>	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		<input checked="" type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input checked="" type="checkbox"/>	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices	<input type="checkbox"/>	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		<input type="checkbox"/>	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.33		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ASSIGNMENT IN RATING			42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. [Signature] ABH'KSW Date: 15 JUL 06 WYKES, D D, ABH1 (AW/SW)		
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. - A hard working individual who has proven himself in a short period of time. Flexible to new job assignments and continually takes positive steps to improve. - Contributed to the safe movement of aircraft and elevator operations in the Hangar Bay in support of maintenance requirements for the embarked Air Combat Element. - His efforts were instrumental in the completion of the rehabilitation of the Hangar Bay for the up coming Essex and PHIBRON 11 Change of Command. - A selfless volunteer. Donated over 8 hours of his off-duty time in Thailand to participate in a community relations project at Phirat Witthika 14 School - Personally encourages others to strive for the highest standards. CONT (BLK 44): A/S32A-32 SPOTTING DOLLY OPERATOR.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. QUALIFICATIONS: 304 AIRCRAFT ELEVATOR, 303 CONFLAG STATION OPERATOR, 302 PHONE TALKER, 301 MAINTENANCE PERSON, 301 CHOCK AND CHAIN HANDLER, 302 FLIGHT DK OBSERVER.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL					X		48. Reporting Senior Address COMMANDING OFFICER
46. SUMMARY	<input checked="" type="checkbox"/>	0	1	1	11	5	USS ESSEX (LHD 2) FPO AP 96643-1661
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. [Signature] ABHC (AW/SW) Date: 15 JUL 06 HERMOSURA, M B, ABHC (AW/SW)					50. Signature of Reporting Senior [Signature] Date: 15 JUL 06 Summary Group Average: 3.45		
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> [Signature] Date: 15 JUL 06					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:		

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABHAN		3. Desig		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> TAR <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 21533		7. Ship/Station LHD 2 ESSEX			8. Promotion Status REGULAR		9. Date Reported 06APR11	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>			Period of Report 14. From: 06JAN04 15. To: 06JUL15							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness P/WS		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) ST. LOUIS, K P			23. Grade LT		24. Desig 1310		25. Title DIVO		26. UIC 21533	
27. SSN [REDACTED]										
28. Command employment and command achievements. Forward deployed Western Pacific-3. COBRA GOLD '06. PVSTS: Thailand.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) PLANE HANDLER Chock and Chain Handler-3. Responsible for the safe and expeditious movement and securing of embarked aircraft in the Hangar Bay. Performs general maintenance and upkeep of 29 divisional spaces. WATCH: Baggage checker-3, CONFLAG-1. LV/TT: 06JAN04-06APR11										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>[Signature]</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	- <input type="checkbox"/>	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	- <input checked="" type="checkbox"/>	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	- <input type="checkbox"/>	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	- <input checked="" type="checkbox"/>	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	- <input type="checkbox"/>	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	- <input checked="" type="checkbox"/>	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input type="checkbox"/>	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input checked="" type="checkbox"/>	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	- <input type="checkbox"/>	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	- <input checked="" type="checkbox"/>	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.					

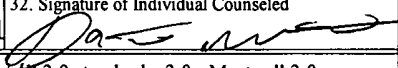
EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D			2. Rate ABHAN		3. Desig		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards		
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	<input type="checkbox"/>	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		<input checked="" type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.		
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input checked="" type="checkbox"/>	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices	<input type="checkbox"/>	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		<input type="checkbox"/>	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.		
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="3.33"/>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ASSIGNMENT IN RATING			42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. <i>Daniel Dwyer ABH/MSW</i> Date: 15 JUL 06 WYKES, D D, ABH1 (AW/SW)			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. - A hard working individual who has proven himself in a short period of time. Flexible to new job assignments and continually takes positive steps to improve. - Contributed to the safe movement of aircraft and elevator operations in the Hangar Bay in support of maintenance requirements for the embarked Air Combat Element. - His efforts were instrumental in the completion of the rehabilitation of the Hangar Bay for the up coming Essex and PHIBRON 11 Change of Command. - A selfless volunteer. Donated over 8 hours of his off-duty time in Thailand to participate in a community relations project at Phirat Witthika 14 School - Personally encourages others to strive for the highest standards. CONT (BLK 44): A/S32A-32 SPOTTING DOLLY OPERATOR.								
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. QUALIFICATIONS: 304 AIRCRAFT ELEVATOR, 303 CONFLAG STATION OPERATOR, 302 PHONE TALKER, 301 MAINTENANCE PERSON, 301 CHOCK AND CHAIN HANDLER, 302 FLIGHT DK OBSERVER.								
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>	
45. INDIVIDUAL					X		48. Reporting Senior Address COMMANDING OFFICER USS ESSEX (LHD 2) FPO AP 96643-1661	
46. SUMMARY	<input checked="" type="checkbox"/>	0	1	1	11	5		
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. <i>Daniel Dwyer ABHC (AW/SW)</i> Date: 15 JUL 06 HERMOSURA, M B, ABHC (AW/SW)					50. Signature of Reporting Senior <i>Robert A. Jones LT</i> Date: 15 JUL 06 Summary Group Average: 3.45			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> <i>Daniel Merwin</i> Date: 15 JUL 06					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABH3		3. Desig		4. SSN 000-00-0000			
5. ACT <input checked="" type="checkbox"/> TAR <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 21533		7. Ship/Station LHD 2 ESSEX			8. Promotion Status FROCKED		9. Date Reported 06APR11		
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 06JUL16 15. To: 07JUN15							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness P/WS			21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) RICHERSON, J P			23. Grade LT		24. Desig 1310		25. Title DIVO		26. UIC 21533		
							27. SSN 000-00-0000				
28. Command employment and command achievements. Forward deployed Western Pacific-11. Ship's Upkeep; CMAV; ULTRA C/D/E; TSTA/FEP; TRAV 06; PHIBLEX; TALON VISION 07; EOC; AST; EVALEX; ARGEX 07-1; NEOEX; FOAL EAGLE 07; TALISMAN SABER 07. PVSTS: RK; Brisbane, AU. CY 2006 Battle "E"; CY 2006 Golden Anchor Award.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DIV. YEOMAN V-3 Divisional Yeoman-11. Responsible for the safe upkeep of 43 divisional personnel training records, manual's and publication's. Performs general maintenance of Hangar Deck Control Office. WATCH: CONFLAG-12, MOOW-12, Bag Checker-12.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled 07JAN15		31. Counselor ROBINSON, B E, ABH1		32. Signature of Individual Counseled 			
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards						
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	- <input type="checkbox"/>	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	- <input checked="" type="checkbox"/>	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction						
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	- <input type="checkbox"/>	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	- <input checked="" type="checkbox"/>	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.						
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	- <input type="checkbox"/>	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	- <input checked="" type="checkbox"/>	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.						
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input type="checkbox"/>	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input checked="" type="checkbox"/>	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.						
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	- <input type="checkbox"/>	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	- <input type="checkbox"/>	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.						

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABH3		3. Desig		4. SSN 000-00-0000			
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>		<ul style="list-style-type: none"> - Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well. <input type="checkbox"/>		<input type="checkbox"/>		<ul style="list-style-type: none"> - Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction. <input type="checkbox"/>		<input type="checkbox"/>		<ul style="list-style-type: none"> - Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction. <input checked="" type="checkbox"/>	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input checked="" type="checkbox"/>		<ul style="list-style-type: none"> - Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices <input type="checkbox"/>		<input type="checkbox"/>		<ul style="list-style-type: none"> - Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment. <input type="checkbox"/>		<input type="checkbox"/>		<ul style="list-style-type: none"> - Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others. <input type="checkbox"/>	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 4.17		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) EAWS				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. <i>Brian Robinson</i> ROBINSON, B E, ABH1 Date: 15 JUN 07					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. <p style="text-align: center;">* This evaluation is being submitted upon ABHAN Merwin selection to ABH3 *</p> <p>ABHAN Merwin's outstanding administrative skills and persistent efforts have made an essential positive impact in V-3 division and the entire Air Department.</p> <ul style="list-style-type: none"> - Self starter and organized. This Airman is the go-to guy to insure administrative work gets done. He takes pride in the upkeep of 43 Division Officer records and assisting the Division's Training Petty Officer in the managing of 43 training jackets by routing and tracking 250 PQS (Personal Qualification Standards) and request chits. - Key person in the rehabilitation of the entire port elevator well and tracks. Greatly contributed to the beautification of the hangar bay for the Commanding Officer's highly successful annual 2007 "spring reception". <p>ABHAN Merwin has a great potential to go far in his Naval career. His proactive cerebral approach to every task assigned to him will hold him in good stead as he hones his leadership skill as an ABH3. I have high hopes for this rising star!!!</p>											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. PQS: Basic D.C. 301-306, 43434-1C 305-Tower Operator, 307-Spotting Dolly Operator, 43523-B 301 Craftsman, 43241-H 302-Repair Parts Petty Officer; GSE LICENSE: Spotting Dolly.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>				
45. INDIVIDUAL					X		48. Reporting Senior Address COMMANDING OFFICER USS ESSEX (LHD-2) FPO AP 96643-1661				
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	5	1					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. <i>Strickland</i> STRICKLAND, J D, ABHC (AW) Date: 15 JUN 07						50. Signature of Reporting Senior <i>[Signature]</i> Summary Group Average: <input type="text"/> Date: 15 JUN 07					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> <i>[Signature]</i> Date: 15 JUN 07						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABH3		3. Desig AW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> TAR <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ <input type="checkbox"/> 265		6. UIC 21533		7. Ship/Station LHD 2 ESSEX			8. Promotion Status REGULAR		9. Date Reported 06APR11		
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>			Period of Report 14. From: 07JUN16 15. To: 08JUN15								
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>			20. Physical Readiness P/WS		21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) SIGURDSON, B C			23. Grade LCDR		24. Desig 1310		25. Title ASST DEPT HEAD		26. UIC 21533		
									27. SSN [REDACTED]		
28. Command employment and command achievements. FORWARD DEPLOYED WESTERN PACIFIC-12. SHIP'S UPKEEP; CMAV; TALISMAN SABER; ULTRA-S; SRA; KITP; BALIKATAN; TSC CAMBODIA; BLUE/GREEN INTGRATED TRAINING; COBRA GOLD. PVSTS: SUBIC BAY, RP; HONG KONG; SAR; SIHANOUKVILLE. 2007 BATTLE "E" AND GREEN "H" WINNER.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DEPT YEOMAN Department Yeoman-12. Responsible for tracking and Maintaining Departmental Correspondence. COLL: Command Assessment Team-12. WATCH: MOOW-4											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled 08DEC15		31. Counselor BOYLE, D N		32. Signature of Individual Counseled [Signature]			
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application		- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.		-		- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.		-		- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction	
NOB <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product.		- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.		-		- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.		-		- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.	
NOB <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community.		- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.		-		- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.		-		- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.	
NOB <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values.		- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.	
NOB <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work.		- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.		-		- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.		-		- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.	
NOB <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont 'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate ABH3		3. Desig AW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards		
38. TEAMWORK: Contributions to team building and team results A	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	-	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.	-	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.		
NOB <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals.	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices	-	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.	-	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.		
NOB <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
40. Individual Trait Avg. total of trait scores divided by number of graded traits.		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific)		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.			
4:14		STA-21		 HEVENER, S W, ABH1 (AW) Date:			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case.							
A vital asset to the department! Essential to administrative success! Self starter. A dependable Petty Officer who aggressively seeks greater responsibilities. Completes tasks ahead of schedule with little to no supervision. - Administrative professional. Innovative techniques in database management tracked, maintained, and accounted for over 4,000 pieces of correspondence. Sought after by peers and seniors alike for advice and counsel in administrative matters. - Emerging leader. Supervises and trains three divisional Yeoman, to ensure all correspondence is submitted in accordance with the department's high standards. Team builder. As a member of the Command Assessment Team he created and maintained multiple training syllabuses in support of retention efforts. **Has my strongest recommendation for advancement and paths leading to a Commission!**							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.							
QUALS: 301-EAWS (Common Core), 301-EAWS (Specific), 305-MOOW. COMP: NRTM: (14222-14226) Information Technician, NKO Courses: Excelling In Internal Customer Service.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL						X	48. Reporting Senior Address COMMANDING OFFICER USS ESSEX (LHD 2) FPO-AP 96643-1661
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	2	1	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.				50. Signature of Reporting Senior			
 THOMSON, W J, ABCM (AW) Date: 6 JUN 08				 Summary Group Average: 3.90 Date: 5 JUN 08			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report			
 Date: 6 JUN 08				Date:			

AGREEMENT TO EXTEND ENLISTMENT

30

NAME: MERWIN, DANIEL DENNISSSN: [REDACTED]BR/CL: USN/11

Having enlisted in the UNITED STATES NAVY / NAVAL RESERVE on 05NOV01 for 4 years, I do voluntarily agree to (further) extend my enlistment for 34 months, (REASON: SCHOOL OTHER X) subject to the provisions and obligations of my enlistment contract. I acknowledge that the provisions of 10 USC 5540 relating to an increase in basic pay do not apply to this agreement. I understand my new contract expiration date to be 12AUG30. This agreement has been fully explained to me, I understand it. I understand that extensions of enlistment totalling 24 months or greater require a physical examination prior to the extension becoming operative. No promises of any kind have been made to me except as indicated:

TO OBLISERV FOR BUPERS ORDER # 0579. I UNDERSTAND THAT THIS EXTENSION BECOMES BINDING UPON EXECUTION AND MAY NOT THEREAFTER BE CANCELLED EXCEPT AS SET FORTH IN MILPERSMAN 1160-040. I HAVE HAD EXPLAINED TO ME THE PROVISIONS OF THE SRB PROGRAM AND THE MONETARY BENEFITS FOR A SUBSEQUENT REENLISTMENT. THIS IS MY FIRST EXTENSION THIS ENLISTMENT.

UIC: 21533 STATUS: ACTIVE X INACTIVE RATE: ABH3COMBAT ZONE: NA PEBD: 05NOV01 TOTAL AGGREGATE MOS: 34SHIP OR STATION: USS ESSEX (LHD 2)LOCATION OF SHIP OR STATION: AT SEA**** SIGNATURE
OF MEMBER:

FIRST

MIDDLE

LAST

Witnessed and accepted

on behalf of the UNITED STATES NAVY

this 28 day of FEBRUARY, A.D. 20 09**** SIGNATURE
AND GRADE:B. L. WILLIAMS, PSC(SW/AW), USNTITLE: PERSONNEL OFFICER

(CERTIFYING OFFICER NAME AND RANK)

CANCELLATION OF EXTENSION TO EXTEND ENLISTMENTTHE EXTENSION IDENTIFIED HEREON FOR MONTHS, IS CANCELLED EFFECTIVE AUTHORITY: **** SIGNATURE
AND GRADE:

(CERTIFYING OFFICER NAME AND RANK)

EVALUATION REPORT & COUNSELING RECORD (EI-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate ABH3		3. Desig AW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> TAR <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 21533		7. Ship/Station LHD 2 ESSEX			8. Promotion Status REGULAR		9. Date Reported 06APR11		
Occasion for Report 10. Periodic <input type="checkbox"/> 11. of Individual <input checked="" type="checkbox"/> 12. Promotion/Frothing <input type="checkbox"/> 13. Special <input type="checkbox"/>			Period of Report 14. From: 08JUN16 15. To: 09APR04								
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>			20. Physical Readiness P/WS		21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) BRADY, D S			23. Grade LCDR		24. Desig 1310		25. Title ASST DEPT HEAD		26. UIC 21533		
								27. SSN [REDACTED]			
28. Command employment and command achievements. Forward Deployed Western Pacific-10. Ship's Upkeep-10; CMAV; TRAV 08; Tokyo/Yokosuka HADR; Blue/Green Integrated Training; EVALEX; PHIBLEX; KITP; ANNUALEX; ULTRA-C/E; COBRA GOLD. PVST: Tokyo, JA; Subic Bay, RP; Hong Kong, SAR; Laem Chabang, KOT.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DEPT YEOMAN Department Yeoman-10. Responsible for tracking and Maintaining Departmental Correspondence. COLL: Command Assessment Team-10, Department Dental Liaison-10, Department Mail Orderly-10. WATCH: Shore Patrol-10, POOW-6.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled 09DEC15		31. Counselor HEATHERLY, K B		32. Signature of Individual Counseled <i>Paula [Signature]</i>			

PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.

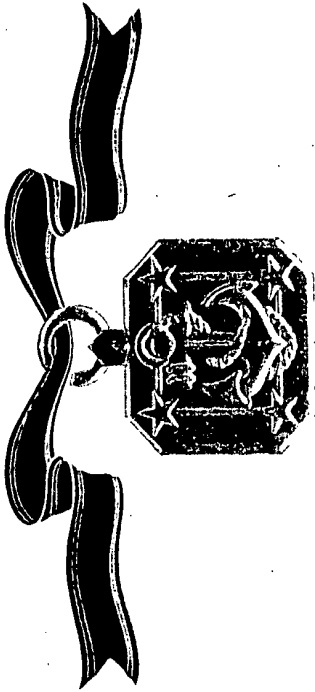
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. EQUIPMENT MAINTENANCE GOLD NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	-	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	-	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction
34. QUALITY OF WORK: Standard of work; value of end product. LEADERSHIP NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	-	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	-	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. Technical NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.
36. MILITARY BEARING/CHARACTER: Appearance; conduct physical fitness, adherence to Navy Core Values. QUALITY OF STANDARDS NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. OR CLIP OPPL NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	-	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	-	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont 'd)

RCS BUPERS 1610-1

Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate ABH3		3. Desig AW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	- <input type="checkbox"/>	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		- <input type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices	- <input type="checkbox"/>	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		- <input type="checkbox"/>	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. (total of trait scores divided by number of graded traits) 4.29		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) "CTN" STA-21 C SCHOOL		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. <i>K B Heatherly</i> HEATHERLY, K B, ABH1 (AW/SW) Date: 04 APR 09			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Evaluation submitted upon member's transfer to NIOCC Pensacola, Florida. *** Superior Performer who brings administrative success to the Air Department *** A consummate professional who flawlessly monitors, tracks, and facilitates correspondence for 193 Sailors in support of mission essential operations. - Highly adaptive work ethic. Quickly mastered the demands of personnel support to over 300 personnel while simultaneously providing leadership to four divisional yeoman consistently ensuring the high standards that are his trademark. - Natural Career Counselor. His efforts in counseling junior sailors in career management positively impact retention within Air Department and ESSEX. Petty Officer Merwin's talents and unwavering positive attitude will surely be missed. I am convinced that he will be an extraordinary asset to his next command.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. QUALS: 301-ESWS (Common Core), 301-ESWS (Specific), 306-PETTY OFFICER OF THE WATCH INPORT.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL						X	48. Reporting Senior Address COMMANDING OFFICER USS ESSEX (LHD 2) FPO-AP 96643-1661
46. SUMMARY		0	0	0	0	1	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. <i>W J Thompson</i> THOMPSON, W J, ABCM (AW) Date: 4 APR 05				50. Signature of Reporting Senior <i>Charles B...</i> Summary Group Average: 4.29 Date: 04 APR 09			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> <i>Daniel Merwin</i> Date: 04 APR 09				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

PRIVACY SENSITIVE



DEPARTMENT OF THE NAVY

THIS IS TO CERTIFY THAT

THE SECRETARY OF THE NAVY HAS AWARDED THE

NAVY AND MARINE CORPS ACHIEVEMENT MEDAL

TO

AVIATION BOATSWAIN'S MATE (HANDLING) THIRD CLASS (AVIATION WARFARE)
DANIEL D. MERWIN, UNITED STATES NAVY

FOR

"PROFESSIONAL ACHIEVEMENT IN THE SUPERIOR PERFORMANCE OF HIS DUTIES WHILE SERVING AS AIR DEPARTMENT YEOMAN ON BOARD USS ESSEX (LHD 2) FROM APRIL 2005 TO APRIL 2009. PETTY OFFICER MERWIN PERFORMED HIS DUTIES IN AN EXEMPLARY AND HIGHLY PROFESSIONAL MANNER. DEMONSTRATING SUPERIOR KNOWLEDGE AND TECHNICAL ACUMEN, HE MONITORED NINE DIVISIONAL YEOMEN IN THE TRACKING AND ACCOUNTING OF OVER 6,000 PIECES OF CORRESPONDENCE FOR 364 SAILORS INCLUDING 532 PERSONNEL QUALIFICATION STANDARDS. HIS EXPERTISE WAS INSTRUMENTAL IN AIR DEPARTMENT'S PERFORMANCE DURING TWO HIGHLY SUCCESSFUL AVIATION READINESS QUALIFICATIONS AND ESSEX' OPERATIONAL READINESS DURING MULTINATIONAL EXERCISES AND OPERATIONS INCLUDING THEATER SECURITY COOPERATION CAMBODIA AND HOPE RENEWAL. PETTY OFFICER MERWIN'S MANAGERIAL ABILITY, PERSONAL INITIATIVE AND UNWAVERING DEVOTION TO DUTY REFLECTED CREDIT UPON HIMSELF AND WERE IN THE HIGHEST TRADITIONS OF THE UNITED STATES NAVAL SERVICE."

GIVEN THIS

10TH

DAY OF

APRIL

2009



FOR THE

SECRETARY OF THE NAVY

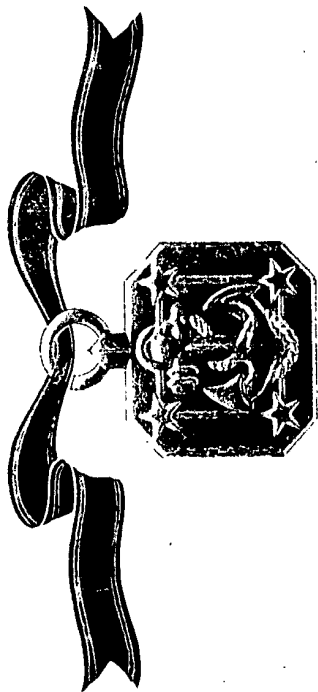
K. B. CANADY

CAPTAIN, UNITED STATES NAVY

USS ESSEX (LHD 2)

AR 3436

PRIVACY SENSITIVE



DEPARTMENT OF THE NAVY

THIS IS TO CERTIFY THAT

THE SECRETARY OF THE NAVY HAS AWARDED THE

NAVY AND MARINE CORPS ACHIEVEMENT MEDAL

TO

AVIATION BOATSWAIN'S MATE (HANDLING) THIRD CLASS (AVIATION WARFARE)

DANIEL D. MERWIN, UNITED STATES NAVY

FOR

"PROFESSIONAL ACHIEVEMENT IN THE SUPERIOR PERFORMANCE OF HIS DUTIES WHILE SERVING AS AIR DEPARTMENT YEOMAN ON BOARD USS ESSEX (LHD 2) FROM APRIL 2005 TO APRIL 2009. PETTY OFFICER MERWIN PERFORMED HIS DUTIES IN AN EXEMPLARY AND HIGHLY PROFESSIONAL MANNER. DEMONSTRATING SUPERIOR KNOWLEDGE AND TECHNICAL ACUMEN, HE MONITORED NINE DIVISIONAL YEOMEN IN THE TRACKING AND ACCOUNTING OF OVER 6,000 PIECES OF CORRESPONDENCE FOR 364 SAILORS INCLUDING 532 PERSONNEL QUALIFICATION STANDARDS. HIS EXPERTISE WAS INSTRUMENTAL IN AIR DEPARTMENT'S PERFORMANCE DURING TWO HIGHLY SUCCESSFUL AVIATION READINESS QUALIFICATIONS AND ESSEX' OPERATIONAL READINESS DURING MULTINATIONAL EXERCISES AND OPERATIONS INCLUDING THEATER SECURITY COOPERATION CAMBODIA AND HOPE RENEWAL. PETTY OFFICER MERWIN'S MANAGERIAL ABILITY, PERSONAL INITIATIVE AND UNWAVERING DEVOTION TO DUTY REFLECTED CREDIT UPON HIMSELF AND WERE IN THE HIGHEST TRADITIONS OF THE UNITED STATES NAVAL SERVICE."

GIVEN THIS 10TH DAY OF APRIL 2009



FOR THE

SECRETARY OF THE NAVY

K. B. CANADY

CAPTAIN, UNITED STATES NAVY

USS ESSEX (LHD 2)

AR 3437

CLASSIFIED INFORMATION NONDISCLOSURE AGREEMENT**AN AGREEMENT BETWEEN****MERWIN, DANIEL D****AND THE UNITED STATES***(Name of Individual - Printed or typed)*

1. Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to classified information. As used in this Agreement, classified information is marked or unmarked classified information, including oral communications, that is classified under the standards of Executive Order 12958, or under any other Executive order or statute that prohibits the unauthorized disclosure of information in the interest of national security; and unclassified information that meets the standards for classification and is in the process of a classification determination as provided in Sections 1.2, 1.3, and 1.4(e) of Executive Order 12958, or under any other Executive order or statute that requires protection for such information in the interest of national security. I understand and accept that by being granted access to classified information, special confidence and trust shall be placed in me by the United States Government.

2. I hereby acknowledge that I have received a security indoctrination concerning the nature and protection of classified information, including the procedures to be followed in ascertaining whether other persons to whom I contemplate disclosing this information have been approved for access to it, and that I understand these procedures.

3. I have been advised that the unauthorized disclosure, unauthorized retention, or negligent handling of classified information by me could cause damage or irreparable injury to the United States or could be used to advantage by a foreign nation. I hereby agree that I will never divulge classified information to anyone unless: (a) I have officially verified that the recipient has been properly authorized by the United States Government to receive it; or (b) I have been given prior written notice of authorization from the United States Government Department or Agency (hereinafter Department or Agency) responsible for the classification of the information or last granting me a security clearance that such disclosure is permitted. I understand that if I am uncertain about the classification status of information, I am required to confirm from an authorized official that the information is unclassified before I may disclose it, except to a person as provided in (a) or (b), above. I further understand that I am obligated to comply with laws and regulations that prohibit the unauthorized disclosure of classified information.

4. I have been advised that any breach of this Agreement may result in the termination of any security clearances I hold; removal from any position of special confidence and trust requiring such clearances; or the termination of my employment or other relationships with the Departments or Agencies that granted my security clearance or clearances. In addition, I have been advised that any unauthorized disclosure of classified information by me may constitute a violation, or violations, of United States criminal laws, including the provisions of Sections 641, 793, 794, 798, *952 and 1924, Title 18, United States Code, * the provisions of Section 783(b), Title 50, United States Code, and the provisions of the Intelligence Identities Protection Act of 1982. I recognize that nothing in this Agreement constitutes a waiver by the United States of the right to prosecute me for any statutory violation.

5. I hereby assign to the United States Government all royalties, remunerations, and emoluments that have resulted, will result or may result from any disclosure, publication, or revelation of classified information not consistent with the terms of this Agreement.

6. I understand that the United States Government may seek any remedy available to it to enforce this Agreement including, but not limited to, application for a court order prohibiting disclosure of information in breach of this Agreement.

7. I understand that all classified information to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of the United States Government unless and until otherwise determined by an authorized official or final ruling of a court of law. I agree that I shall return all classified materials which have, or may come into my possession or for which I am responsible because of such access: (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me a security clearance or that provided me access to classified information; or (c) upon the conclusion of my employment or other relationship that requires access to classified information. If I do not return such materials upon request, I understand that this may be a violation of Section 793 and/or 1924, Title 18, United States Code, a United States criminal law.



8. Unless and until I am released in writing by an authorized representative of the United States Government, I understand that all conditions and obligations imposed upon me by this Agreement apply during the time I am granted access to classified information, and at all times thereafter.

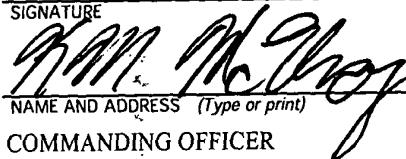

9. Each provision of this Agreement is severable. If a court should find any provision of this Agreement to be unenforceable, all other provisions of this Agreement shall remain in full force and effect.

(Continue on reverse.)

10. These restrictions are consistent with and do not supersede, conflict with or otherwise alter the employee obligations, rights or liabilities created by Executive Order 12958; Section 7211 of Title 5, United States Code (governing disclosures to Congress); Section 1034 of Title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); Section 2302(b)(8) of Title 5, United States Code, as amended by the Whistleblower Protection Act (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that expose confidential Government agents), and the statutes which protect against disclosure that may compromise the national security, including Sections 641, 793, 794, 798, 952 and 1924 of Title 18, United States Code, and Section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. Section 783(b)). The definitions, requirements, obligations, rights, sanctions and liabilities created by said Executive Order and listed statutes are incorporated into this Agreement and are controlling.

11. I have read this Agreement carefully and my questions, if any, have been answered. I acknowledge that the briefing officer has made available to me the Executive Order and statutes referenced in this Agreement and its implementing regulation (32 CFR Section 2003.20) so that I may read them at this time, if I so choose.

SIGNATURE 	DATE 11 MAY 09	SOCIAL SECURITY NUMBER (See Notice below) 
ORGANIZATION (IF CONTRACTOR, LICENSEE, GRANTEE OR AGENT, PROVIDE: NAME, ADDRESS, AND, IF APPLICABLE, FEDERAL SUPPLY CODE NUMBER) (Type or print)		

WITNESS		ACCEPTANCE	
THE EXECUTION OF THIS AGREEMENT WAS WITNESSED BY THE UNDERSIGNED.		THE UNDERSIGNED ACCEPTED THIS AGREEMENT ON BEHALF OF THE UNITED STATES GOVERNMENT.	
SIGNATURE 	DATE 09 05 11	SIGNATURE 	DATE 09 05 11
NAME AND ADDRESS (Type or print) COMMANDING OFFICER CID CORRY STATION 640 ROBERTS AVE CODE N2 PENSACOLA, FL 32511-5138		NAME AND ADDRESS (Type or print) COMMANDING OFFICER CID CORRY STATION 640 ROBERTS AVE CODE N2 PENSACOLA, FL 32511-5138	

SECURITY DEBRIEFING ACKNOWLEDGEMENT

I reaffirm that the provisions of the espionage laws, other federal criminal laws and executive orders applicable to the safeguarding of classified information have been made available to me; that I have returned all classified information in my custody; that I will not communicate or transmit classified information to any unauthorized person or organization; that I will promptly report to the Federal Bureau of Investigation any attempt by an unauthorized person to solicit classified information, and that I (have) (have not) (strike out inappropriate word or words) received a security debriefing.

SIGNATURE OF EMPLOYEE	DATE
NAME OF WITNESS (Type or print)	SIGNATURE OF WITNESS

NOTICE: The Privacy Act, 5 U.S.C. 552a, requires that federal agencies inform individuals, at the time information is solicited from them, whether the disclosure is mandatory or voluntary, by what authority such information is solicited, and what uses will be made of the information. You are hereby advised that authority for soliciting your Social Security Account Number (SSN) is Executive Order 9397. Your SSN will be used to identify you precisely when it is necessary to 1) certify that you have access to the information indicated above or 2) determine that your access to the information indicated has terminated. Although disclosure of your SSN is not mandatory, your failure to do so may impede the processing of such certifications or determinations, or possibly result in the denial of your being granted access to classified information.

* NOT APPLICABLE TO NON-GOVERNMENT PERSONNEL SIGNING THIS AGREEMENT.

STANDARD FORM 312 BACK (Rev. 1-00)

AGREEMENT TO EXTEND ENLISTMENT

NAME: MERWIN,DANIEL DENNIS

SSN: [REDACTED]

BR/CL: USN

Having enlisted in the X UNITED STATES NAVY NAVAL RESERVE on 11/01/2005 for 4 years, I do voluntarily agree to (further) extend my enlistment for 34 month(s) (REASON: SCHOOL OTHER X) subject to the provisions and obligations of my enlistment contract. I acknowledge that the provisions of 10 USC 5540 relating to an increase in basic pay do not apply to this agreement. I understand my new contract expiration date to be 08/31/2012. This agreement has been fully explained to me, I understand it. I understand that extensions of enlistment totaling 24 months or greater require a physical examination prior to the extension becoming operative. No promises of any kind have been made to me except as indicated:

TO INCUR SUFFICIENT OBLISERV FOR BUPERS ORDER 0909. I UNDERSTAND THAT THIS EXTENSION BECOMES BINDING UPON EXECUTION AND CANNOT BE CANCELLED EXCEPT FOR AS SET FORTH IN MILPERSMAN 1160-040.
THIS IS MY FIRST EXTENSION THIS ENLISTMENT.

UIC: 21533 STATUS: ACTIVE X INACTIVE RATE: ABH3

COMBAT ZONE: PEBD: 11/01/2005 TOTAL AGGREGATE MOS: 34

SHIP OR STATION: LHD 2 ESSEX

LOCATION OF SHIP OR STATION: USS ESSEX (LHD 2)

**** SIGNATURE OF MEMBER:

FIRST

MIDDLE

LAST

3 APR 09

Witnessed and accepted on behalf of the United States Navy
this 18th day of March, A.D. 2009

****SIGNATURE
AND GRADE:

J. E. ASSADIQ, PS1(AW), USN

TITLE:

TRF SUP BY DIR

Certifying Officer Name and Rank

Extension of Enlistment Operative/Cancelled

The extension identified hereon for month(s) (REASON: SCHOOL OTHER) is Operative () Cancelled ()
effective .

AUTHORITY: _____

****SIGNATURE
AND GRADE: _____

Certifying Officer Name and Rank

DEPENDENCY APPLICATION/RECORD OF EMERGENCY DATA**MEMBER INFORMATION**

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS
RANK/RATE: CTN3 BR/CL: USN UIC: 41976 RELIGION: NO
SHIP OR STATION: NIOC PCOLA/ISSP INITIAL/CHANGE: I
EFFECTIVE DATE: 11/01/2005 TOTAL NUMBER OF DEPENDENTS: 0
PREVIOUSLY MARRIED: NO MARRIAGE DISSOLVED BY:
DISSOLVED ON: PLACE DISSOLVED:

SPOUSE INFORMATION

NAME: DEPENDENT:
DATE OF BIRTH: CITIZENSHIP: RELATIONSHIP:
DATE MARRIED: PLACE OF MARRIAGE:
ADDRESS:
PREVIOUSLY MARRIED: MARRIAGE DISSOLVED BY:
DISSOLVED ON: PLACE DISSOLVED:
MEMBER OF UNIFORMED SERVICES: DUTY AFFILIATION:
BRANCH: COMPONENT:

SPOUSE NEXT OF KIN

NAME: RELATIONSHIP:
ADDRESS:

FATHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
EFFORT, PA [REDACTED]

MOTHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

OTHER PERSON, NOT ALREADY NAMED TO BE NOTIFIED OF PERSONAL CASUALTY

NAME: NONE RELATIONSHIP
ADDRESS:

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS

BENEFICIARY(IES) FOR UNPAID PAY AND ALLOWANCES

NAME: [REDACTED] RELATIONSHIP: FATHER
ADDRESS: [REDACTED] EFFORT, PA [REDACTED] PERCENTAGE: 100%

PERSON(S) TO RECEIVE ALLOTMENT IF IN A MISSING STATUS, SUBJECT TO SECNAV DETERMINATION

NAME: [REDACTED] RELATIONSHIP: FATHER
ADDRESS: [REDACTED] EFFORT, PA [REDACTED] PERCENTAGE: 100%

BENEFICIARY(IES) FOR GRATUITY PAY (NO SPOUSE OR CHILD SURVIVING)

NAME: [REDACTED] RELATIONSHIP: Father
ADDRESS: [REDACTED] EFFORT, PA [REDACTED] PERCENTAGE 100%

LIFE INSURANCE INFORMATION

COMPANY: NONE POLICY NUMBER:
ADDRESS:

LOCATION OF WILL

ADDRESS: NONE

LOCATION OF OTHER VALUABLE PAPERS

ADDRESS: NONE

PNOK (Name - Relationship - Phone - Address)

[REDACTED] Father, [REDACTED] EFFORT, PA, [REDACTED]

SNOK (Name - Relationship - Phone - Address)

[REDACTED] Mother, [REDACTED]
[REDACTED], LEXINGTON, SC, [REDACTED]

IS BENEFICIARY DESIGNATION OF SGLI ON FILE? YES DESIGNATION DATE: 09/17/2009

REMARKS

PADD: [REDACTED] RELATIONSHIP: Father
ADDRESS: [REDACTED]
NAVPERS 1070/602 Page: 2 of 3

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS

Phone: EFFORT, PA [REDACTED]

NEW PCS CHECK IN AT (NAME OF COMMAND). DTROB: 2009JUL27.
MBR RECEIVING: (BAH W/O DEPS).

PAGE TWO UPDATED BY: PS2(SW) GUMBS, K. E.

IT IS MY RESPONSIBILITY TO NOTIFY MY NAVY PERSONNEL OFFICE/SHIP'S OFFICE OR
CSD/PSD IF THERE IS A CHANGE THAT MAY AFFECT MY BAH ENTITLEMENTS THAT MAY
RESULT IN AN OVER/UNDER PAYMENT.

CERTIFICATION: I HAVE REVIEWED THE DATA ON THIS FORM AND CERTIFY THAT IT IS
CORRECT. I UNDERSTAND THAT ANY CHANGE IN MY FAMILY MEMBER STATUS MUST BE
REPORTED AS A CHANGE TO THE DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM
(DEERS) WITHIN 60 DAYS. THIS INCLUDES SERVICE MEMBERS IN A JOINT SERVICE
MARRIAGE (MILITARY MARRIED TO MILITARY), EVEN THOUGH EACH SPOUSE IS ALREADY
ENROLLED IN DEERS IN HIS OR HER OWN RIGHT AS A MILITARY MEMBER.

SIGNATURE OF DESIGNATOR: [Signature]

DANIEL DENNIS MERWIN

WITNESSED: [Signature]

PATTIE SPEAR

DATE: 17 SEP 09

TITLE: HUMAN RESOURCE SUPER

Official NSIPS/ESR form printed this date 17-SEP-2009

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- ☒ Name or update your beneficiary
☐ Reduce the amount of your insurance coverage
☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name First name Middle name

MERWIN, DANIEL D

Rank, title or grade

CTN3/E-4

Social Security Number

Branch of Service (Do not abbreviate)

UNITED STATES NAVY

Current Duty Location

NIOC PENSACOLA

Amount of Insurance

By law, you are automatically insured for \$400,000. *If you want \$400,000 of insurance*, skip to *Beneficiary(ies) and Payment Options*. *If you want less than \$400,000 of insurance*, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$50,000. *If you do not want any insurance**, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage and traumatic injury protection under the SGLI program.

- ☐ I want coverage in the amount of \$ _____ Your initials _____
☐ _____

(Write "I do not want insurance at this time.")

*Note: Reduced or refused insurance can only be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of Veterans' Group Life Insurance you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1. [REDACTED] Effort, PA [REDACTED]		Father	25%	Lump sum
2. [REDACTED] Lexington, SC [REDACTED]		Mother	25%	Lump sum
3. [REDACTED] Bethlehem, PA [REDACTED]		Step Mother	50 %	Lump sum
4. NO CONTINGENCY				
<input type="checkbox"/> Additional Principals on page 4 (check if applicable)				
Contingent				
1. [REDACTED] Lexington SC [REDACTED]		Sister	100 %	Lump sum
2. NO CONTINGENCY				
3. NO CONTINGENCY				
4. NO CONTINGENCY				
<input type="checkbox"/> Additional Contingents on page 4 (check if applicable)				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- This form cancels any prior beneficiary or payment instructions.
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$400,000.
- If I am married or if I get married after completing this form, **my spouse is automatically covered under Family SGLI for which premiums will be deducted from my pay**, unless I decline Family SGLI coverage by completing SGLV 8286A. For Family SGLI premium deductions, my spouse **MUST** be registered in DEERS. **Failure to do so will result in debts owed for unpaid premiums.**

SIGN HERE IN INK

[Signature]
 (Your signature. Do not print.)

Date: 28 JUL 09

Do not write in space below. For official use only.

RECEIVED BY:

RANK, TITLE OR GRADE

ORGANIZATION

DATE RECEIVED

YB-02, ADMIN

NIOC Pensacola

28 JUL 09

SGLV 8286, December 2007

Copy 1 - Member's Official Personnel File p. 2
 Copy 2 - To Member
 Copy 3 - To Active or Reserve Component of Uniformed Service
 AR 3444

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- ☒ Name or update your beneficiary
☐ Reduce the amount of your insurance coverage
☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name First name Middle name
 MERWIN, DANIEL D

Rank, title or grade
 CTN3/E-4

Social Security Number
 [REDACTED]

Branch of Service (Do not abbreviate)
 UNITED STATES NAVY

Current Duty Location
 NIOC PENSACOLA

Amount of Insurance

By law, you are automatically insured for \$400,000. **If you want \$400,000 of insurance**, skip to Beneficiary(ies) and Payment Options. **If you want less than \$400,000** of insurance, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$50,000. **If you do not want any insurance***, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage and traumatic injury protection under the SGLI program.

- ☐ I want coverage in the amount of \$ _____ Your initials _____
☐ _____

(Write "I do not want Insurance at this time.")

*Note: Reduced or refused insurance can only be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of Veterans' Group Life Insurance you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1. [REDACTED] Effort, PA [REDACTED]		Father	25%	Lump sum
2. [REDACTED] Lexington, SC [REDACTED]		Mother	25%	Lump sum
3. [REDACTED] Bethlehem, PA [REDACTED]		Step Mother	50 %	Lump sum
4. NO CONTINGENCY				
<input type="checkbox"/> Additional Principals on page 4 (check if applicable)				
Contingent				
1. [REDACTED] Lexington SC [REDACTED]		Sister	100 %	Lump sum
2. NO CONTINGENCY				
3. NO CONTINGENCY				
4. NO CONTINGENCY				
<input type="checkbox"/> Additional Contingents on page 4 (check if applicable)				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- This form cancels any prior beneficiary or payment instructions.
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$400,000.
- If I am married or if I get married after completing this form, **my spouse is automatically covered under Family SGLI for which premiums will be deducted from my pay**, unless I decline Family SGLI coverage by completing SGLV 8286A. For Family SGLI premium deductions, my spouse **MUST** be registered in DEERS. **Failure to do so will result in debts owed for unpaid premiums.**

SIGN HERE IN INK

Daniel Merwin

Date:

28 JUL 09

(Your signature. Do not print.)

Do not write in space below. For official use only.

RECEIVED BY:

RANK, TITLE OR GRADE

ORGANIZATION

DATE RECEIVED

SGLV 8286, December 2007

YB 02, ADMIN

NIOC Pensacola

28 JUL 09

AGREEMENT TO EXTEND ENLISTMENT

NAME: MERWIN, DANIEL DENNIS

SSN: [REDACTED]

BR/CL: USN

Having enlisted in the X UNITED STATES NAVY NAVAL RESERVE on 11/01/2005 for 4 years, I do voluntarily agree to (further) extend my enlistment for 34 month(s) (REASON: SCHOOL OTHER X) subject to the provisions and obligations of my enlistment contract. I acknowledge that the provisions of 10 USC 5540 relating to an increase in basic pay do not apply to this agreement. I understand my new contract expiration date to be 08/31/2012. This agreement has been fully explained to me, I understand it. I understand that extensions of enlistment totaling 24 months or greater require a physical examination prior to the extension becoming operative. No promises of any kind have been made to me except as indicated:

TO INCUR SUFFICIENT OBLISERV FOR BUPERS ORDER 0909. I UNDERSTAND THAT THIS EXTENSION BECOMES BINDING UPON EXECUTION AND CANNOT BE CANCELLED EXCEPT FOR AS SET FORTH IN MILPERSMAN 1160-040.
THIS IS MY FIRST EXTENSION THIS ENLISTMENT.

UIC: 21533 STATUS: ACTIVE X INACTIVE RATE: ABH3

COMBAT ZONE: PEBD: 11/01/2005 TOTAL AGGREGATE MOS: 34

SHIP OR STATION: LHD 2 ESSEX

LOCATION OF SHIP OR STATION: USS ESSEX (LHD 2)

*** SIGNATURE OF MEMBER:

FIRST

MIDDLE

LAST

3 APR 09

Witnessed and accepted on behalf of the United States Navy
this 18th day of March, A.D. 2009

****SIGNATURE

AND GRADE:

J. E. ASSADIQ, PS2(AW), USN

TITLE:

TRF SUP BY DIR

Certifying Officer Name and Rank

Extension of Enlistment Operative/Cancelled

The extension identified hereon for month(s) (REASON: SCHOOL OTHER) is Operative () Cancelled () effective .

AUTHORITY: _____

****SIGNATURE

AND GRADE: _____

Certifying Officer Name and Rank

ENLISTMENT/REENLISTMENT DOCUMENT ARMED FORCES OF THE UNITED STATES

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 3331; 32 USC 708; 44 USC 708 and 3101; 10 USC 133, 265, 275, 504, 508, 510, 591, 672(d), 678, 837, 1007, 1071 through 1087, 1168, 1169, 1475 through 1480, 1553, 2107, 2122, 3012, 5031, 8012, 8033, 8496, and 9411; 14 USC 351 and 632; and Executive Order 9397, November 1943 (SSN).

PRINCIPAL PURPOSE(S): To record enlistment or reenlistment into the U.S. Armed Forces. This information becomes a part of the subject's military personnel records which are used to document promotion, reassignment, training, medical support, and other personnel management actions. The purpose of soliciting the SSN is for positive identification.

ROUTINE USE(S): This form becomes a part of the Service's Enlisted Master File and Field Personnel File. All uses of the form are internal to the relevant Service.

DISCLOSURE: Voluntary; however, failure to furnish personal identification information may negate the enlistment/reenlistment application.

A. ENLISTEE/REENLISTEE IDENTIFICATION DATA

1. NAME (Last, First, Middle) MERWIN DANIEL DENNIS		2. SOCIAL SECURITY NUMBER [REDACTED]		
3. HOME OF RECORD (Street, City, State, ZIP Code) [REDACTED] BETHLEHEM, PA [REDACTED]		4. PLACE OF ENLISTMENT/REENLISTMENT (Mil. Installation, City, State) HARRISBURG MEPS MECHANICSBURG, PA 17055-4843		
5. DATE OF ENLISTMENT/ REENLISTMENT (YYYYMMDD) 20051013	6. DATE OF BIRTH (YYYYMMDD) 1985 [REDACTED]	7. PREV MIL SVC UPON ENL/REENLIST	YEARS	MONTHS
		a. TOTAL ACTIVE MILITARY SERVICE		
		b. TOTAL INACTIVE MILITARY SERVICE		

B. AGREEMENTS

8. I am enlisting/reenlisting in the United States (list branch of service) NAVAL RESERVE
this date for 8 years and 00 weeks beginning in pay grade E-1.
The additional details of my enlistment/reenlistment are in Section C and Annex(es)
A

a. FOR ENLISTMENT IN A DELAYED ENTRY/ENLISTMENT PROGRAM (DEP):

I understand that I will be ordered to active duty as a Reservist unless I report to the place shown in item 4 above by (list date (YYYYMMDD)) 0600 20051101 for enlistment in the Regular component of the United States (list branch of service) NAVY for not less than 4 years and 00 weeks. My enlistment in the DEP is in a nonpay status. I understand my period of time in the DEP is **NOT** creditable for pay purposes upon entry into a pay status. However, I also understand that this time is counted toward fulfillment of my military service obligation or commitment. I must maintain my current qualifications and keep my recruiter informed of any changes in my physical or dependency status, moral qualifications, and mailing address.

b. REMARKS: (If none, so state.) **NONE**

c. The agreements in this section and attached annex(es) are all the promises made to me by the Government. ANYTHING ELSE ANYONE HAS PROMISED ME IS NOT VALID AND WILL NOT BE HONORED.

(Initials of Enlistee/Reenlistee) DDM

(Continued on reverse side.)



C. PARTIAL STATEMENT OF EXISTING UNITED STATES LAWS

9. FOR ALL ENLISTEES OR REENLISTEES: Many laws, regulations, and military customs will govern my conduct and require me to do things a civilian does not have to do. The following statements are not promises or guarantees of any kind. They explain some of the present laws affecting the Armed Forces which I cannot change but which Congress can change at any time.

a. My enlistment is more than an employment agreement. As a member of the Armed Forces of the United States, I will be:

(1) Required to obey all lawful orders and perform all assigned duties.

(2) Subject to separation during or at the end of my enlistment. If my behavior fails to meet acceptable military standards, I may be discharged and given a certificate for less than honorable service, which may hurt my future job opportunities and my claim for veteran's benefits.

(3) Subject to the military justice system, which means, among other things, that I may be tried by military courts-martial.

(4) Required upon order to serve in combat or other hazardous situations.

(5) Entitled to receive pay, allowances, and other benefits as provided by law and regulation.

b. Laws and regulations that govern military personnel may change without notice to me. Such changes may affect my status, pay, allowances, benefits, and responsibilities as a member of the Armed Forces **REGARDLESS** of the provisions of this enlistment/reenlistment document.

c. In the event of war, my enlistment in the Armed Forces continues until six (6) months after the war ends, unless my enlistment is ended sooner by the President of the United States.

10. MILITARY SERVICE OBLIGATION FOR ALL MEMBERS OF THE ACTIVE AND RESERVE COMPONENTS, INCLUDING THE NATIONAL GUARD.

a. **FOR ALL ENLISTEES:** If this is my initial enlistment, I must serve a total of eight (8) years. Any part of that service not served on active duty must be served in a Reserve Component unless I am sooner discharged.

b. If I am a member of a Reserve Component of an Armed Force at the beginning of a period of war or national emergency declared by Congress, or if I become a member during that period, my military service may be extended without my consent until six (6) months after the end of that period of war.

c. As a member of a Reserve Component, in time of war or national emergency declared by the Congress, I may be required to serve on active duty (other than for training) for the entire period of the war or emergency and for six (6) months after its end.

d. As a member of the Ready Reserve I may be required to perform active duty or active duty for training without my consent (other than as provided in item 8 of this document) as follows:

(1) In time of national emergency declared by the President of the United States, I may be ordered to active duty (other than for training) for not more than 24 consecutive months.

(2) I may be ordered to active duty for 24 months, and my enlistment may be extended so I can complete 24 months of active duty, if:

(a) I am not assigned to, or participating satisfactorily in, a unit of the Ready Reserve; and

(b) I have not met my Reserve obligation; and

(c) I have not served on active duty for a total of 24 months.

(3) I may be ordered to perform additional active duty training for not more than 45 days if I have not fulfilled my military service obligation and fail in any year to perform the required training duty satisfactorily. If the failure occurs during the last year of my required membership in the Ready Reserve, my enlistment may be extended until I perform that additional duty, but not for more than six months.

(4) When determined by the President that it is necessary to support any operational mission, I may be ordered to active duty as prescribed by law, if I am a member of the Selected Reserve.

11. FOR ENLISTEES/REENLISTEES IN THE NAVY, MARINE CORPS, OR COAST GUARD: I understand that if I am serving on a naval vessel in foreign waters, and my enlistment expires, I will be returned to the United States for discharge as soon as possible consistent with my desires. However, if essential to the public interest, I understand that I may be retained on active duty until the vessel returns to the United States. If I am retained under these circumstances, I understand I will be discharged not later than 30 days after my return to the United States; and, that except in time of war, I will be entitled to an increase in basic pay of 25 percent from the date my enlistment expires to the date of my discharge.

12. FOR ALL MALE APPLICANTS: Completion of this form constitutes registration with the Selective Service System in accordance with the Military Selective Service Act. Incident thereto the Department of Defense may transmit my name, permanent address, military address, Social Security Number, and birthdate to the Selective Service System for recording as evidence of the registration.

NAME OF ENLISTEE/REENLISTEE (Last, First, Middle)

MERWIN DANIEL DENNIS

SOCIAL SECURITY NO OF ENLISTEE/REENLISTEE

D. CERTIFICATION AND ACCEPTANCE

13a. My acceptance for enlistment is based on the information I have given in my application for enlistment. If any of that information is false or incorrect, this enlistment may be voided or terminated administratively by the Government or I may be tried by a Federal, civilian, or military court and, if found guilty, may be punished.

I CERTIFY THAT I HAVE CAREFULLY READ THIS DOCUMENT. ANY QUESTIONS I HAD WERE EXPLAINED TO MY SATISFACTION. I FULLY UNDERSTAND THAT ONLY THOSE AGREEMENTS IN SECTION B OF THIS DOCUMENT OR RECORDED ON THE ATTACHED ANNEX(ES) WILL BE HONORED. ANY OTHER PROMISES OR GUARANTEES MADE TO ME BY ANYONE ARE WRITTEN BELOW: (If none, X "NONE" and initial.)

☒ NONE DDM (Initials of enlistee/reenlistee)

b. SIGNATURE OF ENLISTEE/REENLISTEE

Daniel Dennis Merwin

c. DATE SIGNED (YYYYMMDD)

20051013

14. SERVICE REPRESENTATIVE CERTIFICATION

a. On behalf of the United States (list branch of service) NAVY, I accept this applicant for enlistment. I have witnessed the signature in item 13b to this document. I certify that I have explained that only those agreements in Section B of this form and in the attached Annex(es) will be honored, and any other promises made by any person are not effective and will not be honored.

b. NAME (Last, First, Middle)

BROWN BRYAN C

c. PAY GRADE

E-6

d. UNIT/COMMAND NAME

USN RECRUITING DISTRICT

e. SIGNATURE

B. Brown

f. DATE SIGNED

(YYYYMMDD)

20051013

g. UNIT/COMMAND ADDRESS (City, State, ZIP Code)

PITTSBURGH

PA 15222

E. CONFIRMATION OF ENLISTMENT OR REENLISTMENT

15. IN THE ARMED FORCES EXCEPT THE NATIONAL GUARD (ARMY OR AIR):

I, DANIEL DENNIS MERWIN, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.

16. IN THE NATIONAL GUARD (ARMY OR AIR):

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the State of _____ against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the Governor of _____ and the orders of the officers appointed over me, according to law and regulations. So help me God.

17. IN THE NATIONAL GUARD (ARMY OR AIR):

I do hereby acknowledge to have voluntarily enlisted/reenlisted this _____ day of _____, in the _____ National Guard and as a Reserve of the United States (list branch of service) _____ with membership in the _____ National Guard of the United States for a period of _____ years, _____ months, _____ days, under the conditions prescribed by law, unless sooner discharged by proper authority.a

18a. SIGNATURE OF ENLISTEE/REENLISTEE

X Daniel Dennis Merwin

b. DATE SIGNED (YYYYMMDD)

20051013

19. ENLISTMENT/REENLISTMENT OFFICER CERTIFICATION

a. The above oath was administered, subscribed, and duly sworn to (or affirmed) before me this date.

b. NAME (Last, First, Middle)

FEIGHT WESLEY L

c. PAY GRADE

O-4

d. UNIT/COMMAND NAME

HARRISBURG MEPS

e. SIGNATURE

Wesley L. Feight

f. DATE SIGNED

(YYYYMMDD)

20051013

g. UNIT/COMMAND ADDRESS (City, State, ZIP Code)

MECHANICSBURG

PA 17055-4843



NAME OF ENLISTEE/REENLISTEE (Last, First, Middle) MERWIN DANIEL DENNIS		SOCIAL SECURITY NO OF ENLISTEE/REENLISTEE [REDACTED]	
F. DISCHARGE FROM DELAYED ENTRY/ENLISTMENT PROGRAM			
20a. I request to be discharged from the Delayed Entry/Enlistment Program (DEP) and enlisted in the Regular Component of the United States (list branch of service) <u>NAVY</u> for a period of <u>4</u> years and <u>00</u> weeks. No changes have been made to my enlistment options OR if changes were made they are recorded on Annex(es) <u>NA</u> which replace(s) Annex(es) <u>NA</u> .			
b. SIGNATURE OF DELAYED ENTRY/ENLISTMENT PROGRAM ENLISTEE <i>Daniel Dennis Merwin</i>		c. DATE SIGNED (YYYYMMDD) 20051101	
G. APPROVAL AND ACCEPTANCE BY SERVICE REPRESENTATIVE			
21. SERVICE REPRESENTATIVE CERTIFICATION			
a. This enlistee is discharged from the Reserve Component shown in item 8 and is accepted for enlistment in the Regular Component of the United States (list branch of service) <u>NAVY</u> in pay grade <u>E-1</u> .			
b. NAME (Last, First, Middle) BROWN BRYAN C	c. PAY GRADE E-6	d. UNIT/COMMAND NAME USN RECRUITING DISTRICT	
e. SIGNATURE <i>B. Brown</i>	f. DATE SIGNED (YYYYMMDD) 20051101	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) PITTSBURGH PA 15222	
H. CONFIRMATION OF ENLISTMENT OR REENLISTMENT			
22a. IN A REGULAR COMPONENT OF THE ARMED FORCES:			
I, <u>DANIEL DENNIS MERWIN</u> , do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.			
b. SIGNATURE OF ENLISTEE/REENLISTEE <i>Daniel Dennis Merwin</i>		c. DATE SIGNED (YYYYMMDD) 20051101	
23. ENLISTMENT OFFICER CERTIFICATION			
a. The above oath was administered, subscribed, and duly sworn to (or affirmed) before me this date.			
b. NAME (Last, First, Middle) WILLIAMS THEODORE	c. PAY GRADE O-3	d. UNIT/COMMAND NAME HARRISBURG MEPS	
e. SIGNATURE <i>Theodore Williams</i>	f. DATE SIGNED (YYYYMMDD) 20051101	g. UNIT/COMMAND ADDRESS (City, State, ZIP Code) MECHANICSBURG PA 17055-4843	



History of Assignments

[illegible]

Name(Last,first,Middle)
MERWIN,DANIEL DENNIS

Social Security Number

Rank/Rate
ABH3

NAVPERS 1070/605

Official NSIPS/ESR form printed this date 03/18/2009.

Page 1 of 1

AR 3451

HISTORY OF ASSIGNMENTS											
				10	31						
1. GAIN	2. ACTIVITY	3. UIC	4. LOSS	5. INITIALS							
				GAIN	LOSS						
ENL 000413	MEPS <i>Hamisburgh, Ph</i>		TRF 000413	<i>↓</i>	<i>↓</i>						
TEM DU 000413	NAVCRUITRACOM GREAT LAKES IL	30646	TRF 06 JAN 04	<i>↓</i>	<i>↓</i>						
TEM DU 06 JAN 04	NATTC PCOLA EL	39431	TRF 06 MAR 10	<i>WAS</i>	<i>↓</i>						
DUTY 06 APR 11	USS ESSEX LHD 2 HP: SASEBO, JA	SDCD? 06 APR PRD: 09 APR 21533		GA							
DUTY 09 JUL 27	NIOC PENSACOLA	41976	DISRE 09 OCT 29		<i>SE</i>						
<i>RECORDED</i>											
						Name (Last, first, middle initial)		SOCIAL SECURITY NUMBER		BRANCH/CLASS	
MERWIN, DANIEL D		R20060411		11							

[illegible]

ADMINISTRATIVE REMARKS
NAVPERS 1070/613

SHIP OR STATION: LHD 2 ESSEX

SUBJECT: SEA DUTY COUNTER

Permanent: Yes

Authority: OIC PSD SASEBO

04/04/2009 SEA DUTY COUNTER STOPPED THIS DATE.J. E. ASSADIQ, PS2(AW), USN
TRF SUP BY DIR4/4/2009

DANIEL DENNIS MERWIN

Witnessed:

MERWIN,DANIEL DENNIS

NAME (Last, First Middle)

MERWIN,DANIEL DENNIS

SOCIAL SECURITY NUMBER

BRANCH AND CLASS

USN

Official NSIPS/ESR form printed this date 03/18/2009.

ENLISTMENT GUARANTEES

MERWIN DANIEL DENNIS

NAME (LAST, FIRST, MIDDLE JR.ETC)

SSN

1. **ACKNOWLEDGEMENT:** In connection with my enlistment into the United States Navy, I hereby acknowledge that:

- a. I am enlisting into the U.S. Navy for an active duty period of four years and, at the same time, I agree to extend my enlistment for N/A months to meet the obligations of the N/A program.
I am enlisting with the following guarantees and understandings:
- b. Upon enlistment, I will be enlisting under the provisions of Commander, Navy Recruiting Command Instruction 1130.8 option or options as indicated below:

Option (1) AVIATION BOATSWAIN'S MATE (HANDLING) CLASS "A" SCHOOL GUARANTEE (4YO/SG-ABH)

Option (2) N/A

Option (3) N/A

Option (4) N/A

2. I understand that I must be fully qualified at all times throughout my obligated service for all security, professional, military, physical, psychological and academic requirements of the options guaranteed in section 1b and that my eligibility will be rechecked during recruit training and periodically throughout my enlistment.
3. The Navy will enroll me in the training specified above. If during the periodic reviews of my eligibility, I am found no longer eligible for the options listed in 1b above because of information I provided in my enlistment application; because of a physical or psychological disqualification, or because of some reason that is not due to my fault, negligence, or conduct. I may only choose one of the following options:
- a. Reassignment to an "A" school for which I am qualified and a vacancy exists, or
b. Navy apprentice training for which I am qualified and a vacancy exists.

In any event, the Navy may, at its option, choose to discharge me.

4. If I am not enrolled in the training guarantee specified in section 1b above because of some reason that is due to my own fault, negligence or conduct or if I am disenrolled from it for and other reason not specified in paragraph 3, then I lose that guarantee and at the Navy's option remain subject to continued naval service. I also understand:
- a. If I am retained, I may be required to serve the rest of my enlistment. If given accelerated advancement, post-apprentice training, or an enlistment/reenlistment bonus, I may incur additional service as required by regulation.
b. The Navy may, at its option, discharge me in accordance with law and regulation.
5. I certify that I have read and received a copy of the Classifier Rating/Program Fact Sheet for the Rating/Program for which I am enlisting, and the Statement of Understand required for Option(s) (1). I understand the obligations for the Options and training that I will receive DDM.
(applicant's initials)

R. E. CARR, ECI(SW), USN, BYDIRCO 2005-10-13
(Signature of Enlisting Officer)/Date

Daniel Dennis Merwin
DANIEL DENNIS MERWIN 2005-10-13
(Signature of Enlistee)/Date

ENLISTED QUALIFICATIONS HISTORY

1. EDUCATIONAL EXPERIENCE LEVEL

GED (HS EQUIVALENT TEST)			COLLEGE LEVEL GENERAL EXAMS			PRESENT LEVEL OF EDUCATION						
DATE ISSUE	ISSUING STATE	INIT	DATE PASSED	INIT		12	13	14	15	16	17	

2. CLASSIFICATION/ASVAB TESTING QUALIFICATIONS

TEST FORM ID	DATE ADMIN	AFQT	GS	AR	WK	PC	MK	EI	AS	MC	AOR	VE	CS
01E	12-OCT-05	55	61	51	51	50	56	56	56	56	52	50	0

ASVAB ADMINISTERED BY: MEPS HARRISBURG, PA

SPECIAL TEST SCORES

NAME	FORM	DATE	SCORE
DLAB			
NFQT			

CLASSIFIER'S SIGNATURE: M. L. GORE, PS1(SS), USN

3. RECORD OF OFF-DUTY EDUCATION/VOC/TECH TRAINING AND NON-REQUIRED CORRESPONDENCE COURSES

NUMBER/TITLE OF COURSE OR TEST	SCHOOL	DATE COMPLETED	GRADE	INIT	NUMBER/TITLE OF COURSE OR TEST	SCHOOL	DATE COMPLETED	GRADE	INIT

4. OTHER TRAINING COURSES/INSTRUCTIONS

DATE COMPLETED	TYPE OF COURSE AND/OR INSTRUCTION	DURATION	LOCATION	INIT
05DEC30	(A-950-0001) RECRUIT TRAINING (BMT)	8 WEEKS	RTC GREAT LAKES IL	JER
06JAN05	(A-950-0006) NAVY STUDENT INDOC	1 DAY	NATTC PENSACOLA FL	JER
06JAN09	(A-950-0080) PERSONNEL FINANCIAL MANAGEMENT	2 DAYS	NATTC PENSACOLA FL	JER
06JAN11	(J-495-0413) SHIPBOARD AIRCRAFT FIREFIGHTING	1 DAY	NATTC PENSACOLA FL	JER
06JAN26	(C-100-2021) AVIONICS FUNDAMENTALS	1 WEEK	NATTC PENSACOLA FL	JER

NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

BRANCH AND CLASS

MERWIN, DANIEL DENNIS

USN

NAVPERS 1070/604 (Rev 7/91)
S/N 0106-LF-12-2500

5. NAVY SERVICE SCHOOLS/MILITARY TRAINING COURSES

COURSE TITLE/SCHOOL ABH A1 SCHOOL NATTC PNCLA (C-822-2010)		NEC NA	DATE ENROLLED/COMPLETED 060214/060310		COURSE TITLE/SCHOOL		NEC	DATE ENROLLED/COMPLETED /	
COURSE LENGTH 4 WEEKS	GRADE SAT	MANNER OF COMPLETION <input checked="" type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED		INIT JEN	COURSE LENGTH	GRADE	MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED		INIT
COURSE TITLE/SCHOOL		NEC	DATE ENROLLED/COMPLETED /		COURSE TITLE/SCHOOL		NEC	DATE ENROLLED/COMPLETED /	
COURSE LENGTH	GRADE	MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED		INIT	COURSE LENGTH	GRADE	MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED		INIT

6. CORRESPONDENCE COURSES REQUIRED FOR ADVANCEMENT

DESCRIPTION OF COURSE RATE OR NAVPERS NUMBER	DATE COMPLETED	INIT	DESCRIPTION OF COURSE RATE OR NAVPERS NUMBER	DATE COMPLETED	INIT

7. NAVY ENLISTED CLASSIFICATIONS

PRIMARY CODE	SECONDARY CODE	DATE	INIT
DG 9760	0000	05NOV01	JEN
0000	0000	06MAR10	JEN

8. PERSONNEL ADVANCEMENT REQUIREMENTS

DESCRIPTION	DATE COMPLETED	INIT

9. ENLISTED RATE/RATING

RATE	DATE	TIME IN RATE	INIT
AR	05NOV01	05NOV01	JEN
AA	05DEC30	06JAN01	JEN
ABHAA	06MAR10	06JAN01	JEN

10. DESIGNATOR RATING

DATE	DESIGNATOR	QUAL/ REVOCATION	INIT

NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

BRANCH AND CLASS

MERWIN, DANIEL DENNIS

USN

NAVPERS 1070/604 (Rev 7/91)

S/N 0106-LF-12-2500

11. AWARDS

[illegible]

NAVPERS 1070/604 (Rev 7/91)
S/N 0106-LF-12-2500



TRAINING EDUCATION AND QUALIFICATION HISTORY

PQS

DATE	PQS STATION#	PQS TITLE
11/27/08	43901-4 301	ENLISTED SURFACE WARFARE SPECIALIST (ESWS), UNIT SPECIFIC FOR LHD CLASS
11/27/08	43901 301	ENLISTED SURFACE WARFARE SPECIALIST (ESWS) COMMON CORE
11/12/08	43397-D 306	PETTY OFFICER OF THE WATCH (POOW)
03/14/08	43397-D 305	MESSENGER OF THE WATCH (MOOW)
03/10/08	43902-16 301	EAWS, UNIT SPECIFIC FOR LPH/LHA/LHD/ MCS AVIATION CLASS
10/15/07	43119-J 306	BASIC DAMAGE CONTROL (DC)
11/17/06	43241-H 302	REPAIR PARTS/SUPPLY PETTY OFFICER
11/01/06	43523-B 301	CRAFTSMAN
10/19/06	43434-1C 305	TOWER OPERATOR
10/10/06	43434-1C 307	SPOTTING DOLLY OPERATOR
07/31/06	43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS
07/31/06	43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENSE
07/31/06	43119-I 303	BASIC FIREFIGHTING
07/31/06	43119-I 302	BASIC FIRST AID
07/31/06	43119-I 304	FIRE WATCH STANDER
07/31/06	43119-I 306	BASIC DAMAGE CONTROL (DC)
07/30/06	43119-I 302	BASIC FIRST AID
07/30/06	43119-I 303	BASIC FIREFIGHTING
07/30/06	43119-I 306	BASIC DAMAGE CONTROL (DC)
07/30/06	43119-I 304	FIRE WATCH STANDER
07/30/06	43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENSE
07/30/06	43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS
06/11/06	43241-H 301	MAINTENANCE PERSON
06/08/06	43434-1C 304	AIRCRAFT ELEVATOR OPERATOR
05/23/06	43434-1C 303	CONFLAGRATION STATION OPERATOR
05/20/06	43434-1C 302	SOUND-POWERED TELEPHONE TALKER/OPERATOR
05/17/06	43434-1C 301	CHOCK AND CHAIN HANDLER
05/14/06	43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER
05/13/06	43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER

NAME (Last, First, Middle)

MERWIN, DANIEL DENNIS

SOCIAL SECURITY NUMBER

[REDACTED]

BRANCH AND CLASS

USN

Page: 3 of 3

NAVPERS 1070/881

AR 3460

CLASSIFIED INFORMATION NONDISCLOSURE AGREEMENT**AN AGREEMENT BETWEEN**

Daniel D. Merwin

AND THE UNITED STATES*(Name of Individual - Printed or typed)*

1. Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to classified information. As used in this Agreement, classified information is marked or unmarked classified information, including oral communications, that is classified under the standards of Executive Order 12958, or under any other Executive order or statute that prohibits the unauthorized disclosure of information in the interest of national security; and unclassified information that meets the standards for classification and is in the process of a classification determination as provided in Sections 1.2, 1.3, and 1.4(e) of Executive Order 12958, or under any other Executive order or statute that requires protection for such information in the interest of national security. I understand and accept that by being granted access to classified information, special confidence and trust shall be placed in me by the United States Government.

2. I hereby acknowledge that I have received a security indoctrination concerning the nature and protection of classified information, including the procedures to be followed in ascertaining whether other persons to whom I contemplate disclosing this information have been approved for access to it, and that I understand these procedures.

3. I have been advised that the unauthorized disclosure, unauthorized retention, or negligent handling of classified information by me could cause damage or irreparable injury to the United States or could be used to advantage by a foreign nation. I hereby agree that I will never divulge classified information to anyone unless: (a) I have officially verified that the recipient has been properly authorized by the United States Government to receive it; or (b) I have been given prior written notice of authorization from the United States Government Department or Agency (hereinafter Department or Agency) responsible for the classification of the information or last granting me a security clearance that such disclosure is permitted. I understand that if I am uncertain about the classification status of information, I am required to confirm from an authorized official that the information is unclassified before I may disclose it, except to a person as provided in (a) or (b), above. I further understand that I am obligated to comply with laws and regulations that prohibit the unauthorized disclosure of classified information.

4. I have been advised that any breach of this Agreement may result in the termination of any security clearances I hold; removal from any position of special confidence and trust requiring such clearances; or the termination of my employment or other relationships with the Departments or Agencies that granted my security clearance or clearances. In addition, I have been advised that any unauthorized disclosure of classified information by me may constitute a violation, or violations, of United States criminal laws, including the provisions of Sections 641, 793, 794, 798, *952 and 1924, Title 18, United States Code, * the provisions of Section 783(b), Title 50, United States Code, and the provisions of the Intelligence Identities Protection Act of 1982. I recognize that nothing in this Agreement constitutes a waiver by the United States of the right to prosecute me for any statutory violation.

5. I hereby assign to the United States Government all royalties, remunerations, and emoluments that have resulted, will result or may result from any disclosure, publication, or revelation of classified information not consistent with the terms of this Agreement.

6. I understand that the United States Government may seek any remedy available to it to enforce this Agreement including, but not limited to, application for a court order prohibiting disclosure of information in breach of this Agreement.

7. I understand that all classified information to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of the United States Government unless and until otherwise determined by an authorized official or final ruling of a court of law. I agree that I shall return all classified materials which have, or may come into my possession or for which I am responsible because of such access: (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me a security clearance or that provided me access to classified information; or (c) upon the conclusion of my employment or other relationship that requires access to classified information. If I do not return such materials upon request, I understand that this may be a violation of Section 793 and/or 1924, Title 18, United States Code, a United States criminal law.


8. Unless and until I am released in writing by an authorized representative of the United States Government, I understand that all conditions and obligations imposed upon me by this Agreement apply during the time I am granted access to classified information, and at all times thereafter.

9. Each provision of this Agreement is severable. If a court should find any provision of this Agreement to be unenforceable, all other provisions of this Agreement shall remain in full force and effect.

(Continue on reverse.)



10. These restrictions are consistent with and do not supersede, conflict with or otherwise alter the employee obligations, rights or liabilities created by Executive Order 12958; Section 7211 of Title 5, United States Code (governing disclosures to Congress); Section 1034 of Title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); Section 2302(b)(8) of Title 5, United States Code, as amended by the Whistleblower Protection Act (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that expose confidential Government agents), and the statutes which protect against disclosure that may compromise the national security, including Sections 641, 793, 794, 798, 952 and 1924 of Title 18, United States Code, and Section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. Section 783(b)). The definitions, requirements, obligations, rights, sanctions and liabilities created by said Executive Order and listed statutes are incorporated into this Agreement and are controlling.

11. I have read this Agreement carefully and my questions, if any, have been answered. I acknowledge that the briefing officer has made available to me the Executive Order and statutes referenced in this Agreement and its implementing regulation (32 CFR Section 2003.20) so that I may read them at this time, if I so choose.

SIGNATURE 	DATE 08 FEB 08	SOCIAL SECURITY NUMBER (See Notice below) [REDACTED]
--	-------------------	--

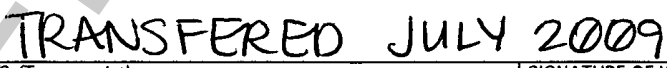
ORGANIZATION (IF CONTRACTOR, LICENSEE, GRANTEE OR AGENT, PROVIDE: NAME, ADDRESS, AND, IF APPLICABLE, FEDERAL SUPPLY CODE NUMBER)
(Type or print)

USS ESSEX (LHD-2)
OPS/OZ
FPO, AP 96643-1661

WITNESS		ACCEPTANCE	
THE EXECUTION OF THIS AGREEMENT WAS WITNESSED BY THE UNDERSIGNED.		THE UNDERSIGNED ACCEPTED THIS AGREEMENT ON BEHALF OF THE UNITED STATES GOVERNMENT.	
SIGNATURE 	DATE 08 FEB 08	SIGNATURE  TSC	DATE 08 FEB 08
NAME AND ADDRESS (Type or print) Clement W. Herron Jr USS ESSEX (LHD-2) OPS/OZ FPO, AP 96643-1661		NAME AND ADDRESS (Type or print) Michael J. Allen ISC (SW/AW) USS ESSEX (LHD-2) OPS/OZ FPO, AP 96643-1661	

SECURITY DEBRIEFING ACKNOWLEDGEMENT

I reaffirm that the provisions of the espionage laws, other federal criminal laws and executive orders applicable to the safeguarding of classified information have been made available to me; that I have returned all classified information in my custody; that I will not communicate or transmit classified information to any unauthorized person or organization; that I will promptly report to the Federal Bureau of Investigation any attempt by an unauthorized person to solicit classified information, and that I (have) (have not) (strike out inappropriate word or words) received a security debriefing.

SIGNATURE OF EMPLOYEE 	DATE
NAME OF WITNESS (Type or print) TRANSFERED JULY 2009	SIGNATURE OF WITNESS

NOTICE: The Privacy Act, 5 U.S.C. 552a, requires that federal agencies inform individuals, at the time information is solicited from them, whether the disclosure is mandatory or voluntary, by what authority such information is solicited, and what uses will be made of the information. You are hereby advised that authority for soliciting your Social Security Account Number (SSN) is Executive Order 9397. Your SSN will be used to identify you precisely when it is necessary to 1) certify that you have access to the information indicated above or 2) determine that your access to the information indicated has terminated. Although disclosure of your SSN is not mandatory, your failure to do so may impede the processing of such certifications or determinations, or possibly result in the denial of your being granted access to classified information.

* NOT APPLICABLE TO NON-GOVERNMENT PERSONNEL SIGNING THIS AGREEMENT.

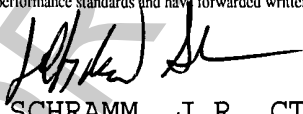
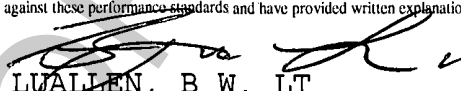
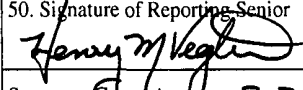
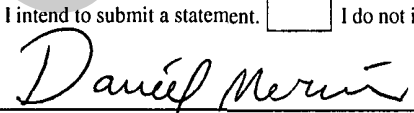
STANDARD FORM 312 BACK (Rev. 1-00)

AR 3462

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig SW/AW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> TAR <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 41976		7. Ship/Station NIOC PENSACOLA FL			8. Promotion Status REGULAR		9. Date Reported 09JUL27	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>			Period of Report 14. From: 09APR05 15. To: 10MAR15							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>			20. Physical Readiness P/WS		21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) VEGTER, H M			23. Grade LCDR		24. Desig 1610		25. Title XO		26. UIC 46828	
									27. SSN [REDACTED]	
28. Command employment and command achievements. Provides Computer Network Operations (CNO) expertise in support of Navy, National and Joint requirements in the areas of Digital Network Intelligence and Computer Network Defense. Awarded 2009 Retention Excellence Award.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DNEA Digital Network Exploitation Analyst-8. Performs global network analysis, target development, and network topology mapping. WATCH: JOOD-8. LV/TRVL: 09APR05-09MAY04. TEMDUINS: 09MAY05-09JUL26.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>Daniel Merwin</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	-	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	-	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	-	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	-	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	-	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	-	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.					

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN2		3. Desig SW/AW		4. SSN [REDACTED]									
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards					
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>		- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.		- <input type="checkbox"/>		- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		- <input type="checkbox"/>		- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.					
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices		- <input type="checkbox"/>		- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		- <input type="checkbox"/>		- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.					
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.43		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) EIDWS				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  SCHRAMM, J R, CTNC Date: 15 MAR 10									
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Petty Officer Merwin has excellent technical abilities and consistently produces exceptional work. - Devoted 30 hours performing research, analysis, and mapping of two high interest targets, accounting for three percent of the Command's reporting for 2009. Efforts supported the execution of enhanced interactive operations, enabled defined target development in support of National agencies and enhanced COCOM's ability to combat chemical, biological, and nuclear proliferation. - Dedicated 75 working days to qualifying on three operational JQRs; completing all three ahead of schedule, and resulted in an eight percent increase in division readiness. - Recognized expert. Hand selected to participate in the Command's inaugural Enlisted Information Dominance Warfare Specialist (EIDWS) qualification group. - Dedicated five hours towards one fundraising event supporting the Command Holiday Party. Efforts helped raise over \$530 and reduced ticket prices for this annual event. Petty Officer Merwin is off to a good start for a promising young CTN2!															
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. Awarded NA. Completed three operational JQRs. Earned 9305 NEC.															
Promotion Recommendation		NOB		Significant Problems		Progressing		Promotable		Must Promote		Early Promote		47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>	
45. INDIVIDUAL		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		48. Reporting Senior Address NAVIOCOM PENSACOLA 475 JONES ST, CORRY STATION PENSACOLA FL 32511-5204	
46. SUMMARY		<input checked="" type="checkbox"/>		1		0		5		23		8			
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  LUALLEN, B W, LT Date: 11 MAR 10						50. Signature of Reporting Senior  Summary Group Average: 3.78 Date: 10 MAR 10									
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 16 MAR 10						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:									

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 10-81)
S/N 0106-LF-010-6991

E-32

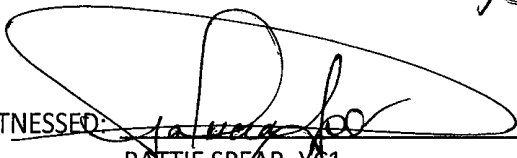
SHIP OR STATION

PERSONNEL SUPPORT DETACHMENT, 421 SAUFLEY STREET SUITE B, PENSACOLA FL 32508-5202

2009OCT30: I hereby acknowledge and agree that I have the duty, as explained below to establish and maintain an account with a United States financial institution for the direct deposit of my Navy net pay and allowances. I understand that I am required to execute the appropriate form at my disbursing office to ensure that my Navy net pay and allowances are deposited directly into this account. I understand that I may freely choose or change U.S. financial institutions to satisfy this requirement. I understand that I will continue to have the duty to maintain such an account for deposit of my navy net pay and allowances as long as I am on active or reserve duty, unless I receive specific exemption from maintaining such an account in the absence of a specific exemption may subject me to administrative and/or disciplinary action under the Uniform Code of Military Justice.


Daniel D. Merwin

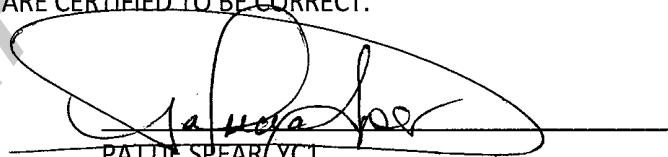
WITNESSED:


PATTIE SPEAR, YC1
MILPERSURV, BYDIR

2009OCT30: Date of reenlistment: Reenlisted this date for 6 years.

Statement of prior service: 2005NOV01 – 2009OCT29
2009OCT30 – PRESENT

THE ABOVE ENTRIES ARE CERTIFIED TO BE CORRECT.


PATTIE SPEAR, YC1
MILPERSUSPV, BYDIR

NAME (Last, First, Middle)	SSN	BRANCH AND CLASS
MERWIN, DANIEL DENNIS		USN

IMMEDIATE REENLISTMENT CONTRACT

NAME: **MERWIN,DANIEL DENNIS** SSN: [REDACTED] BR/CL: **USN**

FIRST: I am reenlisting in the ☒ UNITED STATES NAVY ☐ NAVAL RESERVE for **6** years from **10/30/2009**, unless sooner discharged by proper authority. My new contract expiration date is **10/29/2015**.

SECOND: I have read and understand the following SECTION OF TITLE 10 OF THE UNITED STATES CODE:

SECTION 5540 OF TITLE 10 OF THE UNITED STATES CODE; "(a) The senior officer present afloat in foreign waters shall send to the United States by Government or other transportation as soon as possible each enlisted member of the naval service who is serving on a naval vessel, whose term of enlistment has expired, and who desires to return to the United States. However, when the senior officer present afloat considers it essential to the public interest, he may retain such a member on active duty until the vessel returns to the United States. (b) Each member retained under this section: (1) shall be discharged not later than 30 days after arrival in the United States; and (2) except in time of war is entitled to an increase in basic pay of 25 percent. (c) The substance of this section shall be included in the enlistment contract of each person enlisting in the naval service."

THIRD: I understand that I may be extended on, or ordered to active duty for the duration of any war or national emergency declared by Congress, and for six months thereafter, and that my agreed period of active service may be extended as otherwise authorized by law.

FOURTH: I have had this contract fully explained to me, I understand it, and certify that no promise of any kind has been made to me concerning assignment to duty, geographical area, schooling, special programs, assignment of government quarters, or transportation of dependents except as indicated:

REENLISTING FOR SRB; ZONE A; AWARD LEVEL 3.5

UIC: 41976 STATUS: ACTIVE ☒ INACTIVE RADO MONTHS/DAYS: 000 / 000 DOB: [REDACTED] 985

PLACE OF REENLISTMENT: NIOC PENSACOLA FL HOME OF RECORD: BETHLEHEM, PA

CITIZENSHIP: US CITIZEN COUNTRY: RATE: CTN3 DATE OF PAYGRADE: 09/16/2007

ADSD: 11/01/2005 PEBD: 11/01/2005 DATE LAST DISCHARGE: 10/29/2009 LSL SELLBACK: 00.0

TOTAL ACTIVE SERVICE: 03 / 11 / 29 YEARS/MONTHS/DAYS TOTAL PRIOR INACTIVE SERVICE: 00 / 00 / 00 YEARS/MONTHS/DAYS

"OATH OF ENLISTMENT: "I, **DANIEL DENNIS MERWIN**, do solemnly swear (or affirm) that I will support and defend the constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same, and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulation and the Uniform Code of Military Justice. So help me God. I swear (or affirm) that I am fully aware and fully understand the conditions under which I am enlisting."

*** SIGNATURE OF REENLISTEE

FIRST

MIDDLE

LAST

Subscribed and sworn before me on this 30th day of October, A.D. 2009

SIGNATURE
AND GRADE:
TITLE:

K. STEELE, LTJG, USN

OFFICIAL

Reenlisting Officer Name and Rank

MISSION MANAGER

[illegible]

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 10-81)
S/N 0106-LF-010-6991

E-32

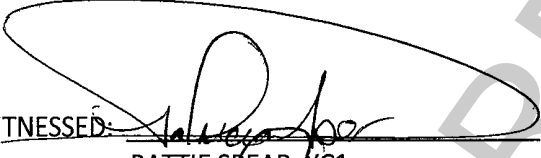
SHIP OR STATION

PERSONNEL SUPPORT DETACHMENT, 421 SAUFLEY STREET SUITE B, PENSACOLA FL 32508-5202

2009OCT30: I understand that continued entitlement to unpaid Selective Reenlistment Bonus (SRB) installments may be terminated and a pro-rated portion of advance bonus payments, including lump sum payments, will be recouped if I am considered not technically qualified in the bonus rating/NEC designator because I am no longer classified in that rating/NEC, the rating/NEC is removed from my records, and current and further assignment in that military specialty is precluded from any of the following reasons within my control:

- (1) Should I refuse to perform certain duties for effective performance in the military specialty when I have volunteered for such duties in writing prior to accepting the bonus.
- (2) Should disciplinary action be taken under the Uniform Code of Military Justice (UCMJ) or upon court conviction when such action renders me unqualified for future performance in the military specialty; or
- (3) Should I have withdrawal of the minimum-security clearance, loss of qualification under the Personnel Reliability Program (PRP), or loss of any other mandatory qualification required for effective performance in the military specialty, when such withdrawal or loss is voluntary or caused by my own misconduct, and results in removal from the military specialty.


WITNESSED:


PATTIE SPEAR, YC1
MILPERSUPV, BYDIR


Daniel D. Merwin

2009OCT30: Reenlisted this date. Entitled to SRB based on the CTN rating, SRB Zone A. The total SRB entitlement is \$46,821.59. First installment of \$23,410.79 will be paid by direct deposit to my account upon confirmation or reenlistment. Member has acknowledged that approval of advance of remaining amount payment is not automatic but depends on funds available and hardship relative to others requesting similar payment.

WITNESSED:


PATTIE SPEAR, YC1
MILPERSUPV, BYDIR


Daniel D. Merwin

NAME (Last, First, Middle)

SSN

BRANCH AND CLASS

MERWIN, DANIEL DENNIS

USN

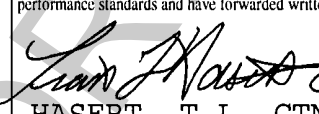
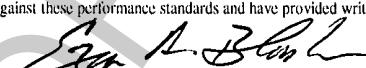
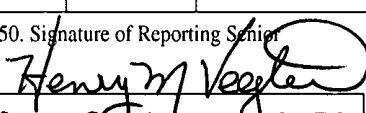
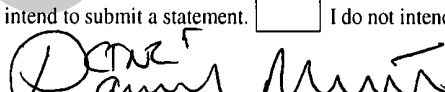
U.S. Government Printing Office: 1985-605-009/26675 2-1

13

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 41976		7. Ship/Station NIOC PENSACOLA FL			8. Promotion Status REGULAR		9. Date Reported 09JUL27		
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>			Period of Report 14. From: 10MAR16 15. To: 11MAR15								
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>			20. Physical Readiness PP		21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) VEGTER, H M			23. Grade LCDR		24. Desig 1810		25. Title XO		26. UIC 46828		
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28. Command employment and command achievements. Provides Computer Network Operations (CNO) expertise in support of Navy, National, and Joint requirements in the areas of Digital Network Intelligence (DNI) and Computer Network Defense (CND). Awarded Meritorious Unit Commendation and 2010 Retention Excellence Award.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) ASST TEAM LEAD Digital Network Exploitation Analyst (DNEA) Assistant Team Lead-12. Led three Sailors performing global network analysis, target development, and network topology mapping. WATCH: OOD-11; JOOD-1. PFA: 10-1/10-2.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled 10SEP15		31. Counselor KAVENEY, S D		32. Signature of Individual Counseled <i>Daniel Merwin</i> 18 MAR 15			
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
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		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>		- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.		- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>		- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.		- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>		- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
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		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
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		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>		- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.		- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>		- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.		- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>		- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	- <input type="checkbox"/>	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		- <input checked="" type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices	- <input type="checkbox"/>	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		- <input checked="" type="checkbox"/>	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="3.86"/>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) SPECIAL WARFARE ION PROGRAM			42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0.  HASERT, T L, CTNCS Date: 18 MAR 11		
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Petty Officer Merwin has proven himself to be the go-to technical expert at the Command! - Led three Sailors conducting over 3K hours of research, analysis, and production, reviewing over 70K files from 476 queries and 154 router configurations. Efforts resulted in the release of two network topology maps and eight high value informal reports in support of one Information Need and overseas contingency operations. - As a recognized target expert, provided over 15 mission production and development briefs to multi-force audiences including VIPs from TENTHFLT, NSA, MARFORCYBER, USSTRATCOM, NCDOD, Chief Of Naval Operations Staff and 68 Junior Intelligence Officers. - As an SME, dedicated over 400 hours of research and training to the development of the Command's EIDWS program. Instrumental in the qualification of 11 other SMEs and accreditation of the Command's program which was lauded by the Force Master Chief as "one of the best I've seen to date!" - A dedicated trainer, provided 47 hours of Command wide training to 32 Sailors, covering three sections of the EIDWS Personal Qualification Standard. An exceptional leader with unsurpassed technical knowledge and analytical ability, Petty Officer Merwin is ready for the challenges of a PO1!!							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. Qualified EIDWS. Completed two operational JQRS. Volunteered 13 hours Holiday Party Committee beer booth, three hours Command picnic, three hours BRACE event.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL					X		48. Reporting Senior Address NAVIOCOM PENSACOLA
46. SUMMARY	<input checked="" type="checkbox"/>	0	1	18	18	10	475 JONES ST, CORY STATION PENSACOLA, FL 32511-5204
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0.  BLANCHE, E A, LT Date: 15 MAR 11				50. Signature of Reporting Senior  Summary Group Average: 3.70 Date: 15 MAR 11			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 18 MAR 11				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

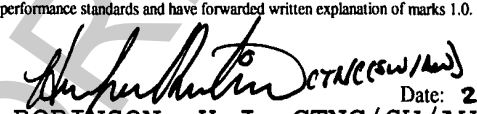

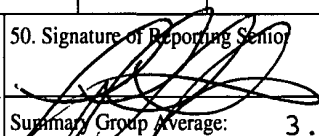
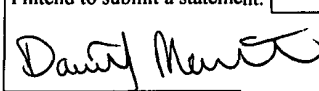
EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

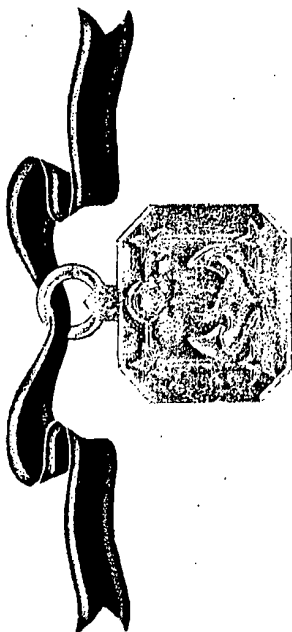
1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 46828		7. Ship/Station NIOC PENSACOLA FL			8. Promotion Status REGULAR		9. Date Reported 09JUL27	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 11MAR16 15. To: 12MAR15						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness PP		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) LAWRENCE, L S			23. Grade LCDR		24. Desig 1810		25. Title XO		26. UIC 46828	
									27. SSN [REDACTED]	
28. Command employment and command achievements. Provides Computer Network Operations (CNO) expertise in support of Navy, National, and Joint requirements in the areas of Digital Network Intelligence (DNI) and Computer Network Defense (CND).										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) SENIOR ANALYST Digital Network Exploitation Analyst (DNEA) Senior Analyst-5; Team Lead-7. Led five teams operationally performing global network analysis, target development, and network topology mapping. COLL: ACFL-12; CTT-9. WATCH: OOD-12. PFA: 11-1/11-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet, sign 32.)				30. Date Counseled 11SEP15		31. Counselor ROBINSON, H J		32. Signature of Individual Counseled <i>Daniel Merwin</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application NOB <input type="checkbox"/>	- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.	- <input type="checkbox"/>	- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.	- <input type="checkbox"/>	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction <input checked="" type="checkbox"/>					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.	- <input type="checkbox"/>	- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.	- <input checked="" type="checkbox"/>	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources. <input type="checkbox"/>					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	- <input type="checkbox"/>	- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	- <input checked="" type="checkbox"/>	- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths. <input type="checkbox"/>					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input type="checkbox"/>	- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	- <input checked="" type="checkbox"/>	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT. <input type="checkbox"/>					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.	- <input type="checkbox"/>	- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.	- <input checked="" type="checkbox"/>	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs. <input type="checkbox"/>					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont 'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D			2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]				
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro-gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results NOB <input type="checkbox"/>		- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.		- <input type="checkbox"/>		- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		- <input type="checkbox"/>		- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices		- <input type="checkbox"/>		- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations - Clear, timely communicator. - Ensures safety of personnel and equipment.		- <input type="checkbox"/>		- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.86		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ION				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0.  ROBINSON, H J, CTNC (SW/AW) Date: 25 FEB 12					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. ***MY #10 OF 64 HIGHLY COMPETITIVE SECOND CLASS PETTY OFFICERS*** CTN2 MERWIN IS A LEADER COMMITTED TO FURTHERING MISSION AND SAILORIZATION COMMAND WIDE. - TECHNICAL LEADER. Led five teams conducting 130,000 hours of research, analysis, and production leading to the release of 29 DNI reports and additional high value command tasking. Directly responsible for the addition and production of network diagrams filling a critical need for National agencies. - EXEMPLARY TRAINER. As a Command Training Team member, he provided training to 103 command members in Navy Pride and Professionalism. As an Enlisted Information Dominance Warfare Specialist Subject Matter Expert, he provided 106 hours of training directly contributing to the qualification of 23 command members. - COMMAND INVOLVED. As an Assistant Command Fitness Leader, he assisted with more than 124 hours of command physical training, nine mock, and six Physical Fitness Assessments resulting in a 98 percent command pass rate for 2011. A HARD CHARGING SAILOR WITH AN UNPARALLELED LEVEL OF INITIATIVE AND DEDICATION!											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. AWARDED: NAM (2ND). QUAL: DNEA. COMP: ANSK 2020, NETA 2002, NETA 2008, Navy Operational Fitness and Fueling Series (NOFFS), Command Training Team Indoc. VOL: COMREL events 20hrs.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>				
45. INDIVIDUAL						X	48. Reporting Senior Address NAVICOM PENSACOLA 475 JONES ST, CORRY STATION PENSACOLA, FL 32511-5204				
46. SUMMARY		0	0	20	21	11					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0.  HOWARD, E B, LCDR Date: 28 FEB 12						50. Signature of Reporting Senior  Summary Group Average: 3.51 Date: 29 FEB 12					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 29 FEB 11						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

PRIVACY SENSITIVE



DEPARTMENT OF THE NAVY

THIS IS TO CERTIFY THAT
THE SECRETARY OF THE NAVY HAS AWARDED THE

NAVY AND MARINE CORPS ACHIEVEMENT MEDAL

(GOLD STAR IN LIEU OF SECOND AWARD)

TO
CRYPTOLOGIC TECHNICIAN NETWORKS SECOND CLASS (INFORMATION DOMINANCE WARFARE) DANIEL D. MERWIN
UNITED STATES NAVY
FOR

PROFESSIONAL ACHIEVEMENT AS A DIGITAL NETWORK EXPLOITATION ANALYST AT NAVY INFORMATION OPERATIONS COMMAND PENSACOLA, FLORIDA FROM 01 MARCH 2011 TO 01 JUNE 2011. PETTY OFFICER MERWIN'S LEADERSHIP, TECHNICAL EXPERTISE, AND PERSONAL INITIATIVE WERE ESSENTIAL TO THE SUCCESSFUL ESTABLISHMENT OF AN ONGOING INTELLIGENCE AND TECHNICAL RESEARCH SUPPORT RELATIONSHIP WITH COMMANDER TASK FORCE 1050. HIS ACTIONS PROVIDED VITAL SIGHT SUPPORT TO CENTRAL COMMAND, U.S. CYBER COMMAND, FLEET CYBER COMMAND, AND U.S. TENTH FLEET FOR PLANNING, SIGNIFICANTLY IMPROVING SITUATIONAL AWARENESS, ENABLING NATIONAL AUTHORITIES TO MAKE VITAL DECISIONS SUPPORTING FUTURE OPERATIONS PLANNING. PETTY OFFICER MERWIN'S EXCEPTIONAL PROFESSIONALISM AND SELFLESS DEVOTION TO DUTY REFLECTED CREDIT UPON HIM AND WERE IN KEEPING WITH THE HIGHEST TRADITIONS OF THE UNITED STATES NAVAL SERVICE.

GIVEN THIS 28TH DAY OF February 2012



FOR THE SECRETARY OF THE NAVY
S. R. HERITAGE
COMMANDER, UNITED STATES NAVY
COMMANDING OFFICER

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265		6. UIC 46828		7. Ship/Station NIOC PENSACOLA FL			8. Promotion Status REGULAR		9. Date Reported 09JUL27	
Occasion for Report 10. Periodic <input type="checkbox"/> 11. Detachment of Individual <input checked="" type="checkbox"/> 12. Promotion/Frothing <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 12MAR16 15. To: 12JUL30						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness P		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) LAWRENCE, L S			23. Grade LCDR		24. Desig 1810		25. Title XO		26. UIC 46828	
									27. SSN [REDACTED]	
28. Command employment and command achievements. Provides Computer Network Operations (CNO) expertise in support of Navy, National, and Joint requirements in areas of Digital Network Intelligence (DNI) and Computer Network Defense (CND).										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) [TEAM LEAD] Digital Network Exploitation Analyst (DNEA) Team Lead-4. Led four Sailors operationally performing global network analysis, target development, and network topology mapping. COLL: ACFL-4; CTT-4. WATCH: OOD-4. PFA: 12-1.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Couseled NOT REQ		31. Counselor		32. Signature of Individual Couseled [Signature]		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

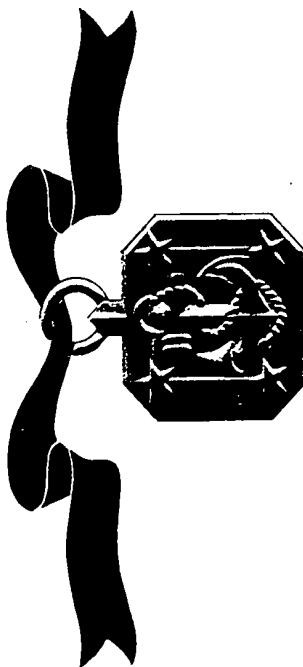
EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]			
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>		- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.		- <input type="checkbox"/>		- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		- <input type="checkbox"/>		- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices.		- <input type="checkbox"/>		- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations. - Clear, timely communicator. - Ensures safety of personnel and equipment.		- <input type="checkbox"/>		- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 4.00		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ION				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. <i>Robert H. Robinson</i> Date: 12 JUL 12 ROBINSON, H J, CTNC (SW/AW)					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. EVALUATION SUBMITTED UPON MEMBER'S TRANSFER TO NIOC MARYLAND. TECHNICAL FRONT RUNNER AND VITAL TEAM LEADER DURING TENURE AT NIOC PENSACOLA. HIS ABSENCE WILL BE NOTICED. - TECHNICALLY DRIVEN. Led four personnel and dedicated 720 hours conducting research and analysis on 3,000 data files. Efforts resulted in release of two serialized reports and two digital network topology diagrams supporting national priorities. - NATURAL LEADER. Led from the front for 10 command physical training sessions, facilitated one mock Physical Fitness Assessment (PFA), and facilitated one official command PFA cycle, resulting in a 93 percent overall passing rate. - COMMAND INVOLVED. Provided 80 hours of Enlisted Information Dominance Warfare Specialist training, directly resulting in the EIDWS qualification of 11 command members. Provided four hours of Navy Pride and Professionalism training to newly arrived personnel. SUPERB LEADER AMONGST HIS PEER GROUP AND A TEACHER TO SUPERIORS. DEDICATED SAILOR WHO IS FOCUSED ON MISSION AND ON GETTING THE JOB DONE WELL. HE WILL BE A WELCOME ASSET AT ANY COMMAND!											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>				
45. INDIVIDUAL						X	48. Reporting Senior Address NAVICOM PENSACOLA 475 JONES ST, CORRY STATION PENSACOLA, FL 32511-5204				
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	0	1	49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. <i>E. B. Howard</i> Date: 12 JUL 12 HOWARD, E B, LCDR				
50. Signature of Reporting Senior <i>[Signature]</i> Date: 18 JUL 12 Summary Group Average: 4.00						51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> <i>Daniel Merwin</i> Date: 18 JUL 12					
52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:											

PRIVACY SENSITIVE

31-May-2012



DEPARTMENT OF THE NAVY

THIS IS TO CERTIFY THAT

THE SECRETARY OF THE NAVY HAS AWARDED THE

NAVY AND MARINE CORPS ACHIEVEMENT MEDAL

(GOLD STAR IN LIEU OF THIRD AWARD)

TO

CRYPTOLOGIC TECHNICIAN NETWORKS SECOND CLASS (INFORMATION DOMINANCE WARFARE) DANIEL D. MERWIN
 UNITED STATES NAVY
 FOR

PROFESSIONAL ACHIEVEMENT AS A TEAM LEAD AT NAVY INFORMATION OPERATIONS COMMAND PENSACOLA, FLORIDA FROM JULY 2009 THROUGH JULY 2012. PETTY OFFICER MERWIN LED 26 SAILORS IN THE PROSECUTION OF FOUR HIGH PRIORITY TARGETS RESULTING IN THE RELEASE OF 52 DIGITAL NETWORK INFORMATION REPORTS, NETWORK DIAGRAMS, AND TIPPERS DIRECTLY SUPPORTING MULTIPLE COMBATANT COMMANDERS AND NATIONAL LEVEL CUSTOMER INITIATIVES. AS A PLANKOWNER OF THE COMMAND'S ENLISTED INFORMATION DOMINANCE WARFARE SPECIALIST PROGRAM, HE SHAPED ITS IMPLEMENTATION AND DEDICATED 586 HOURS OF RESEARCH AND TRAINING RESULTING IN THE QUALIFICATION OF 55 SAILORS. PETTY OFFICER MERWIN'S EXCEPTIONAL PROFESSIONALISM AND SELFLESS DEVOTION TO DUTY REFLECTED CREDIT UPON HIM AND WERE IN KEEPING WITH THE HIGHEST TRADITIONS OF THE UNITED STATES NAVAL SERVICE.



GIVEN THIS 31ST DAY OF May 2012

FOR THE SECRETARY OF THE NAVY

S. R. HERITAGE
 COMMANDER, UNITED STATES NAVY
 COMMANDING OFFICER

AR 3476

DEPENDENCY APPLICATION/RECORD OF EMERGENCY DATA

MEMBER INFORMATION

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS
RANK/RATE: CTN2 BR/CL: USN UIC: 41976 RELIGION: NO
SHIP OR STATION: NIOC PCOL/CYBDE INITIAL/CHANGE: I
EFFECTIVE DATE: 11/01/2005 TOTAL NUMBER OF DEPENDENTS: 0
PREVIOUSLY MARRIED: NO MARRIAGE DISSOLVED BY:
DISSOLVED ON: PLACE DISSOLVED:

SPOUSE INFORMATION

NAME: DEPENDENT:
DATE OF BIRTH: CITIZENSHIP: RELATIONSHIP:
DATE MARRIED: PLACE OF MARRIAGE:
ADDRESS:
PREVIOUSLY MARRIED: MARRIAGE DISSOLVED BY:
DISSOLVED ON: PLACE DISSOLVED:
MEMBER OF UNIFORMED SERVICES: DUTY AFFILIATION:
BRANCH: COMPONENT:

SPOUSE NEXT OF KIN

NAME: RELATIONSHIP:
ADDRESS:

FATHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
EFFORT, PA [REDACTED]

MOTHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

OTHER PERSON, NOT ALREADY NAMED TO BE NOTIFIED OF PERSONAL CASUALTY

NAME: NONE RELATIONSHIP
ADDRESS:

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS

BENEFICIARY(IES) FOR UNPAID PAY AND ALLOWANCES

NAME: [REDACTED] RELATIONSHIP: MOTHER
ADDRESS: [REDACTED] LEXINGTON, SC [REDACTED] PERCENTAGE: 100%

PERSON(S) TO RECEIVE ALLOTMENT IF IN A MISSING STATUS, SUBJECT TO SECNAV DETERMINATION

NAME: [REDACTED] RELATIONSHIP: MOTHER
ADDRESS: [REDACTED] LEXINGTON, SC [REDACTED] PERCENTAGE: 100%

BENEFICIARY(IES) FOR GRATUITY PAY

NAME: [REDACTED] RELATIONSHIP: Mother
ADDRESS: [REDACTED] LEXINGTON, SC [REDACTED] PERCENTAGE: 100%

LIFE INSURANCE INFORMATION

COMPANY: NONE POLICY NUMBER:
ADDRESS:

LOCATION OF WILL

ADDRESS: NONE

LOCATION OF OTHER VALUABLE PAPERS

ADDRESS: NONE

PNOK (Name - Relationship - Phone - Address)

[REDACTED] Mother, [REDACTED]
[REDACTED] LEXINGTON, SC [REDACTED]

SNOK (Name - Relationship - Phone - Address)

[REDACTED] Father, 000-000-0000, 000-000-0000 [REDACTED] EFFORT, PA
[REDACTED]

IS BENEFICIARY DESIGNATION OF SGLI ON FILE? YES DESIGNATION DATE: 09/17/2009

REMARKS

PADD: [REDACTED] RELATIONSHIP: Mother
ADDRESS: [REDACTED]
NAVPERS 1070/602

Page: 2 of 3

SSN: [REDACTED] NAME: MERWIN, DANIEL DENNIS

Phone: LEXINGTON, SC [REDACTED]

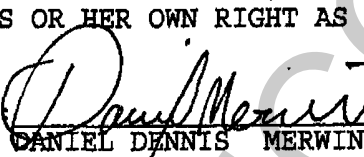
UPDATE DUE TO PCS TRANSFER. NO PAY CHANGES.

UPDATED BY: CINDY WILSON PSD PENSACOLA FLORIDA
DATE: 30 JULY 2012

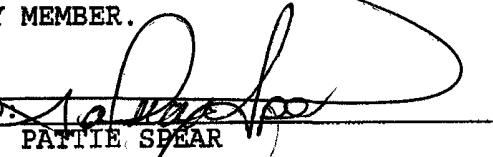
IT IS MY RESPONSIBILITY TO NOTIFY MY NAVY PERSONNEL OFFICE/SHIP'S OFFICE OR CSD/PSD IF THERE IS A CHANGE IN MY ASSIGNMENT TO QUARTERS THAT MAY AFFECT MY BAH ENTITLEMENTS THAT MAY RESULT IN AN OVER/UNDER PAYMENT.

CERTIFICATION: I HAVE REVIEWED THE DATA ON THIS FORM AND CERTIFY THAT IT IS CORRECT. I UNDERSTAND THAT ANY CHANGE IN MY FAMILY MEMBER STATUS MUST BE REPORTED AS A CHANGE TO THE DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS) WITHIN 60 DAYS. THIS INCLUDES SERVICE MEMBERS IN A JOINT SERVICE MARRIAGE (MILITARY MARRIED TO MILITARY), EVEN THOUGH EACH SPOUSE IS ALREADY ENROLLED IN DEERS IN HIS OR HER OWN RIGHT AS A MILITARY MEMBER.

SIGNATURE OF DESIGNATOR:


DANIEL DENNIS MERWIN

WITNESSED:


PATTIE SPEAR

DATE: 30 July 12

TITLE: HUMAN RESOURCE SUPER

Official NSIPS/ESR form printed this date 30-JUL-2012


Prudential

 Office of Servicemembers'
Group Life Insurance

**Servicemembers' Group Life Insurance
Election and Certificate**
1. About You

Daniel D Merwin

Print Name (First, Middle, Last)

NIOC Maryland

Duty Location

E5

Rank, title or grade

Navy

Branch of Service

Social Security Number

400,000

Current Amount of SGLI

I am completing this form to: (Check all that apply)

- ☒ Name or update my SGLI beneficiary. You must complete sections 3 & 5.
- ☐ Increase or restore my SGLI coverage to \$. You must complete sections 3, 4, & 5.
- ☐ Reduce my SGLI coverage to \$. You must complete sections 3 & 5.
- ☐ Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5.

 Coverage is
available in
increments of
\$50,000 up to
a maximum
of \$400,000

3. About Your Beneficiaries Complete this section unless you are declining coverage

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts)	Payment Option (Lump sum* or 36 equal monthly payments)
Lexington SC		mother	40%	Lump sum
Bethlehem, PA		Step-Mother	30%	Lump sum
Effort, PA		father	10%	36 pmts
				Lump sum
Secondary PRIMARY + dm				
Gilbert, SC		Sister	10%	36 pmts
Phillipsburg, NJ		Sister	10%	36 pmts
				Lump sum
				Lump sum

☒ Have more beneficiaries? Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S.

If you do not name beneficiaries above, your insurance will be paid by law (see page 3).

*If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

Open Solutions Inc. is the Service Provider of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by UMB Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions Inc., UMB Bank, N.A., and First Data Payment Services are not Prudential Financial companies.

4. About Your Health *Complete this section ONLY if you are restoring or increasing coverage.*

[REDACTED] 1985

Your date of birth (MM, DD, YYYY)

150 Lbs

Your weight

5 FT 9 INCHES

Your height

Your gender ☐ Female
☒ Male**Have you had, been treated for, or had known indications of:**

- a. A heart condition?
- b. High blood pressure?
- c. A neurological disorder?
- d. Diabetes?
- e. Cancer or tumors?
- f. Have you ever been diagnosed as having a disease of the immune system?
- g. Do you have any known physical impairments, deformities, or ill health not covered above?

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.

Any request to increase coverage does not take effect until approved by OSGLI.

5. Your Signature *You must complete this section.***I have read the instructions and understand that:**

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and VGLI coverage at the same time, but the combined amount cannot be more than \$400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, Family SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. *Failure to register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

[Signature]
Service Member Signature[REDACTED]
Social Security Number07 27 2012
Date (MM, DD, YYYY)[REDACTED]
Address

[REDACTED] Hanover, MD [REDACTED]

For Branch of Service Use Only

Name of Personnel Clerk Velda A. Cunningham
Velda Cunningham
 Rank, title or grade
GG-07
 Contact telephone/email
850-452-0299/velda.cunningham@navy.mil
 Date
27 July 2012
 Address **475 Jones Street, Corry Station**
Pensacola, FL 32511-5204

For OSGLI Use Only

Representative

Approve ☐Disapprove ☐

Date



Prudential

Office of Servicemembers'
Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

1. About You

DANIEL D MURWIN

Print Name (First, Middle, Last)

ES

Rank, title or grade

Social Security Number

NIOC Maryland

Duty Location

USN

Branch of Service

2. About Your Coverage

I am completing this form to: (Check all that apply)

☒ Name or update my SGLI beneficiary. You must complete sections 3 & 5.

☐ Increase or restore my SGLI coverage to \$ _____ you must complete sections 3, 4, & 5.

☐ Reduce my SGLI coverage to \$ _____ you must complete sections 3 & 5.

☐ Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5.

"

"

Coverage is
available in
increments of
\$50,000 up to
a maximum
of \$400,000

3. About Your Beneficiaries Complete this section unless you are declining coverage

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts)	Payment Option (Lump sum* or 36 equal monthly payments)
1. [REDACTED] LEXINGTON, SC	[REDACTED]	MOTHER	40%	Lump sum
2. [REDACTED] DETROIT, MI	[REDACTED]	STEPMOTHER	30%	Lump sum
3. [REDACTED] EFFORT, PA	[REDACTED]	FATHER	10%	36 Payments
4. [REDACTED] GILBERT, SC	[REDACTED]	SISTER	10%	36 Payments

Secondary

1.

2.

3.

4.

☒ **Have more beneficiaries?** Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S
If you do not name beneficiaries above, your insurance will be paid by law (see page 3).

*If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

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4. About Your Health Complete this section *ONLY* if you are restoring or increasing coverage.

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender ☒ Female ☐ Male**Have you had, been treated for, or had known indications of:**

- a. A heart condition?
- b. High blood pressure?
- c. A neurological disorder?
- d. Diabetes?
- e. Cancer or tumors?
- f. Have you ever been diagnosed as having a disease of the immune system?
- g. Do you have any known physical impairments, deformities, or ill health not covered above?

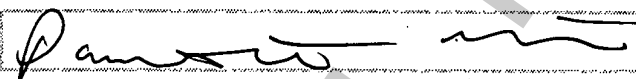

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>


Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.


Any request to increase coverage does not take effect until approved by OSGLI.

5. Your Signature You must complete this section.**I have read the instructions and understand that:**

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and VGLI coverage at the same time, but the combined amount cannot be more than \$400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, Family SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. *Failure to register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

Service Member Signature  Social Security Number  Date (MM, DD, YYYY) 2012

Current Amount of SGLI 400,000 Address HANOVER, MD 

For Branch of Service Use Only	For OSGLI Use Only
Name of Personnel Clerk 	Representative
Rank, title or grade UN3(10W) TOELLNER	Approve <input type="checkbox"/>
Contact telephone/email 301-677-0796	Disapprove <input type="checkbox"/>
Date 20120808	Date
Address 9800 SAVAGE RD FORT MEADE MD 20755	


Prudential

 Office of Servicemembers'
Group Life Insurance

Servicemembers' Group Life Insurance Supplemental SGLI Beneficiary Form
1. About You

Print Name (First, Middle, Last)

DANIEL D MERWIN

Rank, title or grade

E5

Social Security Number

[REDACTED]

Current Amount of SGLI Coverage

400,000

Duty Location

N16C MARLAND

Branch of Service

NAVY

2. About Your Beneficiaries

Date (month day year)

AUGUST 8TH 2012

The beneficiaries listed below are in addition to those listed on my completed SGLV 8286.

Primary

Name and Address

 Social Security Number
(If available)

 Relationship
to you

 Share
to each
(% or \$
amounts)

 Payment Option
(Lump sum* or
36 equal monthly
payments)

[REDACTED]

[REDACTED]

[REDACTED]

SISTER

100%

36 Lump sum

[REDACTED]

[REDACTED]

[REDACTED]

Secondary

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Service Member's Signature

[Signature]

Date: 8 AUG 12

* If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

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Prudential

 Office of Servicemembers'
Group Life Insurance

Servicemembers' Group Life Insurance Supplemental SGLI Beneficiary Form
1. About You

Print Name (First, Middle, Last)

DANIEL D MERRIN

Current Amount of SGLI Coverage

400,000

Rank, title or grade

E5

Social Security Number

Branch of Service

Duty Location

N10C MARLAND

NAVY

2. About Your Beneficiaries

Date (month day year)

AUGUST 8TH 2012

The beneficiaries listed below are in addition to those listed on my completed SGLV 8286.

Primary

Name and Address

 Social Security Number
(If available)

 Relationship
to you

 Share
to each
(% or \$
amounts)

 Payment Option
(Lump sum* or
36 equal monthly
payments)

[Redacted]

[Redacted]

[Redacted]

SISTER

100%

36 Lump sum

[Redacted]

[Redacted]

[Redacted]

Secondary

[Redacted]

[Redacted]

[Redacted]

[Redacted]

Service Member's Signature

[Signature]

Date

8 AUG 12

* If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

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EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ <input type="checkbox"/> 265		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 12AUG07	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 12JUL31 15. To: 13MAR15						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness P			21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) LIND, R J			23. Grade CDR		24. Desig 1810		25. Title XO		26. UIC 62936	
							27. SSN [REDACTED]			
28. Command employment and command achievements. Conducts information operations, provides cryptologic and intelligence information to Fleet combatants/shore commands, and supports USFLTCYBERCOM/C10F and NSA/CSS. Naval District Washington Service Program of the Year Award 2012.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) [SUPPORT DEPT] Command Support Division-7: Provides command support to include grounds maintenance, building upkeep and support to several highly visible command programs. Temporarily assigned to Support Department while awaiting access to NSA/CSS. COLL: Command Training Team-4. WATCH: OOD-7. LV/TVL: 12JUL30-12AUG06. PFA: 12-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 12SEP15		31. Counselor GUTIERREZ, B R		32. Signature of Individual Counseled <i>Daniel Merwin</i>		

PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.

PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN2		3. Desig IDW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	- - -	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		- - -	-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	- - - - - -	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		- - - - - -	-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.86	41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ION SPECIAL PROGRAMS		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. [Signature] CTIC (IDW/SG) Date: 11 MAR 13 PURVIS, J O, CTIC (IDW/SG)				
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Petty Officer Merwin is a highly motivated leader committed to training and physical readiness of peers, subordinates, and superiors. - Led a team of 30 Sailors responsible for base and barracks enhancement including room renovations, painting, and all maintenance of outdoor Command areas and equipment, resulting in improved quality of life for BEQ residents and first impressions of NIOC Maryland. - Provided Navy Pride and Professionalism (NR&R) training to 120 Sailors; efforts raised awareness of Command and Navy regulations, benefits, and standards. - Facilitated 66 hours of IDW training and line item signatures for 60 Sailors. Efforts directly contributed to better preparation for their boards and future qualifications. - Revamped the N53 division PT program in an effort to improve the division's overall physical readiness and PFA pass rate. - Mentored 60 Sailors, providing counseling on career progression, physical training, education, and Naval tradition in an effort to produce a more disciplined and informed workforce. Petty Officer Merwin has proven himself as a vital member of the Command. He has my HIGHEST recommendation for advancement to PO1!							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. AWARDED: NA(3rd). COMPLETED: PO1SLC. QUALIFIED: OOD.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL					X		48. Reporting Senior Address EXECUTIVE OFFICER NAVICOM MARYLAND FT MEADE, MD 20755-5290
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	126	126	63	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. [Signature] GOODWIN, J L, LT Date: 12 MAR 13					50. Signature of Reporting Senior [Signature] 1 COR USN Date: 07 MAR 13 Summary Group Average: 3.64		
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> [Signature] DANIEL MERWIN Date: 15 MAR 13					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:		

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]	
5. ACT <input checked="" type="checkbox"/>		FTS <input type="checkbox"/>		INACT <input type="checkbox"/>		AT/ADSW/ 265		6. UIC 62936	
7. Ship/Station NIOC MARYLAND				8. Promotion Status FROCKED		9. Date Reported 12AUG07			
Occasion for Report 10. Periodic <input checked="" type="checkbox"/>				Detachment 11. of Individual <input type="checkbox"/>		Promotion/ 12. Frocking <input type="checkbox"/>		13. Special <input type="checkbox"/>	
Period of Report 14. From: 13MAR16				15. To: 12NOV15		16. Not Observed Report <input type="checkbox"/>			
Type of Report 17. Regular <input checked="" type="checkbox"/>				18. Concurrent <input type="checkbox"/>		20. Physical Readiness PP		21. Bmer Subcategory (if any) NA	
22. Reporting Senior (Last, FI MI) ELAM, D E				23. Grade CAPT		24. Desig 1810		25. Title CO	
26. UIC 62936				27. SSN [REDACTED]					
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.									
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) [TEAM LEAD] Lead Digital Network Exploitation Analyst-8. Leads 8 Sailors in conducting network mapping and target research in support of USCYBERCOM, C10F, C6F, NAVEUR and NAVAF. COLL: Division Mentor-7, Command Training Team-7, ACFL-6. WATCH: OOD-7. PFA: 13-1/13-2.									
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 13MAY15		31. Counselor SCHRAMM, J R		32. Signature of Individual Counseled	
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.									
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards				
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.				
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.				
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.				
36. MILITARY BEARING/ CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.				
37. PERSONAL JOB ACCOMPLISHMENT/ INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.				

NAVPER 1616/26 (08-10) FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

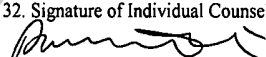
RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro-gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		- <input type="checkbox"/> - <input type="checkbox"/> - <input checked="" type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	- <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		- <input type="checkbox"/> - <input type="checkbox"/> - <input checked="" type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/>	-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 2.86		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) SPECIAL PROGRAMS LPO		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. [Signature] Date: SCHRAMM, J R, CTNC (IDW)			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. An energetic, leader who is mission-focused and dedicated. - Technical leader. Led eight Sailors in conducting research and analysis on more than 100,000 pieces of information. Tipped 59 significant items for further analysis resulting in the release of 20 tactical reports supporting afloat commanders in the C6F AOR. - Driven. Analyzed workflow for division of 20 Sailors and implemented refinements to processes including knowledge management, task tracking, and training. Resulted in a 45% increase in efficiency by removing duplication of effort among analysts. - Provided 15 hours of mentorship to 10 Sailors on career progression, evaluation writing, and education opportunities. Efforts resulted in four Sailors enrolling in college and seeking more leadership opportunities and collateral duties. - Subject matter expert. As a Command Training Team Member, provided 200 man hours of Navy Pride and Professionalism training to incoming command members. - Led and mentored two ACFs in conducting physical training, nutrition counseling, and testing. Efforts included 48 hours of physical training, and one mock PFA. Failed to re-qualify EIDWS within 12 months required. Subsequently re-qualified.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: 1 NCS course. EDUCATION: ECON103, LIBS150, CMIT139, CMIS102 (10 Semester Hours)							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL				X			48. Reporting Senior Address COMMANDING OFFICER NAVIOMC MARYLAND FT MEADE, MD 20755-5290
46. SUMMARY	X	0	0	14	15	8	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. [Signature] SEARS, J D, CDR				50. Signature of Reporting Senior [Signature] Date: 18NOV13 Summary Group Average: 3.10			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input type="checkbox"/> CERTIFIED COPY PROVIDED Date:				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

NAVPERS 1616/26 (08-10) FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE




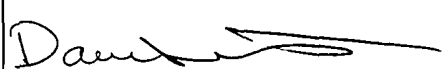
EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 12AUG07		
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 13NOV16 15. To: 14NOV15							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness PP		21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) ELAM, D E				23. Grade CAPT		24. Desig 1810		25. Title CO		26. UIC 62936	
								27. SSN [REDACTED]			
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) [DIVISION LPO] Division LPO-8. Leads 23 Sailors conducting cyberspace operations to include reconnaissance, surveillance, and target acquisition, block, and counter against imminent or hostile cyber activity. Network Exploitation Analyst (NEA)-8. COLL: Command Training Team (CTT)-12. WATCH: OOD-12. PFA: 14-1/14-2.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 14MAY15		31. Counselor SCILEPPI, R W			32. Signature of Individual Counseled 		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>		-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.		-		-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.		-		-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>		-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.		-		-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.		-		-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>		-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.		-		-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.		-		-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>		-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>		-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.		-		-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.		-		-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	- Creates conflict, unwilling to work with others, puts self above team. - Fails to understand team goals or teamwork techniques. - Does not take direction well.	<input type="checkbox"/>	- Reinforces others' efforts, meets commitments to team. - Understands goals, employs good teamwork techniques. - Accepts and offers team direction.		<input type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices.	<input type="checkbox"/>	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful, realistic goals that support command mission. - Performs well in stressful situations. - Clear, timely communicator. - Ensures safety of personnel and equipment.		<input type="checkbox"/>	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.86		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) ION LDO		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  LEITNER, R C, CTNC (IDW) Date: 14NOV19			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Exceptional leader, already performing as Chief Petty Officer. Constantly strives to meet bigger challenges and achieve more innovative feats for betterment of Sailors and mission. - Deckplate leader. Led 22 Sailors encompassing three workcenters, resulted in 100% (2/2) retention, 100% (22/22) PFA pass rate, 100% (2/2) advancement rate, 23 career development boards, four college enrollments and one certification. - Lead analyst. Led eight analysts in over 140 hours of cyber operations and over 240 hours of analysis supporting USCYBERCOM priorities. Efforts led to collection of critical intelligence; increased target knowledge and expanded network access by 25%. - Mission focused. Completed 640 hours of classroom training and 245 hours of OJT to satisfy USCYBERCOM technical training requirements and qualified as Network Exploitation Analyst. Efforts directly contributed to newly established Navy Cyber Unit 12 reaching initial operational capability. - Brilliant on the Basics. Dedicated 32 hours teaching Navy Pride and Professionalism to over 400 Sailors during Command indoctrination; provided Naval heritage training to 12 Sailors bolstering service knowledge and promoting Navy pride. Consistently displays tenacious drive for mission success and unyielding passion for taking care of Sailors. Has my HIGHEST recommendation for advancement to Chief Petty Officer!							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: JACWC; NETW3004; COMP2050; COMP1000; CYBER3800; CYBER1100. QUALIFIED: NEA.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL					X		48. Reporting Senior Address COMMANDING OFFICER NAVIOCOM MARYLAND FT MEADE, MD 20755-5290
46. SUMMARY		14	0	189	118	61	
49. Signature of Senior Rater (Typed Name & Grade Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  LAWRENCE, L B, LCDR Date: 21NOV19					50. Signature of Reporting Senior  Summary Group Average: 3.49 Date: 14NOV19		
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 14NOV19					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:		


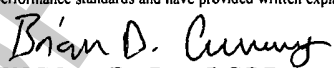
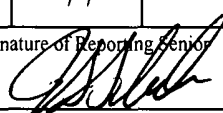
EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

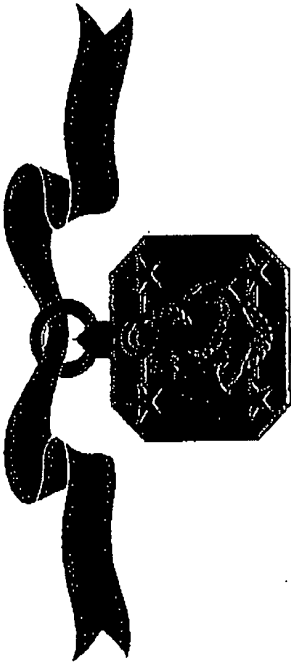
1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265 <input type="checkbox"/>		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 13JUL22	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 14NOV16 15. To: 15NOV15						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness PP			21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) SCHEIDT, J S			23. Grade CAPT		24. Desig 1810		25. Title CO		26. UIC 62936	
									27. SSN [REDACTED]	
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DNEA Digital Network Exploitation Analyst-5; Exploitation Analyst(EA)-7. COLL: Asst Dept DAPA-4. WATCH: OOD-12. Performs global network analysis, target development, and network topology mapping. TEMDUINS: 15MAR25-15APR22. PFA: 15-1/15-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 15MAY15		31. Counselor LEITNER, R C		32. Signature of Individual Counseled		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	- Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D			2. Rate CTN1		3. Desig IDW/SW		4. SSN [REDACTED]								
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards					
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>		-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.		-		-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		-		-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.					
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.		-		-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		-		-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.					
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.43		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) LPO SPECIAL PROGRAMS				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  Date: 8 JAN 16 LEITNER, R C, CTNC (IDW)									
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Talented FCPO performing at an advanced technical level. - Mission focused. Led more than 20 hours of interactive operations, conducted over 40 hours of analysis; efforts resulted in expanded capabilities and acquisition of critical intelligence in support of Cyber National Mission Force(CNMF) and national priorities. - Technical expert. Devoted over 80 hours to on-the-job training; qualified two weeks ahead of schedule as a Digital Network Exploitation Analyst and database auditor. Efforts led to greater impact in target development and increased mission capability by 15%. - Dedicated mentor. Provided 26 hours of mentorship for two junior Sailors on Navy career progression, short and long-term goals, and benefits of special programs. - Command involved. Facilitated 20 hours of training on identification of alcohol and substance abuse problems and available assistance programs to 100 Sailors leading to increased substance abuse knowledge and command DAPA program awareness. - Selfless volunteer. Dedicated 56 off-duty hours to organizing and personally transporting two junior Sailors to Alcoholic Anonymous(AA) meetings; ensured 100% AA meeting attendance for 28 sessions. Reclassified to DNEA work-role; failed to meet EA work-role qualification requirements. Recommended for advancement.															
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: Introduction to Python; CPO 365 Phase I PQS. QUALIFIED: DNEA.															
Promotion Recommendation		NOB		Significant Problems		Progressing		Promotable		Must Promote		Early Promote		47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>	
45. INDIVIDUAL								X						48. Reporting Senior Address COMMANDING OFFICER NAVICOM MARYLAND FT MEADE, MD 20755-5290	
46. SUMMARY		<input checked="" type="checkbox"/>		3		0		188		149		77			
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  Date: 7 Jan 2016 CUMMINGS, B D, LCDR										50. Signature of Reporting Senior  Summary Group Average: 3.51 Date: 12/14/2015					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input type="checkbox"/> CERTIFIED COPY PROVIDED Date:										52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

FOUO PRIVACY SENSITIVE: [REDACTED]



DEPARTMENT OF THE NAVY

NAVY AND MARINE CORPS ACHIEVEMENT MEDAL

THIS IS TO CERTIFY THAT
THE SECRETARY OF THE NAVY HAS AWARDED THE

(GOLD STAR IN LIEU OF FOURTH AWARD)

CRYPTOLOGIC TECHNICIAN NETWORKS FIRST CLASS (INFORMATION WARFARE) DANIEL D. MERWIN
UNITED STATES NAVY
FOR

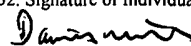
PROFESSIONAL ACHIEVEMENT AS 21 NATIONAL MISSION TEAM DIGITAL NETWORK EXPLOITATION ANALYST AT NAVY INFORMATION OPERATIONS COMMAND MARYLAND FROM AUGUST 2012 TO AUGUST 2016. PETTY OFFICER MERWIN LED SEVEN JOINT SERVICE ANALYSTS IN REVIEW OF 4,000 TECHNICAL DOCUMENTS, PRODUCING 180 INTELLIGENCE REPORTS AND SUCCESSFULLY CREATING 25 TAILORED DEFENSIVE CYBER OPTIONS FOR CYBER PROTECTION TEAMS. AS DIVISION LEADING PETTY OFFICER, HE LED 22 SAILORS ACROSS THREE WORKCENTERS ACHIEVING 100 PERCENT OF REQUIRED OPERATIONAL QUALIFICATIONS AND RESULTING IN FULL OPERATING CAPABILITY. ADDITIONALLY, HE DEDICATED 460 HOURS TO THE COMMAND TRAINING TEAM, ENHANCING PROFESSIONAL DEVELOPMENT OF MORE THAN 700 SAILORS. PETTY OFFICER MERWIN'S EXCEPTIONAL PROFESSIONALISM AND SELFLESS DEVOTION TO DUTY REFLECTED CREDIT UPON HIM AND WERE IN KEEPING WITH THE HIGHEST TRADITIONS OF THE UNITED STATES NAVAL SERVICE.

GIVEN THIS 16th DAY OF August, 2016




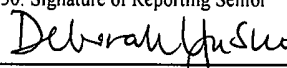

[Signature]

FOR THE SECRETARY OF THE NAVY
J/S. SCHEIDT
CAPTAIN, UNITED STATES NAVY
COMMANDING OFFICER

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ 265		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 13JUL22		
Occasion for Report 10. Periodic <input type="checkbox"/> 11. Detachment of Individual <input checked="" type="checkbox"/> 12. Promotion/ Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 15NOV16 15. To: 16SEP01							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness P			21. Billet Subcategory (if any) NA				
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title DIR HEAD		26. UIC 62936		
									27. SSN [REDACTED]		
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) CYBER ANALYST CYBER INTELLIGENCE ANALYST-11. Responsible for conducting research, analysis and multi-organization collaboration in support of USCYBERCOM. COLL: ASSISTANT DEPARTMENT DAPA-5. PFA: 16-1.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 15MAY16		31. Counselor KELLY, A J			32. Signature of Individual Counseled 		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>		- Marginal knowledge of rating, specialty or job. - Unable to apply knowledge to solve routine problems. - Fails to meet advancement/PQS requirements.		<input type="checkbox"/>		- Strong working knowledge of rating, specialty and job. - Reliably applies knowledge to accomplish tasks. - Meets advancement/PQS requirements on time.		<input type="checkbox"/>		- Recognized expert, sought out by all for technical knowledge. - Uses knowledge to solve complex technical problems. - Meets advancement/PQS requirements early/with distinction.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>		- Needs excessive supervision. - Product frequently needs rework. - Wasteful of resources.		<input type="checkbox"/>		- Needs little supervision. - Produces quality work. Few errors and resulting rework. - Uses resources efficiently.		<input type="checkbox"/>		- Needs no supervision. - Always produces exceptional work. No rework required. - Maximizes resources.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>		- Actions counter to Navy's retention/reenlistment goals. - Uninvolved with mentoring or professional development of subordinates. - Actions counter to good order and discipline and negatively affect Command/Organizational climate. - Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.		<input type="checkbox"/>		- Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. - Actions adequately encourage/support subordinates' personal/professional growth. - Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. - Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.		<input checked="" type="checkbox"/>		- Measurably contributes to Navy's increased retention and reduced attrition objectives. - Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. - Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. - The model of achievement. Develops unit cohesion by valuing differences as strengths.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>		- Consistently unsatisfactory appearance. - Poor self-control; conduct resulting in disciplinary action. - Unable to meet one or more physical readiness standards. - Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.		<input type="checkbox"/>		- Excellent personal appearance. - Excellent conduct conscientiously complies with regulations. - Complies with physical readiness program. - Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.		<input checked="" type="checkbox"/>		- Exemplary personal appearance. - Model of conduct, on and off duty. - A leader in physical readiness. - Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>		- Needs prodding to attain qualification or finish job. - Prioritizes poorly. - Avoids responsibility.		<input type="checkbox"/>		- Productive and motivated. Completes tasks and qualifications fully and on time. - Plans/prioritizes effectively. - Reliable, dependable, willingly accepts responsibility.		<input type="checkbox"/>		- Energetic self-starter. Completes tasks or qualifications early, far better than expected. - Plans/prioritizes wisely and with exceptional foresight. - Seeks extra responsibility and takes on the hardest jobs.	
		<input type="checkbox"/>		<input type="checkbox"/>				<input checked="" type="checkbox"/>		<input type="checkbox"/>	

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D		2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	-	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		-	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.	
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	-	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		-	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.	
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. 3.43		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) LPO SPECIAL PROGRAMS		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  Date: 01SEP16 SACZYNSKI, C T, CTCR (IW/EXW)			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Submitted upon transfer to 02 National Mission Team. Executing a local UIC swap. - Deckplate leader. Led seven joint-service analysts in the review of 4,000 technical documents which produced 180 intelligence reports. Production resulted in the creation of 25 tailored defensive cyber options for USCYBERCOM's Cyber Protection Teams (CPT). - Outstanding Sailor. Dedicated over 300 hours to the establishment of USCYBERCOM's operational planning team in support of multiple CPTs. Collaborated with multiple National Security Agency offices and Joint organizations to create over 25 Defensive Cyber Operations options for USCYBERCOM's J3, leading to seven TASKORDs directing CPT operations. - Subject matter expert. Developed procedures to respond to 347 requests for information. Efforts led to the review of 57,000 documents and identified 25 critical information gaps. - Devoted mentor. Provided 40 hours of computer network exploitation training to nine joint-service cyber analysts. Qualified 7 of 9 personnel, resulting in an 80 percent increase in qualified analysts. - Command impact. Dedicated 40 hours of training to 260 Sailors on the Command's drug and alcohol program. Additionally provided Chart the Course training to 84 Sailors within his department meeting fleet standards ahead of required deadline. Highly recommended for advancement to Chief Petty Officer.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: AREA1120.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input checked="" type="checkbox"/>
45. INDIVIDUAL						X	48. Reporting Senior Address COMMANDING OFFICER NAVICOM MARYLAND FT MEADE, MD 20755-5290
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	0	1	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. UNAVAILABLE CUMMINGS, B D, LCDR Date:				50. Signature of Reporting Senior  Date: 01SEP16 Summary Group Average: 3.43			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 01SEP16				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			



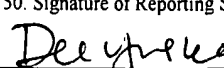

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ <input type="checkbox"/> 265		6. UIC 62936		7. Ship/Station NIOC MARYLAND			8. Promotion Status REGULAR		9. Date Reported 16SEP01	
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. Detachment of Individual <input type="checkbox"/> 12. Promotion/Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 16SEP02 15. To: 16NOV15						
16. Not Observed Report <input checked="" type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>		20. Physical Readiness P			21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title DIR HEAD		26. UIC 62936	
									27. SSN [REDACTED]	
28. Command employment and command achievements. To conduct cyber and information operations and provide cryptologic and related capability to fleet, joint and national commanders as well as support to all Department of the Navy members assigned to Fort Meade.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) DNEA DIGITAL NETWORK EXPLOITATION ANALYST-2. Provides digital network analysis and target development in support of USCYBERCOM and Cyber National Mission Force (CNMF) operations. PFA: 16-2.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>Daniel Merwin</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input checked="" type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input checked="" type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input checked="" type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct, physical fitness, adherence to Navy Core Values. NOB <input checked="" type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input checked="" type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]			
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB. <input checked="" type="checkbox"/>		-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.		-		-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		-		-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB. <input checked="" type="checkbox"/>		-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.		-		-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		-		-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="0.00"/>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific)				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  TRAYLOR, M R, CTNC (IW/EXW) Date: 12 Dec 16					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Member on board less than 90 days.											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input type="checkbox"/> Recommended <input type="checkbox"/>				
45. INDIVIDUAL	X						48. Reporting Senior Address COMMANDING OFFICER NAVIJCOM MARYLAND FT MEADE, MD 20755-5290				
46. SUMMARY	<input checked="" type="checkbox"/>	0	0	0	0	0					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  WORDEN, B P, LCDR Date: 9 Dec 16						50. Signature of Reporting Senior  Date: 28 Nov 16 Summary Group Average: <input type="text" value="0.00"/>					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 19 Dec 16						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

FOR OFFICIAL USE ONLY - PRIVACY SENSITIVE

BUPERS USE ONLY		P1343		BUPERS USE ONLY	
NOTIFICATION OF CHANGE IN SERVICE MEMBERS OFFICIAL RECORDS				1. DATE PREPARED 08/31/17	
2. NAME (LAST, FIRST, MIDDLE) MERWIN DANIEL DENNIS			3. GRADE/RATE CTN2	4. BRANCH & COMPONENT USN	
5. SSN [REDACTED]	6. [REDACTED]	7. DATE ENL/IND/COMM 151016	8. DATE OF BIRTH 85 [REDACTED]		
FROM: COMMANDER, BUREAU OF NAVAL PERSONNEL			9.		
COMMANDING OFFICER NAVY PERSONNEL COMMAND ATTN PERS CODE 312E 5720 INTEGRITY DRIVE MILLINGTON TN 38055			10.		
			11.		
THE FOLLOWING CHANGE HAS BEEN RECORDED IN THE OFFICIAL SERVICE RECORDS. APPROPRIATE RECORDS WILL BE CHANGED ACCORDINGLY.					
RECORD ITEM		CHANGED TO:			
12. NAME (LAST, FIRST, MIDDLE)		ANDERSON DANIEL			
13. [REDACTED]		[REDACTED]			
14. SSN		[REDACTED]			
15. DATE OF BIRTH		[REDACTED]			
16. PLACE OF BIRTH		[REDACTED]			
17. PRIOR SERVICE		[REDACTED]			
18. OTHER (SPECIFY)		[REDACTED]			
19. REASON AND AUTHORITY FOR CHANGE COURT ORDER			20. AUTHENTICATION JOSEPH JACKSON NSIPS/CDM CUSTOMER RELATIONS MANAGER		
21. COPY TO:					
DISTRIBUTION NUMBER - 01					
01.	02.	03.	04.	05.	06.
07.	08.	09.	10.	11.	12.
13.	14.	15.	16.	17.	18.
19.	20.	21.	22.	23.	24.
25.					

DD FORM 1343

REVISED 03/2015


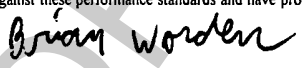
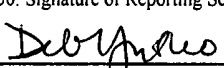
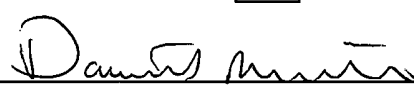
EVALUATION REPORT & COUNSELING RECORD (EI-E6)

RCS BUPERS 1610-1

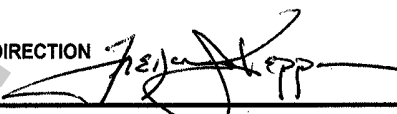
1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ 265		6. UIC 37700		7. Ship/Station CYBERSTRKACT 63			8. Promotion Status REGULAR		9. Date Reported 16SEP15	
Occasion for Report 10. Periodic <input type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input checked="" type="checkbox"/>				Period of Report 14. From: 16NOV16 15. To: 17JUL20						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness P		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title CO		26. UIC 37700	
							27. SSN [REDACTED]			
28. Command employment and command achievements. Provide and deploy trained personnel, expertise, and equipment to conduct Offensive and Defensive Cyberspace Operations in support of U.S. Cyber Command (USCYBERCOM) and the Cyber National Mission Force (CNMF) Defend the Nation missions.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) NWCP NETWORK WARFARE CYBER PLANNER-10. Creates and submits detailed cyber plans in support of 02 National Mission Team (02 NMT) and Cyber National Mission Force (CNMF) objectives. COLL: DEPT CAREER COUNSELOR-7; FULL SPEED AHEAD FACILITATOR-3. PFA: 17-1.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 17MAY15		31. Counselor FISHER, C M		32. Signature of Individual Counseled [Signature]		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) MERWIN, DANIEL D				2. Rate CTN1		3. Desig IW/SW		4. SSN [REDACTED]			
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>		-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well. <input checked="" type="checkbox"/>		<input type="checkbox"/>		-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction. <input type="checkbox"/>		<input type="checkbox"/>		-Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction. <input type="checkbox"/>	
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>		-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices. <input checked="" type="checkbox"/>		<input type="checkbox"/>		-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment. <input type="checkbox"/>		<input type="checkbox"/>		-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others. <input type="checkbox"/>	
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="1.86"/>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) NONE				42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  FISHER, C M, CTNC (IW/AW) Date: 1 AUG 17					
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Submitted upon member's reduction in rate to E-5. - Member found guilty at Commanding Officer's Nonjudicial Punishment held on 20 July 2017 for violation of UCMJ Article 92 (Violation of a Lawful General Regulation, two specifications). Concluding date: 27 July 2017. - Member relieved of all positions of leadership and trust, to include Department Career Counselor and Full Speed Ahead collaterals.											
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period.											
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input checked="" type="checkbox"/> Recommended <input type="checkbox"/>				
45. INDIVIDUAL		X					48. Reporting Senior Address COMMANDING OFFICER CYBERSTRKACT 63 9800 SAVAGE RD FT MEADE, MD 20755-6585				
46. SUMMARY	<input checked="" type="checkbox"/>	1	0	0	0	0					
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  WORDEN, B P, LCDR Date: 1 AUG 17						50. Signature of Reporting Senior  Date: 28 JUL 17 Summary Group Average: 1.86					
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 02 AUG 17						52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:					

COURT MEMORANDUM

1. DATE SUBMITTED: 17JUL21		2. SHIP OR STATION AND LOCATION: CSA SIXTY THREE		
3. DATE OF REFERRAL:		4. TYPE OF COURT: NJP		5. DATE OF COURT/MAST: 17JUL20
6. UCMJ ARTICLE(S): 92				
7. DATE OF ACTION: 17JUL20	<input checked="" type="checkbox"/> 8. TYPE OF ACTION & REPORT OF ACTION	<input type="checkbox"/> 9. MODIFICATION OF ACTION	<input type="checkbox"/> 10. CORRECTION TO PREVIOUS 1070/607	11. DATE OF ACTION ON 1070/607 MOD OR CORRECTION:
<input checked="" type="checkbox"/> 12. RATE ADJUSTMENT	13. FROM: CTN1		14. TO: CTN2	15. TIR: 17JUL20
<input checked="" type="checkbox"/> 16. FORFEITURE	17. MONTHLY AMOUNT: \$1606.00			18. NO. MONTHS: 2
<input type="checkbox"/> 19. FINE	20. AMOUNT:			<input type="checkbox"/> 21. CONSENT TO CHECKAGE:
<input type="checkbox"/> 22. DOES NOT CONSENT TO CHECKAGE		23. MO. AMT. OF CHECKAGE:		24. NO. MOS.:
<input type="checkbox"/> 25. DESERTION MARK REMOVED		<input type="checkbox"/> 26. ADJUDGED		<input type="checkbox"/> 27. ADJUDGED AND DISAPPROVED
PRE-TRIAL CONFINEMENT 28. FROM: 29. TO:		30. DAYS LOST TIME (30 DAY BASIS): 0		31. DAYS LOST TIME (DAY FOR DAY): 0
CONFINEMENT ORDERED AND COMPLETED 32. FROM: 33. TO:		34. DAYS LOST TIME (30 DAY BASIS): 0		35. DAYS LOST TIME (DAY FOR DAY): 0
36. CHANGE EAOS TO: _			37. CHANGE EXP. ENL. TO:	
38. (SYNOPSIS OF OFFENSE(S), DATE(S), AND SENTENCE ADJUDGED ALSO AMPLIFYING REMARKS, MAY BE CONTINUED ON REVERSE): CO'S NJP VUCMJ ART 92 (2 SPECS) SPEC 1 - VIOLATION OF US NAVY REG 1166 BY WRONGFULLY SEXUALLY HARASSING ONE CIVILIAN PERSONNEL AND ONE MILITARY E5. NJP AWD: FOP 1/2 MOS PAY X 2 MOS; REDUCTION IN RATE TO E5.				
39. DATE APPROVED/MODIFIED:			40. AUTHORITY TYPE:	
41.				
42. (SIGNATURE) BY DIRECTION  GRADE CIVILI FREDERIC J KEPPE				
43. UNIT I.D. CODE: 37700			44. RATE: CTN2	
45. NAME (LAST, FIRST, MIDDLE): MERWIN, DANIEL DENNIS		46. SSN: [REDACTED]		47. BRANCH/CLASS: USN

NAVPERS 1070/607 | Official NSIPS/ESR form printed this date: 07/27/2017

The data contained herein is protected by the Privacy Act of 1974. All measures required to protect this information should be taken.

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DEPENDENCY APPLICATION/RECORD OF EMERGENCY DATA

MEMBER INFORMATION

SSN: [REDACTED] NAME: ANDERSON, DANIEL
RANK/RATE: CTN2 BR/CL: USN UIC: 37700 RELIGION: NO
SHIP OR STATION: CSA SIXTY THREE INITIAL/CHANGE: C
EFFECTIVE DATE: 11/01/2005 TOTAL NUMBER OF DEPENDENTS: 2
PREVIOUSLY MARRIED: NO MARRIAGE DISSOLVED BY:
DISSOLVED ON: PLACE DISSOLVED:
SEX: M

SPOUSE INFORMATION

NAME: [REDACTED] DEPENDENT: YES
DATE OF BIRTH: [REDACTED] CITIZENSHIP: US RELATIONSHIP: SPOUSE
DATE MARRIED: 11/07/2017 PLACE OF MARRIAGE: PRINCE GEORGES, MD
ADDRESS: [REDACTED]
GLEN BURNIE, MD
PREVIOUSLY MARRIED: YES MARRIAGE DISSOLVED BY: DIVORCE
DISSOLVED ON: 04/24/2008 PLACE DISSOLVED: PRINCE GEORGES, MD
MEMBER OF UNIFORMED SERVICES: NO DUTY AFFILIATION:
BRANCH: COMPONENT:
SEX: F

SPOUSE NEXT OF KIN

NAME: [REDACTED] RELATIONSHIP: SISTER
ADDRESS: [REDACTED]
GREENBELT, MD [REDACTED]

FATHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
EFFORT, PA [REDACTED]

MOTHER INFORMATION

NAME: [REDACTED] DEPENDENT: NO SUPPORT: N/A
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

OTHER PERSON, NOT ALREADY NAMED TO BE NOTIFIED OF PERSONAL CASUALTY

NAME: NONE RELATIONSHIP
ADDRESS:

SSN: [REDACTED] NAME: ANDERSON, DANIEL

CHILD AND/OR DEPENDENT INFORMATION

NAME: [REDACTED]
DOB: [REDACTED]
ADDRESS: [REDACTED]

DEPENDENT: YES SUPPORT: N/A
RELATIONSHIP: DAUGHTER

Glen Burnie, MD [REDACTED]
NAME OF CUSTODIAN OTHER THAN CLAIMANT: NOT APPLICABLE

BENEFICIARY(IES) FOR UNPAID PAY AND ALLOWANCES

NAME: [REDACTED]
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

RELATIONSHIP: MOTHER

PERCENTAGE: 100%

PERSON(S) TO RECEIVE ALLOTMENT IF IN A MISSING STATUS, SUBJECT TO SECNAV DETERMINATION

NAME: [REDACTED]
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

RELATIONSHIP: MOTHER

PERCENTAGE: 100%

BENEFICIARY(IES) FOR GRATUITY PAY

NAME: [REDACTED]
ADDRESS: [REDACTED]
LEXINGTON, SC [REDACTED]

RELATIONSHIP: Mother

PERCENTAGE: 100%

LIFE INSURANCE INFORMATION

COMPANY: NONE
ADDRESS:

POLICY NUMBER:

LOCATION OF WILL

ADDRESS: NONE

LOCATION OF OTHER VALUABLE PAPERS

ADDRESS: NONE

PNOK (Name - Relationship - Phone - Address)

[REDACTED] Spouse [REDACTED]
[REDACTED], GLEN BURNIE, MD, [REDACTED]

SSN: [REDACTED] NAME: ANDERSON, DANIEL

SNOX (Name - Relationship - Phone - Address)

[REDACTED] LEXINGTON, SC

SNOX (Name - Relationship - Phone - Address)

[REDACTED] Father, 000-000-0000, 000-000-0000, [REDACTED] EFFORT, PA

IS BENEFICIARY DESIGNATION OF SGLI ON FILE? YES DESIGNATION DATE: 08/08/2012

REMARKSPADD:
ADDRESS:

RELATIONSHIP: Mother

[REDACTED] LEXINGTON, SC [REDACTED]

Phone: [REDACTED]

NAVPERS 1070/602 UPDATED DUE TO MARRIAGE ON 11/07/17 MARRIAGE CERTIFICATE
VERIFIED. MARRIAGE LICENSE/DOCUMENT NO: 162017-005093BAH CHANGE FROM "R" TO "A" (DEPENDENT BAH - MARRIED TO CIVILIAN SPOUSE)
EFFECTIVE 11/07/2017
//VERIFIED BY: PS1 Hancock 11/17/2017.PSD CLERK: KLJ
17 JAN 2018I UNDERSTAND THAT FAMILY SGLI AUTOMATICALLY COVERS MY SPOUSE AND IT IS MY
RESPONSIBILITY TO ENROLL MY SPOUSE IN DEERS SO MY BRANCH OF SERVICE CAN DEDUCT
PREMIUMS FROM MY PAY AND THAT FAILURE TO REGISTER MY SPOUSE IN DEERS WILL
RESULT IN MY OWING DEBTS FOR UNPAID PREMIUMS. I CAN DECLINE FAMILY SGLI
COVERAGE BY COMPLETING SGLI 8286A.MEMBER ALLOWED 60 DAYS TO PROVIDE ORIGINAL DOCUMENTS. FAILURE TO PROVIDE
ORIGINAL MARRIAGE/BIRTH CERTIFICATE WOULD RESULT IN A LOSS OF BAH ALLOWANCE.IT IS MY RESPONSIBILITY TO NOTIFY MY NAVY PERSONNEL OFFICE/SHIP'S OFFICE OR
CSD/PSD IF THERE IS A CHANGE IN MY ASSIGNMENT TO QUARTERS THAT MAY AFFECT MY
BAH ENTITLEMENTS THAT MAY RESULT IN AN OVER/UNDER PAYMENT.

SSN: [REDACTED]

NAME: ANDERSON, DANIEL

CERTIFICATION: I HAVE REVIEWED THE DATA ON THIS FORM AND CERTIFY THAT IT IS CORRECT. I UNDERSTAND THAT ANY CHANGE IN MY FAMILY MEMBER STATUS MUST BE REPORTED AS A CHANGE TO THE DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS) WITHIN 60 DAYS. THIS INCLUDES SERVICE MEMBERS IN A JOINT SERVICE MARRIAGE (MILITARY MARRIED TO MILITARY), EVEN THOUGH EACH SPOUSE IS ALREADY ENROLLED IN DEERS IN HIS OR HER OWN RIGHT AS A MILITARY MEMBER.

SIGNATURE OF DESIGNATOR: Daniel Anderson

DANIEL ANDERSON

WITNESSED: A. S. Cann

A. S. CANN, GS-7

DATE: 29 JAN 18

TITLE: MILPERS SUPERVISOR

Official NSIPS/ESR form printed this date 17-JAN-2018



DEPARTMENT OF THE NAVY
CYBER STRIKE ACTIVITY SIXTY THREE
FORT GEORGE G MEADE MARYLAND 20755-6585

1621
Ser N00L/008
2 Aug 17

From: Commanding Officer, Cyber Strike Activity SIXTY THREE
To: Commander, Navy Personnel Command (PERS-832)
Via: CTN2 Daniel D. Merwin, USN

Subj: REPORT OF NONJUDICIAL PUNISHMENT ICO CTN1 DANIEL D. MERWIN, USN

Ref: (a) MILPERSMAN 1616-040

Encl: (1) NAVPERS 1626/7, Report and Disposition of Offense of 14 Jul 17
(2) Preliminary Inquiry Report of 22 May 17
(3) Chain of Command Recommendations of 28 Jun 17
(4) Command Disciplinary Review Board Report of 5 Jul 17
(5) CTN1 Merwin, Daniel D. ltr of 13 Jul 17 (Career Representation)
(6) CTN1 Merwin, Daniel D. ltr of 13 Jul 17 (Medicine Periods)
(7) CTN1 Merwin, Daniel D. ltr of 13 Jul 17 (Intent on Medical Board)
(8) CTN1 Merwin, Daniel D. ltr of 13 Jul 17 (Character Statements)
(9) Major Schlessinger, Andrew G. Memorandum of 13 Jul 17
(10) Cyber Strike Activity SIXTY THREE email of 14 Jul 17
(11) Memorandum for the Record of 17 Jul 17
(12) Memorandum for the Record 5812 of 19 Jul 17
(13) CTN1 Merwin, Daniel D. ltr of 18 Jul 17
(14) Accused Acknowledgment of NJP Appeal Rights of 20 Jul 17
(15) NAVPERS 1070/607 of 27 Jul 17

1. Per reference (a), this report and enclosures (1) through (15) are forwarded for inclusion into CTN2 Merwin's official record. As provided in enclosure (1), CTN2 Merwin received Non-Judicial Punishment (NJP) on 20 July 2017 for the following violation of the Uniform Code of Military Justice: Article 92 – Violation of a Lawful General Regulation, to wit: Sexual Harassment.

2. Enclosure (2), and its enclosures (a) through (p), is the investigation relied upon as evidence at the NJP hearing. In addition to the preliminary inquiry, enclosures (3) through (13) were used as evidence in addition to CTN2 Merwin's electronic training jacket.

3. As substantiated by the preliminary inquiry investigation and his own admissions, CTN2 Merwin communicated to his female coworkers in a manner that created a hostile environment. Leadership was forced to alter working hours and change seating locations as a result of CTN2 Merwin's actions.


FINISH FILE PERS 832 FICHE

Subj: REPORT OF NONJUDICIAL PUNISHMENT ICO CTN1 DANIEL D. MERWIN, USN

4. The evidence sufficiently supported all charges and specifications. During NJP, CTN2 Merwin read a personal statement aloud, included as enclosure (13) At NJP, he was awarded a reduction to the next inferior paygrade (E-5) and forfeiture of \$1,606 per month for two months. After acknowledging his NJP appeal rights as documented in enclosure (14), CTN2 Merwin declined to submit an appeal. Accordingly, NJP is now final, per enclosure (15), and has been reflected in the special evaluation for reduction in rate.

5. This report will be sent via CTN2 Merwin for acknowledgment, verification of his declination to appeal the NJP, and an opportunity to submit a statement. This serves as notice of his right, per reference (a), to submit his comments within 10 days of receipt concerning this report of NJP, which will be included as an adverse matter in his official record. His comments, if any, will be reflected in the first endorsement to this letter.

7. My point of contact for this matter is LT Pellittiere, Legal Officer, (443) 654-1908 or mmpelli@nsa.gov.


S. D. PINDER
Acting

1621
2 Aug 17

FIRST ENDORSEMENT on Cyber Strike Activity SIXTY THREE ltr 1621 Ser N00L/008 of
2 Aug 17

From: CTN2 Daniel D. Merwin, USN

To: Commander, Navy Personnel Command (PERS-832)

Subj: REPORT OF NONJUDICIAL PUNISHMENT ICO CTN1 DANIEL D. MERWIN, USN

1. I hereby acknowledge receipt of the report of Nonjudicial Punishment (NJP). I have read the above documents and understand my rights.
2. I was informed of my rights to appeal the NJP on 20 July 17 and declined to do so.
3. I have been advised of the adverse action taken by the command and understand that this report will be part of my official record.
4. I understand that I have 10 days to submit a statement and that failure to submit one within that time period will constitute a waiver of my right to do so.
5. I do not intend to make an additional statement at this time.


D. D. MERWIN

REPORT AND DISPOSITION OF OFFENSE(S)

To: Commanding Officer Cyber Strike Activity SIXTY THREE				Date of Report		
I hereby report the following named person for the offense(s) noted				14 July 2017		
NAME OF ACCUSED	SERIAL NO	SOCIAL SECURITY NO	RATE/GRADE	BR & CLASS	DIV/DEPT	
MERWIN, Daniel D.	N/A	[REDACTED]	CTN1/E6	USN	B/33	
PLACE OF OFFENSE(S)			DATE OF OFFENSE(S)			
Fort George G. Meade, MD			16 Feb 2017-9 Apr 2017, 18 Apr 2017			
DETAILS OF OFFENSE(S) (Refer by Article of UCMJ if known. If unauthorized absence, give following info: time and date of commencement, whether over leave or liberty, time and date of apprehension or surrender and arrival on board, loss of ID card and/or liberty card, etc.)						
Charge: Violation of UCMJ Article 92, Violation of a Lawful General Regulation						
<p>Specification 1: In that Cryptologic Technician Networks First Class Daniel D. Merwin, United States Navy, on active duty, Cyber Strike Activity SIXTY THREE, did, at or near Fort George G. Meade, Maryland, on divers occasions between 16 February 2017 and 9 April 2017, violate a lawful general regulation, to wit: Article 1166, U.S. Navy Regulations, dated 14 September 1990, by wrongfully sexually harassing [REDACTED]</p> <p>Specification 2: In that Cryptologic Technician Networks First Class Daniel D. Merwin, United States Navy, on active duty, Cyber Strike Activity SIXTY THREE, did, at or near Fort George G. Meade, Maryland, on or about 18 April 2017, violate a lawful general regulation, to wit: Article 1166, U.S. Navy Regulations, dated 14 September 1990, by wrongfully sexually harassing Cryptologic Technician Networks Second Class [REDACTED] and Cryptologic Technician Networks Second Class [REDACTED]</p>						
AND NO OTHERS.						
NAME OF WITNESS	RATE/GRADE	DIV/DEPT	NAME OF WITNESS	RATE/GRADE	DIV/DEPT	
LCDR			J. A. MCCAULEY			
(Rate/Grade/Title of person submitting report)			(Signature of Accuser)			
I have been informed of the nature of the accusation(s) against me. I understand I do not have to answer any questions or make any statement regarding the offense(s) of which I am accused or suspected. However, I understand any statement made or questions answered by me may be used as evidence against me in event of trial by court-martial (Article 31, UCMJ).						
Witness		Acknowledged				
(Signature)		(Signature)		(Signature of Accused)		
PRE-TRIAL RESTRAINT	<input type="checkbox"/> PRE-TRIAL CONFINEMENT		<input type="checkbox"/> RESTRICTED: You are restricted to the limits of _____ in lieu of arrest by order of the CO. Until your status as a restricted person is terminated by the CO, you may not leave the restricted limits except with the express permission of the CO or XO. You have been informed of the times and places which you are required to muster.			
	<input checked="" type="checkbox"/> NO RESTRICTION					
(Signature and title of person imposing restraint)			(Signature of Accused)			
INFORMATION CONCERNING ACCUSED						
CURRENT ENL DATE	EXPIRATION CURRENT ENL DATE	TOTAL ACTIVE NAVAL SERVICE	TOTAL SERVICE ON BOARD	EDUCATION	AFQT	AGE
16 Oct 2015	15 Oct 2021	11 years 8 months	4 years	12	55	32
MARITAL STATUS	NO. OF DEPENDENTS	CONTRIBUTION TO FAMILY OR QTRS ALLOWANCE (Amount required by law)		PAY PER MONTH (including sea or foreign duty pay, if any)		
Single	0	\$2,052.00		E-6=\$3,480.30 (1/2=\$1,740.15) E-5=\$3,213.60 (1/2=\$1,606.80)		
RECORD OF PREVIOUS OFFENSE(S) (Date, type, action taken, etc. Non-judicial punishments are to be included)						
None on Record						

PRELIMINARY INQUIRY REPORT

From Commanding Officer, Cyber Strike Activity SIXTY THREE
To LT Michael M. Pellittere USN

Date

14 July 2017

1 Transmitted herewith for preliminary inquiry and report by you, including, if appropriate in the interest of justice and discipline, the preferring of such charges as appeal to you to be sustained by expected evidence

REMARKS OF DIVISION OFFICER (Performance of duty, etc.)

See attached statement.

NAME OF WITNESS

RATE/GRADE

DIV/DEPT

NAME OF WITNESS

RATE/GRADE

DIV/DEPT

RECOMMENDATION AS TO
DISPOSITION☒ DISPOSE OF CASE AT MAST☐ REFER TO COURT-MARTIAL FOR TRIAL OF ATTACHED CHARGES
(Complete Charge Sheet (DD Form 458) through Page 2)☐ NO PUNITIVE ACTION NECESSARY OR DESIRABLE☐ OTHER

COMMENT (Include data regarding availability of witnesses, summary of expected evidence, conflicts in evidence, if expected. Attach statements of witnesses, documentary evidence such as service record entries in UA cases, items of real evidence, etc.)

See attached recommendations.

(Signature of Investigating Officer)

ACTION OF EXECUTIVE OFFICER

☐ DISMISSED☒ REFER TO CAPTAIN'S MAST

SIGNATURE OF EXECUTIVE OFFICER

RIGHT TO DEMAND TRIAL BY COURT-MARTIAL

(Not applicable to persons attached to or embarked in a vessel)

I understand that nonjudicial punishment may not be imposed on me if, before the imposition of such punishment, I demand in lieu thereof trial by court-martial. I therefore (do) (do not) demand trial by court-martial

WITNESS

SIGNATURE OF ACCUSED

ACTION OF COMMANDING OFFICER

☐ DISMISSED☐ DISMISSED WITH WARNING (Not considered NJP)☐ ADMONITION ORAL/IN WRITING☐ REPRIMAND ORAL/IN WRITING☐ REST TO _____ FOR _____ DAYS☐ REST TO _____ FOR _____ DAYS WITH SUSP FROM DUTY☒ FORFEITURE TO FORFEIT \$ 1,406 PAY PER MO FOR 2 MO(S)☐ DETENTION TO HAVE \$ _____ PAY PER
MO FOR (1 2 3) MO(S) DETAINED FOR _____ MO(S)☐ CONF ON _____ 1 2 OR 3 DAYS☐ CORRECTIONAL CUSTODY FOR _____ DAYS☒ REDUCTION TO NEXT INFERIOR PAY GRADE☐ REDUCTION TO PAY GRADE OF _____☐ EXTRA DUTIES FOR _____ DAYS☐ PUNISHMENT SUSPENDED FOR _____☐ REFER TO ART 32 INVESTIGATION☐ RECOMMENDED FOR TRIAL BY GCM☐ AWARDED SPCM☐ AWARDED SCM

DATE OF MAST

DATE ACCUSED INFORMED OF ABOVE ACTION

SIGNATURE OF COMMANDING OFFICER

It has been explained to me and I understand that if I feel this imposition of nonjudicial punishment to be unjust or disproportionate to the offenses charged against me, I have the right to immediately appeal my conviction to the next higher authority within 5 days

SIGNATURE OF ACCUSED

DATE

I have explained the above rights of appeal to the accused

SIGNATURE OF WITNESS

DATE

FINAL ADMINISTRATIVE ACTION

APPEAL SUBMITTED BY ACCUSED

DATED _____
FORWARDED FOR DECISION
ON _____

FINAL RESULT OF APPEAL

APPROPRIATE ENTRIES MADE IN SERVICE RECORD AND PAY ACCOUNT ADJUSTED
WERE REQUIRED

DATE

FILED IN UNIT PUNISHMENT BOOK

DATE

(Initials)

(Initials)

22 May 2017

From: [REDACTED]

To: Commanding Officer, Navy Information Operations Command Maryland

Subj: PRELIMINARY INQUIRY INTO THE CIRCUMSTANCES SURROUNDING ALLEGATIONS OF INAPPROPRIATE BEHAVIOR AND SEXUAL HARASSMENT ICO CTN1 DANIEL MERWIN (ANDERSON), USN

Ref: (a) JAGMAN Section 0203
(b) Preliminary Inquiry Officer appointment letter

Encl: (a)
(b)
(c)
(d)
(e)
(f)
(g)
(h)
(i)
(j)
(k)
(l)
(m)
(n)
(o)
(p)

1. This reports completion of the preliminary inquiry conducted in accordance with references (a) and (b) into the circumstances surrounding allegations of inappropriate behavior and sexual harassment ICO CTN1 Daniel Merwin (Anderson), USN. References (a) through (p) are submitted for consideration.

2. Personnel contacted:

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.

I. [REDACTED] (301) 688-0456

3. Materials reviewed: All materials reviewed are part of official statements or included in reference (O).

4. Summary of findings:

- a. I did not find a culture within the workcenter that facilitated the behavior of CTN1 Merwin (Anderson).
- b. I do not believe that CTN1 Merwin (Anderson) propositioned [REDACTED] in sending her the chat message, "Must be busy being the TF commander!" While this is familiar and unacceptable, it is not sexual harassment.
- c. There were several instances of sexual harassment of [REDACTED] CTN1 Merwin (Anderson) made several unwanted statements to her about how she looked including statements that she was "super cute" or how red looked good "especially on someone so beautiful." CTN1 Merwin (Anderson) also sent [REDACTED] two videos via social media that crossed the line into sexual harassment. In the first video, CTN1 Merwin (Anderson) is laying on his bed without a shirt making kissing gestures and showing his two boxer dogs. The second video is CTN1 Merwin (Anderson) entering his kitchen with meat cooking with one of his boxer dogs standing on hind legs smelling the meat. CTN1 Merwin (Anderson) repeatedly asks his dog, "Are you trying to lick my meat?" While these videos are available on CTN1 Merwin's (Anderson) Facebook page, I believe it constitutes sexual harassment in the context of what was being discussed and the desired relationship. CTN1 Merwin (Anderson) also sent a picture from the movie, "Julia & Julia" where Meryl Streep is holding what appears to be a turkey upside down with its legs spread. It did not have relevance to the discussion and CTN1 Merwin (Anderson) states, "JK! that's not the one I was looking for." CTN1 Merwin (Anderson) volunteered to babysit [REDACTED] child so she could drink after a long day.
- d. CTN1 Merwin (Anderson) did not receive the response he wanted with [REDACTED] and turned his attention to [REDACTED]. After friending her on Facebook, he went through numerous pictures making comments on her pictures that she was "cute" and a "hottie." CTN1 Merwin (Anderson) also told [REDACTED] that "she could do better" in regards to her current boyfriend. No Facebook records were provided.
- e. Once [REDACTED] reported to the division, CTN1 Merwin (Anderson) shifted his attention to her. He made several comments to [REDACTED] about his interest in [REDACTED] and began sitting next to [REDACTED] in the workcenter and following her around. This made [REDACTED] uncomfortable and she asked [REDACTED] to walk with her to prevent CTN1 Merwin (Anderson) from following her.
- f. In a conversation with [REDACTED] and [REDACTED] CTN1 Merwin (Anderson) stated that the medication he was currently taking affected his libido stating, "he didn't mind that it slowed down because his overactive sex drive was a problem in the past." He then motioned down to his crotch and commented how strongly it had returned.
- g. CTN1 Merwin (Anderson) has created a hostile work environment where the female Sailors are not comfortable being alone with CTN1 Merwin (Anderson). As a result, [REDACTED] and [REDACTED] have altered their work schedule to ensure one of them is always in the workcenter.
- h. Several Sailors expressed concerns about the fear of retribution from CTN1 Merwin (Anderson).

- i. CTN1 Merwin made several attempts to find out what was happening despite the verbal order from [REDACTED] to not talk about this with anyone. During these discussions, CTN1 Merwin (Anderson) expressed that he would refuse Non-Judicial Punishment and opt for Court Martial instead. He also expressed he would not receive punishment due to his previous mental health issues.
5. Recommendation: Based on statements, associated chat logs and social media files, I believe CTN1 Merwin (Anderson) is guilty of sexual harassment of [REDACTED] and [REDACTED]. CTN1 Merwin (Anderson) lacks comprehension of what appropriate actions and relationships are in and out of the workcenter. As a result, he often says and does things that violate acceptable behavioral standards within the Navy. It is my opinion that he also sees female Sailors in his workcenter first as potential dates and then Sailors. Based on this, I recommend that CTN1 Merwin (Anderson) receive Non-Judicial Punishment and be reduced in rank to E-5. Based on his entry into Naval Service, he will reach High Year Tenure for an E-5 – 12 years – in November 2017, and be separated from Naval Service. He should not be allowed to lead or be around Sailors.
- [REDACTED]



DEPARTMENT OF THE NAVY

NAVY INFORMATION OPERATIONS COMMAND MARYLAND
FORT GEORGE G MEADE MARYLAND 20755-5290

5830

Ser N15/050

21 Apr 17

From: Commanding Officer, Navy Information Operations Command Maryland
To: CDR BLAKE JACOBSON, USN

Subj: PRELIMINARY INQUIRY INTO THE CIRCUMSTANCES SURROUNDING
ALLEGATIONS OF INAPPROPRIATE BEHAVIOR AND SEXUAL
HARASSMENT ICO CTN1 DANIEL MERWIN, USN

Ref: (a) JAGINST 5800.7F, Chapter II

Encl: CDR Sharon Pinder's e-mail Detailing Allegations of Inappropriate Behavior
and Sexual Harassment of 21 Apr 17

1. This appoints you, per chapter II of reference (a), to inquire into the facts and circumstances surrounding the allegations of inappropriate behavior and sexual harassment in the workplace reported in enclosure (1).
2. You are to investigate all facts and circumstances surrounding the allegations and determine if misconduct occurred. If you have not previously done so, read chapter II of reference (a) in its entirety before beginning your investigation. Report your findings of facts, conclusions, and recommendations by 27 April 2017, unless an extension of time is granted.
3. You may seek assistance from LT James Moxness, II, JAGC, USN, (301) 677-0877, Staff Judge Advocate, Navy Information Operations Command Maryland, during the course of your investigation.
4. By copy of this appointing order, the NIOC Staff Judge Advocate Office is directed to furnish any necessary clerical assistance.

A handwritten signature in black ink, appearing to read "J. S. Scheidt", is written over the typed name.

J. S. SCHEIDT

SUSPECT'S RIGHTS

Suspect's Full Name	SSN	Rate/Rank	Service (Branch)
MERWIN, Daniel	[REDACTED]	CTN1/E6	USN
Activity/Unit			DOB/Age
Navy Information Operations Command Maryland			[REDACTED] 35/32yrs old
Interviewer's Name	SSN	Rate/Rank	Service (Branch)
JACOBSON, Blake	N/A	CDR/05	USN
Organization			Billet
Navy Information Operations Command Maryland			PIO
Location of interview	Time	Date	
OPS 2B 7058	0930	22 MAY 17	

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he/she warned me that:

- (1) I am suspected of having committed the following offenses: 1 DA

Article 92 - Failure to obey order or regulation.

- (2) I have the right to remain silent; 2 DA
- (3) Any statement I do make may be used as evidence against me in a trial by court-martial; 3 DA
- (4) I have the right to consult with an attorney prior to any questioning. This attorney may be a civilian attorney retained by me at my own expense, a military attorney without cost to me, or both; and 4 DA
- (5) I have the right to have such retained civilian attorney and/or military attorney present during this interview; 5 DA
- (6) If I decide to answer questions now without a lawyer present, I will have the right to stop this interview at any time. 6 DA

WAIVER OF RIGHTS

- (1) I further certify and acknowledge that I Have read the above statement of my rights And fully understand them, and that; 1 DA
- (2) I expressly desire to waive my right to remain silent; 2 DA
- (3) I expressly do not desire to consult with either a civilian attorney retained by me or a military attorney without cost to me prior to any questioning; 3 DA
- (4) I expressly desire not to have a attorney present with me during this interview; and 4 DA
- (5) This acknowledgment and waiver of rights is made freely and voluntarily by me, without any promises or threats having been made to me or pressure or coercion of any kind having been used against me. 5 DA
- (6) I further understand that, even though I initially waive my rights to an attorney and to remain silent, I may, during the interview, assert my right to an attorney or to remain silent. 6 DA

NOTE: IF THE SUSPECT INDICATES HE IS WILLING TO MAKE A STATEMENT, HE SHOULD FIRST BE ASKED WHETHER HE HAS MADE A STATEMENT IN RESPONSE TO QUESTIONS ABOUT THE SUSPECTED OFFENSE TO ANYONE HE PRIOR TO THE PRESENT INTERVIEW. IF THE SUSPECT INDICATES HE HAS PREVIOUSLY MADE SUCH A STATEMENT, ADVISE THE SUSPECT AS FOLLOWS:

- (1) Your previous statement may not be admissible at courts-martial and may not be usable against you. (It may not be possible to determine whether a previous statement made by the suspect will be admissible at some future court-martial; this suggests it may be wise to treat it as inadmissible and provide the cleansing warning).
- (2) Regardless of the fact that you have talked about this offense before, you still have the right to remain silent now.
- (3) (Continue with the Rights Advisement and Waiver of Rights above.)

Signature of Suspect <i>Daniel Anderson</i>	Time 0930	Date 22 MAY 17
Signature of Interviewer <i>Blake Jacobson</i>	Time 0930	Date 22 MAY 17
Signature of Witness (only required if member refuses to sign)	Time	Date

The statement which appears on this page (and the following 2 ² DA page(s), all of which are signed by me), is made freely and voluntarily by me, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.

I HAVE NEVER HAD ILL INTENTIONS. I CURRENTLY HAVE RECREATIONSHIP DISTORTIONS / ISSUES SEE BEHAVIOR HEALTH, WALTER RECD, MEDICAL RECD. THE LAST TWO YEARS OR SO I HAVE NOT WORKED W/ SAILORS IN CLOSE PROXIMITY. THE LAST SEVERAL YEAR I HAVE BEEN WORKING TO RESOLVE MY PERCEPTION / RECREATIONSHIPS PROBLEMS W/ 2 PHYSICIANS. ~~FOR~~ RACHEZ I HAD SOME CONTACT OUTSIDE OF WORK

Daniel Anderson 22 MAY 17
Signature of Suspect/Date

DANIEL ANDERSON
Printed Name of Suspect

Subscribed and sworn to before me this 22 day of MAY 2017.

Blake Jacobson 22 MAY 17
Signature of Interviewer/Date

BLAKE JACOBSON
Printed Name of Interviewer

CONTINUATION OF SUSPECT'S STATEMENT ICO CTN1 DANIEL MERWIN, USN

MONTHS AGO BUT STOPPED. SHE HAD
 GALLING PROFILES POP UP ON 3 DATING
 SITE THAT I ~~WAS~~^{AM} ON AND DUE TO
 HER PHYSICAL LOCATION AT HOME BEING
 CLOSE TO MINE, IT WOULD POP UP UNTIL
 I BLOCK HER PROFILE FROM SHOWING UP.
 SALLY. DISCLOSED BOYFRIEND PROBLEMS ON
 FACEBOOK, I MAY HAVE MADE BORDERLINE
 COMMENT IN EFFORT TO TRY AND EXPRESS THAT
 SHE COULD DO BETTER. KADIAN SAID I COULD
 ADD HER ON INSTAGRAM, I DID I TOOK THAT
 AS AN INVITATION TO CONVERSE. I AS A
 SAILOR PRIDE MYSELF IN THE WORK I DO AS
 A (PRIVATE/ON) ACT, CC, MENTOR, COMMAND TRAINING TEAM,
 BY STANDARD INTENTION, CHART THE COURSE AND FULL
 SPEED AHEAD FACILITATOR. I TRY AND
 SHARE MY PERSONAL INFO TO HELP OTHER OPEN UP.

Daniel Merwin 22 MAY 17
 Signature of Suspect/Date

DANIEL MERWIN
 Printed Name of Suspect

Subscribed and sworn to before me this 22 day of MAY 2017.

Blake Jacobson 22 MAY 17
 Signature of Interviewer/Date

BLAKE JACOBSON
 Printed Name of Interviewer

CONTINUATION OF SUSPECT'S STATEMENT ICO CTN1 DANIEL MERWIN, USN

During time from 1 month prior to
 April 27th, was withdrawing from
 high dosage of ~~Lexapro~~^{Naltrexone} which caused
 significant withdrawal symptoms affecting
 my personality and behavior in some forms.

[Signature] 22 MAY 17
 Signature of Suspect/Date

DANIEL ANDERSON
 Printed Name of Suspect

Subscribed and sworn to before me this 22 day of MAY 2017.

[Signature] 22 MAY 17
 Signature of Interviewer/Date

BLAKE JACOBSON
 Printed Name of Interviewer


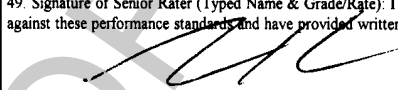
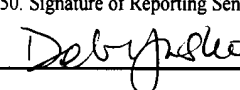

EVALUATION REPORT & COUNSELING RECORD (EI-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) ANDERSON, DANIEL D				2. Rate CTN2		3. Desig IW/SW		4. SSN [REDACTED]			
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/ 265		6. UIC 37700		7. Ship/Station CYBERSTRKACT 63			8. Promotion Status REGULAR		9. Date Reported 16SEP15		
Occasion for Report 10. Periodic <input checked="" type="checkbox"/> 11. of Individual <input type="checkbox"/> 12. Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 17JUL21 15. To: 18MAR15							
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness W		21. Billet Subcategory (if any) NA			
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title CO		26. UIC 37700		
									27. SSN [REDACTED]		
28. Command employment and command achievements. Provide and deploy trained personnel, expertise, and equipment to conduct Offensive and Defensive Cyberspace Operations in support of U.S. Cyber Command (USCYBERCOM) and the Cyber National Mission Force (CNMF) Defend the Nation (DTN) missions.											
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) GARRISON SUPP PRI: GARRISON SUPPORT-8. Provides personnel support to Cryptologic Warfare Group SIX (CWG-6). TEMADD: 17AUG29-17SEP26. WATCH: OFFICER OF THE DECK-8. PFA: 17-2.											
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled 17OCT06		31. Counselor JORDAN, S C		32. Signature of Individual Counseled [Signature]			
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.											
PERFORMANCE TRAITS		1.0* Below Standards		2.0 Pro- gressing		3.0 Meets Standards		4.0 Above Standards		5.0 Greatly Exceeds Standards	
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>		-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.		-		-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.		-		-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>		-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.		-		-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.		-		-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>		-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.		-		-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.		-		-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>		-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.		-		-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>		-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.		-		-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.		-		-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.	
		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) ANDERSON, DANIEL D			2. Rate CTN2		3. Desig IW/SW		4. SSN <div style="background-color: black; width: 100px; height: 1.2em;"></div>	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards		
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	<input type="checkbox"/>	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		<input checked="" type="checkbox"/>	- Team builder, inspires cooperation and progress. -Focuses goals and techniques for teams. -The best at accepting and offering team direction.		
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	<input type="checkbox"/>	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		<input checked="" type="checkbox"/>	-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.		
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <div style="border: 1px solid black; padding: 2px; display: inline-block;">3.00</div>		41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) NONE			42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0. <div style="text-align: center;"> SPRAGUE, F L, ISC</div> Date: 16 MAR 18			
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Petty Officer Anderson reassigned to CWG-6/CSA-63 holding department in a limited duty status; currently addressing medical treatment requirements approximately 3-4 days a week. - WARFARE TRAINER. Provided 18 hours of EIWS training to 15 personnel to include four First Class Petty Officers, three Second Class Petty Officers and eight junior Sailors that led to those Sailors completing EIWS Books 1 and 2. - GARRISON SUPPORTER. Assisted in the completion of a Standard Operating Procedure for CWG-6 N55 Garrison Division, which assisted leadership establishing overall processes and organization for the 15 Sailor Garrison Division. CTN2 Anderson is not recommended for retention or advancement.								
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. QUALIFIED: OOD.								
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input checked="" type="checkbox"/> Recommended <input type="checkbox"/>	
45. INDIVIDUAL			X				48. Reporting Senior Address COMMANDING OFFICER CYBERSTRKACT 63 9800 SAVAGE RD, SUITE 6235 FT MEADE, MD 20755-6585	
46. SUMMARY	<div style="text-align: center; border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;">X</div>	0	1	0	0	1		
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0. <div style="text-align: center;"> HOWELL, D J, LT</div> Date: 16 MAR 18					50. Signature of Reporting Senior <div style="text-align: center;"> Summary Group Average: 3.50</div> Date: 16 MAR 18			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/> <div style="text-align: center;"> Date: 27 MAR 18</div>					52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).

PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. **For military personnel,** it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. **For civilian personnel,** it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancé), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. **This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death.** It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: **Section 1 - Emergency Contact Information** and **Section 2 - Benefits Related Information.** **READ THE INSTRUCTIONS ON PAGES AND BEFORE COMPLETING THIS FORM.**

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME (Last, First, Middle Initial)

ANDERSON, DANIEL

2. SSN

3a. SERVICE/CIVILIAN CATEGORY

☐ ARMY ☒ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ DoD ☐ CIVILIAN ☐ CONTRACTOR

b. REPORTING UNIT CODE/DUTY STATION

37700

4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial)

AND TELEPHONE NUMBER

GLEN BURNIE, ANNE ARUNDEL, MD, US

☐ SINGLE ☐ DIVORCED ☐ WIDOWED

5. CHILDREN

a. NAME (Last, First, Middle Initial)

b. RELATIONSHIP

Daughter

c. DATE OF BIRTH
(YYYYMMDD)

d. ADDRESS (Include ZIP Code) **AND TELEPHONE NUMBER**

GLEN BURNIE, ANNE ARUNDEL, MD
US,

6a. FATHER NAME (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) **AND TELEPHONE NUMBER**

Unknown

7a. MOTHER NAME (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) **AND TELEPHONE NUMBER**

LEXINGTON, SC, US

8a. DO NOT NOTIFY DUE TO ILL HEALTH

None

b. NOTIFY INSTEAD

None

b. ADDRESS (Include ZIP Code) **AND TELEPHONE NUMBER**

GLEN BURNIE, ANNE ARUNDEL, MD, US,

10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)

N/A

1. NAME (Last, First, Middle Initial) ANDERSON,DANIEL		2. SSN [REDACTED]	
SECTION 2 - BENEFITS RELATED INFORMATION			
11a. BENEFICIARY(IES) FOR DEATH GRATUITY [REDACTED]	b. RELATIONSHIP Wife	c. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER [REDACTED] GLEN BURNIE, ANNE ARUNDEL, MD [REDACTED] US [REDACTED]	d. PERCENTAGE 100
12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES [REDACTED] RELATIONSHIP Wife		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER [REDACTED] GLEN BURNIE, ANNE ARUNDEL, MD, [REDACTED] US, [REDACTED]	c. PERCENTAGE 100
13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) (Military only) NAME AND RELATIONSHIP [REDACTED] Wife	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER [REDACTED] GLEN BURNIE, ANNE ARUNDEL, MD [REDACTED] US, [REDACTED]		
14. CONTINUATION/REMARKS Funeral Travel Authorized for: [REDACTED] LEN BURNIE, ANNE ARUNDEL, MD [REDACTED] S, [REDACTED] Other Person to be Notified: [REDACTED] GLEN BURNIE, ANNE ARUNDEL, MD, [REDACTED] US, [REDACTED] Other Person to be Notified: [REDACTED] LEXINGTON, SC, [REDACTED] US Beside Travel Authorized for: [REDACTED] GLEN BURNIE, ANNE ARUNDEL, MD, [REDACTED] US, [REDACTED]			

1. NAME <i>(Last, First, Middle Initial)</i> ANDERSON,DANIEL	2. SSN [REDACTED]	
15. SIGNATURE OF SERVICE MEMBER/CIVILIAN <i>(Include rank, rate, or grade if applicable)</i>	16. SIGNATURE OF WITNESS <i>(Include rank, rate, or grade as appropriate)</i> Not Required	17. DATE SIGNED <i>(YYYYMMDD)</i> 20180906

INSTRUCTIONS FOR PREPARING DD FORM 93*(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)*

All entries explained below are for electronic or typewriter completion, except those specifically noted. If a computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP Code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD Numbers should indicate in Item 14, "Continuations/Remarks", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 14" should be included in the item pertaining to the particular next of kin or when the space for a particular item is insufficient. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. Those items that are considered not applicable to civilians will be left blank.

ITEM 1. Enter full last name, first name, and middle initial.

ITEM 2. Enter social security number (SSN).

ITEM 3a. Service. **Military:** Mark X in appropriate block. **Civilian:** Mark two blocks as appropriate. Examples: an Army civilian would mark Army and either Civilian or Contractor; a DoD civilian, without affiliation to one of the Military Services, would mark DoD and then either Civilian or Contractor as appropriate.

ITEM 3b. Reporting Unit Code/Duty Station. See Service Directives.

ITEM 4a. Spouse Name. Enter last name (if different from Item 1), first name and middle initial on the line provided. If single, divorced, or widowed, mark appropriate block.

ITEM 4b. Address and Telephone Number. Enter the "actual" address and telephone number, not the mailing address. Include civilian title or military rank and service if applicable. If one of the blocks in 4a is marked, leave blank.

ITEM 5a-d. Children. Enter last name (only if different from Item 1) first name and middle initial, relationship, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Relationship examples: son, daughter, stepson or daughter, adopted son or daughter or ward. Date of birth example: 19950704. For children not living with the member's current spouse, include address and name and relationship of person with whom residing in item 5d.

ITEM 6a. Father Name. Last name, first name and middle initial.

ITEM 6b. Address and Telephone Number of Father. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural father is listed, indicate relationship.

ITEM 7a. Mother Name. Last name, first name and middle initial.

ITEM 7b. Address and Telephone Number of Mother. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons Not to be Notified Due to Ill Health.

- a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan." Otherwise, enter "None".
- b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a. If "None" is entered in Item 8a, leave blank.

ITEM 9a. This item will be used to record the name of the person or persons, if any, other than the member's primary next of kin or immediate family, to whom information on the whereabouts and status of the member shall be provided if the member is placed in a missing status. Reference 10 USC, Section 655. **NOT APPLICABLE to civilians.**

ITEM 9b. Address and telephone number of Designated Person(s). **NOT APPLICABLE to civilians.**

ITEM 10. Contracting Agency and Telephone Number **(Contractors only). NOT APPLICABLE to military personnel.** Civilian contractors will provide the name of their contracting agency and its telephone number. Example: XYZ Electric, (703) 555-5689. The telephone number should be to the company or corporation's personnel or human resources office.

ITEM 11a. Beneficiary(ies) for Death Gratuity **(Military only).** Enter first name(s), middle initial, and last name(s) of the person(s) to receive death gratuity pay. A member may designate one or more persons to receive all or a portion of the death gratuity pay. The designation of a person to receive a portion of the amount shall indicate the percentage of the amount, to be specified only in 10 percent increments, that the person may receive. If the member does not wish to designate a beneficiary for the payment of death gratuity, enter "None," or if the full amount is not designated, the payment or balance will be paid as follows:

- (1) To the surviving spouse of the person, if any;
- (2) To any surviving children of the person and the descendants of any deceased children by representation;
- (3) To the surviving parents or the survivor of them;
- (4) To the duly appointed executor or administrator of the estate of the person;
- (5) If there are none of the above, to other next of kin of the person entitled under the laws of domicile of the person at the time of the person's death.

The member should make specific designations, as it expedites payment.

INSTRUCTIONS FOR PREPARING DD FORM 93

(Continued)

ITEM 11a. (Continued) Seek legal advice if naming a minor child as a beneficiary. If a member has a spouse but designates a person other than the spouse to receive all or a portion of the death gratuity pay, the Service concerned is required to provide notice of the designation to the spouse. **NOT APPLICABLE to civilians.**

Item 11b. Relationship. **NOT APPLICABLE to civilians.**

ITEM 11c. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 11d. Show the percentage to be paid to each person. Enter 10%, 20%, 30%, up to 100% as appropriate. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named. **NOT APPLICABLE to civilians.**

ITEM 12a. Beneficiary(ies) for Unpaid Pay/Allowance (**Military only**). Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "By Law." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2771) in the absence of a designation. Seek legal advice if naming a minor child as beneficiary. **NOT APPLICABLE to civilians.**

ITEM 12b. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 12c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent. **NOT APPLICABLE to civilians.**

ITEM 13a. Enter the name and relationship of the Person Authorized to Direct Disposition (PADD) of your remains should you become a casualty. Only the following persons may be named as a PADD: surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these three can be found, a person standing in loco parentis may be named. **NOT APPLICABLE to civilians.**

ITEM 13b. Address and telephone number of PADD. **NOT APPLICABLE to civilians.**

ITEM 14. Continuations/Remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./son/ 19851220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed. This block offers the greatest amount of flexibility for the member to record other important information not otherwise requested but considered extremely useful in the casualty notification and assistance process. Besides continuing information from other blocks on this form, the member may desire to include additional information such as: NOK language barriers, location or existence of a Will, additional private insurance information, other family member contact numbers, etc. If additional space is required, attach a supplemental sheet of standard bond paper with the information.

ITEM 15. Signature of Service Member/Civilian. Check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade if applicable. May be electronically signed (see DoD Instruction 1300.18 for guidelines).

ITEM 16. Signature of Witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade as appropriate. A witness signature is not required for electronic versions of the DD Form 93 (see DoD Instruction 1300.18).

ITEM 17. Date the member or civilian signs the form. This item is an ink entry and must be completed on all copies.

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

This Report Contains Information Subject to the Privacy Act of 1974, As Amended.

1. NAME (Last, First, Middle) ANDERSON, DANIEL "NMN"		2. DEPARTMENT, COMPONENT AND BRANCH NAVY-USN		3. SOCIAL SECURITY NUMBER [REDACTED]	
4a. GRADE, RATE OR RANK CTN2	b. PAY GRADE E5	5. DATE OF BIRTH (YYYYMMDD) 198 [REDACTED]	6. RESERVE OBLIGATION TERMINATION DATE (YYYYMMDD) NA		
7a. PLACE OF ENTRY INTO ACTIVE DUTY MECHANICSBURG PA		b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) [REDACTED] BETHLEHEM PA [REDACTED]			
8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND CYBER STRIKE ACTIVITY 63			b. STATION WHERE SEPARATED PERSUPDET MEMPHIS		
9. COMMAND TO WHICH TRANSFERRED NA			10. SGLI COVERAGE <input type="checkbox"/> NONE AMOUNT: \$400,000		
11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.) 0000 CTN - 0000 1YR 0MOS X		12. RECORD OF SERVICE a. DATE ENTERED AD THIS PERIOD 2005 11 01 b. SEPARATION DATE THIS PERIOD 2018 10 19 c. NET ACTIVE SERVICES THIS PERIOD 12 11 19 d. TOTAL PRIOR ACTIVE SERVICE 00 00 00 e. TOTAL PRIOR INACTIVE SERVICE 00 00 00 f. FOREIGN SERVICE 00 00 00 g. SEA SERVICE 00 00 00 h. INITIAL ENTRY TRAINING 00 02 06 i. EFFECTIVE DATE OF PAY GRADE 2017 07 20			
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) GW-TERRORISM SERVICE MEDAL (1);GOOD CONDUCT MEDAL ACTIVE (3);MERITORIOUS UNIT COMMENDATION (1);NATIONAL DEFENSE SERVICE MEDAL (1);NAVY "E" RIBBON (1);NAVY/MC ACHIEVEMENT MEDAL (4);NAVY/MC "SEE REMARKS"		14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed) RTC BMT, 8 WKS, DEC05; AVIATION FUNDAMENTALS, 1 WKS, JAN06; ABH A1, 4 WKS, MAR06; ABH REFR AMPHIB, 1 WKS, DEC06; CTN CLASS A SCHOOL, 4 WKS, JUN09; BASIC DIGITAL NETWORK ANALYSIS, 7 WKS, JUL09; JOINT NETWORK ATTACK "SEE REMARKS"			
15a. COMMISSIONED THROUGH SERVICE ACADEMY				YES	<input checked="" type="checkbox"/> NO
b. COMMISSIONED THROUGH ROTC SCHOLARSHIP (10 USC Sec. 2107b)				YES	<input checked="" type="checkbox"/> NO
c. ENLISTED UNDER LOAN REPAYMENT PROGRAM (10 USC Chap. 109) (If Yes, year of commitment:)				YES	<input checked="" type="checkbox"/> NO
16. DAYS ACCRUED LEAVE PAID 10.5	17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION				YES <input checked="" type="checkbox"/> NO
18. REMARKS SERIAL NUMBER: N2018102200062-0; TRANSACTION CODE: A; CONTACT INFORMATION AFTER SEPARATION: EMAIL [REDACTED]@GMAIL.COM PHONE [REDACTED] X X X X X BLK 13 CONT: OVERSEAS SVC RIBBON (1); SEA SERVICE DEPLOYMENT RIBBON (1); X X X BLK 14 CONT: COURSE, 4 WKS, NOV13; CMD TRN TEAM INDOCTRINATION, 1 WKS, APR11 X X X X X X X X X X X X X X X The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.					
19a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code) [REDACTED] GLEN BURNIE MD [REDACTED]		b. NEAREST RELATIVE (Name and address - include ZIP Code) [REDACTED] LEXINGTON SC [REDACTED]			
20. MEMBER REQUESTS COPY 6 BE SENT TO (Specify state/locality) MD		OFFICE OF VETERANS AFFAIRS		<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
a. MEMBER REQUESTS COPY 3 BE SENT TO THE CENTRAL OFFICE OF THE DEPARTMENT OF VETERANS AFFAIRS (WASHINGTON, DC)				<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
21a. MEMBER SIGNATURE Signature Unattainable	b. DATE (YYYYMMDD) 20181019	22a. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title, signature) GS7, Authorizing Official		b. DATE (YYYYMMDD) 20181022	

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION Discharged	24. CHARACTER OF SERVICE (Include upgrades) HONORABLE	
25. SEPARATION AUTHORITY MILPERSMAN 1910-120	26. SEPARATION CODE KFV	27. REENTRY CODE RE-3G
28. NARRATIVE REASON FOR SEPARATION CONDITION, NOT A DISABILITY		
29. DATES OF TIME LOST DURING THIS PERIOD (YYYYMMDD) TL - NONE		30. MEMBER REQUESTS COPY 4 (Initials) DDA

HISTORY OF ASSIGNMENTS

DATE GAINED	TYPE GAIN	ACTIVITY	UIC	DATE OF LOSS	TYPE LOSS
11/01/2005	TEM DU	S CRU TRCOM GTLK	30646		TRF
01/04/2006	TEM DU	S NATTC PCOLA FL	39831	03/10/20 6	TRF
04/11/2006	DUTY	LHD 2 ESSEX	21533	04/04/2009	TRF
05/04/2009	TEM DU	S CID ST CORRY	30930	07/27/2009	TRF
07/27/2009	DUTY	NIOC PCOL/CYBDEF	419 6	7/30/2012	TRF
08/07/2012	DUTY	NIOC MD/CYBER OP	49947		
07/22/2013	DUTY	21 NMT	37707	09/15/2016	TRF
09/15/2016	DUTY	CSA SIXTY THREE	37700	10/19/2018	DIS

NAME (LAST, FIRST MIDDLE)

ANDERS N,DANIEL

SOCIAL SECURITY NUMBER**RANK/RATE**

CTN2



MEMBER DATA SUMMARY

MEMBER INFORMATION

Br/Cls	: USNR	Rank/Rate	: CTN2
PEBD	: 11/01/2005	ADSD	:
ACBD	:	SSED	:
Pay Grade	: E05	Special Prog. Ind	:
Off/Enl	: Enlisted	Designator	:
PNEC	: 0000	Primary AQD	:
SNEC	:	Enlisted Designator	: Info Dominance Warfare Spec

SECURITY

Eligibility	: Top Secret - SCI Eligible	Investigation Date	: 12/17/2014
Investigation Type	:	Clearance Date	: 01/06/2015
Security Clearance	: Top Secret - SCI Eligible	Agency	:

CURRENT ASSIGNMENT

UIC	: 37700	CSA SIXTY THREE
Report Date	: 09/15/2016	
PRD	: 09/01/2019	
Sea Shore Code	: Shore Duty	
Homeport	: Shore Duty	
ACC	:	
SDCD/SHDCD	:	
BSC	: 0.00	

PERSONAL INFORMATION

Sex	: Male		
DOB	: [REDACTED] 1985	Age :	3 Yr
Marital Status	: Married		
Citizenship	: U.S. Citizen by Birth		
Race	: White(E)		
Ethnic Group	: Not Assoc with any Group		
Religion	: No Religious Preference		
HOR - City	: BETHLEHEM		
HOR - State	: PA	Country :	US Zip:

DEPENDENTS INFORMATION

No. of Depn.	: 2
Primary	: Spouse and 1 Child
Secondary	: No dependent parents
Arrival Date	: 11/01/2005
On Station Nbr	: Not Sponsored / Overseas
Fmly Care Plan	:
Res. In Hsehold	: 1

EDUCATION

Education Certif	: High school Diploma				
Education Years	: 12				
ASVAB Test ID	: ASV B 01E				
AFQT Score	: 55				
GS/GI:	61	NO/AR:	52	MC :	56
AR/NO:	51	CS/SP:	0	EI/GS:	56
WK/AD:	51	AS/MK:	56	VE/SI:	50
PC/WK:	50	MK/EI:	56	DLAB :	666
				AI :	0
				SONAR:	0
				RADAR:	0
				ETST :	0

NAME (Last, First Middle)

ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

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BRANCH AND CLASS

32



MEMBER DATA SUMMARY

UNIVERSITY DATA

College Name	Degree Attained	Major	Months Attended	Last Yr Attended
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SERVICE SCHOOLS

Course Code	Course Title	Course Length	Completion Date
00C7	JOINT NETWORK ATTACK COURSE	26 Days	11/25/2013
652X	CMD TRN TEAM INDOCTRINATION	4 Days	04/15/2011
UR51	PO2 SELECTEE LEADERSHIP COUR	1 Days	12/09/2009
639G	BASIC DIGITAL NETWORK ANALYS	47 Days	07/27/2009
00C9	CTN CLASS A SCHOOL	26 Days	06/04/2009
N1CF	IT MOD04-COMMUNICATIONS HRDW	1 Days	02/10/2008
N1D0	IT MOD 05--COMMS CENTER OPS	1 Days	02/10/2008
N1CC	INF SYS TCH TRG SR MD 2-CMP	1 Days	02/09/2008
N1CD	IT MOD 03--NETWORK COMMS	1 Days	02/09/2008
N1CB	IT MOD 01--ADMIN & SECURITY	1 Days	02/04/2008
N168	EQUAL OPPORTUNITY IN THE NAV	1 Days	04/22/2007
N215	MRPO THIRD & SECOND CLASS	1 Days	04/22/2007
551H	ABH REFR AMPHIB	5 Days	12/08/2006
N13D	AVIATION MAINTENANCE RATINGS	1 Days	09/07/2006
626D	ABH A1	31 Days	03/10/2006
00FV	AVIATION FUNDAMENTALS	8 Days	01/26/2006
5387	SHBD ACFF	1 Days	01/11/2006
636N	PFM	2 Days	01/09/2006
3804	NAVY STU INDOC	2 Days	01/05/2006
6387	RTC BMT	63 Days	12/29/2005

SERVICE COLLEGE

College Cd Jr/Sr	Brd. Selected Jr/Sr	Yr Elig Jr/Sr	Status Cd Jr/Sr	Program Code
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PERSONNEL QUALIFICATION STANDARDS

Station#	Title	Completion Date
43901 301	ENLISTED SURFACE WARFARE SPECIALIST (ESWS) COMMON CORE	11/27/2008
43901-4 301	ESWS UNIT SPECIFIC FOR LHD CLASS	11/27/2008
43397-D 306	PETTY OFFICER OF THE WATCH (POOW)	11/12/2008
43119-J 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS	09/26/2008
43119-J 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENS	09/26/2008
43119-J 304	FIRE WATCH STANDER	09/26/2008
43119-J 303	BASIC FIREFIGHTING	09/26/2008
43119-J 302	BASIC FIRST AID	09/26/2008
43119-J 308	TEAM LEADER	06/05/2008
43119-J 307	ADVANCED DAMAGE CONTROL (DC)	05/30/2008
43397-D 305	MESSENGER OF THE WATCH (MOOW)	03/14/2008
43902-16 301	EAWS UNIT SPECIFIC FOR LPH/LHA/LHD/ MCS AVIATION CLASS	03/10/2008
43119-J 306	BASIC DAMAGE CONTROL (DC)	10/15/2007
43241-H 302	REPAIR PARTS/SUPPLY PETTY OFFICER	11/17/2006
43523-B 301	CRAFTSMAN	11/01/2006
43434-1C 305	TOWER OPERATOR	10/19/2006
43434-1C 307	SPOTTING DOLLY OPERATOR	10/10/2006
43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS	07/31/2006
43119-I 306	BASIC DAMAGE CONTROL (DC)	07/31/2006
43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENS	07/31/2006
43119-I 304	FIRE WATCH STANDER	07/31/2006
43119-I 303	BASIC FIREFIGHTING	07/31/2006
43119-I 302	BASIC FIRST AID	07/31/2006
43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS	07/30/2006

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ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

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BRANCH AND CLASS

32

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43119-I 306	BASIC DAMAGE CONTROL (DC)	07/30/2006
43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENS	07/30/2006
43119-I 304	FIRE WATCH STANDER	07/30/2006
43119-I 303	BASIC FIREFIGHTING	07/30/2006
43119-I 302	BASIC FIRST AID	07/30/2006
43241-H 301	MAINTENANCE PERSON	06/11/2006
43434-1C 304	AIRCRAFT ELEVATOR OPERATOR	06/08/2006
43434-1C 303	CONFLAGRATION STATION OPERATOR	05/23/2006
43434-1C 302	SOUND-POWERED TELEPHONE TALKER/OPERATOR	05/20/2006
43434-1C 301	CHOCK AND CHAIN HANDLER	05/17/2006
43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER	05/14/2006
43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER	05/13/2006

FOREIGN LANGUAGE PROFICIENCY

Foreign Language	: ENGLISH
Proficiency Source	: ENGLISH
Evaluation Method	: Self-Appraisal
Evaluation Date	: 11/01/2005
Listening	
Speaking	

Reading
Writing

CONTRACT INFORMATION

CED	: 10/16/2015		
EAOS	:	Soft EAOS	:
EREN	: 10/15/2021	Soft EREN	: 10/15/2021
EDLN Reason Cd	:	EDLN	:
ENCORE CREO Dt	:	FORMAN Appr Dt	: 11/14/2009

NEC HISTORY

NEC	Effective Date	Grade Limit	Priority
9305	07/01/2009	A	4
0000	12/01/2005	2	1
9760	12/01/2005	2	1

WARFARE QUALIFICATIONS HISTORY

Designator	Effective Date	Platform	Qual/Revoke
D	07/23/2010		
S	11/27/2008		
A	03/13/2008	LHA	QUAL

DESIGNATOR HISTORY

Designator	Effective Date
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SUBSPECIALTY HISTORY

Subspecialty

BSC HISTORY

BSC	BSC Date	UIC
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AQD HISTORY

AQD	Effective Date
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ADDITIONAL DUTY BSC HISTORY

ADDU BSC	Report Date	Detach Date	UIC
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NAME (Last, First Middle)

ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

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BRANCH AND CLASS

32



MEMBER DATA SUMMARY

PREVIOUS MILITARY SERVICE

Service Branch :
 Service Branch 2 :
 Service Branch 3 :
 Service From Date :
 Service High Gr/Rank :
 Service Months : 0

PROMOTION HISTORY

Rank/Rate	Grade	Rank Date	Rate Change Authority	TIR Date	Rate Chg Type
AR	E01	11/01/2005		11/01/2005	
AA	E02	12/30/2005	Other Rate/Rating Change	01/01/2006	Advancement
ABHAA	E02	12/30/2005		01/01/2006	
AA	E02	11/01/2005		11/01/2005	
ABHAN	E03	03/10/2006	Other Rate/Rating Change	03/01/2006	Advancement
ABH3	E04	09/16/2007	Examination - NETPMSA	07/01/2007	Advancement
CTN3	E04	09/16/2007	Other Rate/Rating Change	07/01/2007	Lateral Chang
CTN2	E05	02/16/2010	Examination - NETPMSA	01/01/2010	Advancement
CTN2	E05	07/20/2017		07/20/2017	Reduction
CTN1	E06	12/16/2013	Examination - NETPMSA	07/01/2013	Advancement

SPOT Promotion Grd	:		DOR-SPOT Promotion	:
Permanent Grd	:		Promotion Status	:
Promotion Stat FY1	:	Promotion Stat FY2	:	Promotion Stat FY3
Precedence Grp	:		:	Precedence Yr Grp
Precedence No.	:		:	Prec. No.- Inactive
Cmd Screen Results	:			

NAME (Last, First Middle)

ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

BRANCH AND CLASS

32



TRAINING EDUCATION AND QUALIFICATION HISTORY

CIVILIAN EDUCATION

YEARS EDUCATION	EDUCATION CERTIFICATION
12	L High School Diploma

DEGREE	SCHOOL	MAJOR	COMPLETED
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SPECIAL QUALIFICATION TEST SCORES

NAPT CD	NAPT SCORE	AFQT	DLAB	SONAR	RADAR	ETST
	0	55	666	0	0	0

RECORD OF OFF-DUTY EDUCATION, VOC/TECH TRAINING AND CORRESPONDENCE COURSES

TITLE	SCHOOL/NAVEDTRA NUMBER	COMPLETED	GRADE	LENGTH
INTRODUCTORY PROGRAMMING	UNIVERSITY OF MARYLAND	08 10/2014	P	3 Semstr Hrs
INTRODUCTION TO PROBLEM SOLV	UNIVERSITY OF MARYLAND	07/ 3/2014	P	3 Semstr Hrs
INTRODUCTORY ALGEBRA	UNIVERSITY OF MARYLAND	07/13/2014	W	3 Semstr Hrs
INTRO PROB SOLVING ALG	UNIVERSITY OF MARYLAND	08/18/2013	P	3 Semstr Hrs
DESIG				
LINUX SYSTEM ADMINISTRATION	UNIVERSITY OF MARYLAND	08/18/2013	B	3 Semstr Hrs
ECONOMICS IN THE	UNIVERSITY OF MARYLAND	07/07/2013	B	3 Semstr Hrs
INFORMATION				
FUNDAMENTALS OF WRITING	UNIVERSITY OF MARYLAND	07/07/2013	P	3 Semstr Hrs
AND				
PRINCIPLES AND STRATEGIES	UNIVERSITY OF MARYLAND	07/07/2013	W	3 Semstr Hrs
OF				
INTRODUCTION TO RESEARCH	UNIVERSITY OF MARYLAND	07/07/2013	A	1 Semstr Hrs
FOUNDATIONS OF ONLINE	AMERICAN MILITARY UNIVE	04/25/2010	P	3 Semstr Hrs
LEARNI				
PROFICIENCY IN WRITING	AMERICAN MILITARY UNIVE	04/25/2010	P	3 Semstr Hrs

NAVY SERVICE SCHOOLS/MILITARY TRAINING EDUCATION COURSES

TITLE	SCHOOL	COMPLETED	GRADE	LENGTH	NEC
JOINT NETWORK ATTACK	A-531-0031	11/25/2013	P	26 Days	
COURSE					
CMD TRN TEAM INDOCTRINATION	A-050-0001	04/15/2011	P	4 Days	
PO2 SELECTEE LEADERSHIP	CPPD	12/09/2009	P	1 Days	
COUR					
BASIC DIGITAL NETWORK ANALYS	A-531-0035	07/27/2009	P	47 Days	
CTN CLASS A SCHOOL	A-150-0036	06/04/2009	P	26 Days	
IT MOD04-COMMUNICATIONS	14225A	02/10/2008	3.6	1 Days	
HRDW					
IT MOD 05--COMMS CENTER OPS	14226	02/10/2008	3.5	1 Days	
INF SYS TCH TRG SR MD 2-CMP	14223	02/09/2008	3.5	1 Days	
IT MOD 03--NETWORK COMMS	14224	02/09/2008	3.4	1 Days	
IT MOD 01--ADMIN & SECURITY	14222	02/04/2008	3.4	1 Days	
EQUAL OPPORTUNITY IN THE NAV	14082	04/22/2007	3.7	1 Days	
MRPO THIRD & SECOND CLASS	14504	04/22/2007	3.6	1 Days	

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USNR

NAVPERS 1070/881 (REV 8-2010)

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TRAINING EDUCATION AND QUALIFICATION HISTORY

ABH REFR AMPHIB	C-604-2027	12/08/2006	P	5	Days
AVIATION MAINTENANCE RATINGS	14022	09/07/2006	3.5	1	Days
ABH A1	C-822-2010	03/10/2006	P	31	Days
AVIATION FUNDAMENTALS	C-100-2021	01/26/2006	P	8	Days
SHBD ACFF	J-495-0413	01/11/2006	P	1	Days
PFM	A-950-0080	01/09/2006	P	2	Days
NAVY STU INDOC	A-950-0006	01/05/2006	P	2	Days
RTC BMT	A-950-0001	12/29/2005	P	63	Days

OTHER TRAINING COURSES/INSTRUCTIONS COMPLETED

TITLE	LOCATION	COMPLETED	LENGTH
DOD CYBER AWARENESS CHALLENGE	DOD-IC-IAA-V15.0	05/07/2018	1 Days
DOD CYBER AWARENESS CHALLENGE	DOD-IAA-V15.0	04/24/2018	1 Days
OPERATIONAL RISK MANAGEMENT	CPPD-GMT-ORMTC-1.0	01/22/2018	1 Days
ANTITERRORISM LVL I AWARENES	CENSECFOR-AT-010-1.0	12/04/2017	1 Days
DON ANNUAL PRIVACY TRAINING	DON-PRIV-1.0	12/04/2017	1 Days
UNCLE SAMS OPSEC	NIOC-USOPSEC-2.0	11/16/2017	1 Days
RECORDS MANAGEMENT IN THE DO	DOR-RM-010-1.2	11/16/2017	1 Days
COMB TRFKNG IN PERS (CTIP) C	DOD-CTIP-2.0	11/16/2017	1 Days
NCIS CNTR INTEL/INSIDER THRE	DON-CIAR-1.0	11/16/2017	1 Days
THE ACTIVE SHOOTER	CNIC-TRTAS-1.1	10/25/2017	1 Days
DOD CYBER AWARENESS CHALLENGE	DOD-IC-IAA-V14.0	10/19/2017	1 Days
INDV-MANAGING YOUR RISK	CPPD-ORM-MYR-1.0	07/31/2017	1 Days
UNCLE SAMS OPSEC	NIOC-USOPSEC-2.0	07/31/2017	1 Days
RECORDS MANAGEMENT IN THE DO	DOR-RM-010-1.2	07/31/2017	1 Days
SEXUAL HEALTH/RESPONSIBILITY ENERGY GMT	CPPD-GMT-SHR-1.0	07/31/2017	1 Days
COMB TRFKNG IN PERS (CTIP) C	OPNAV-GMTE-1.0	07/31/2017	1 Days
FULL SPEED AHEAD (FSA) CF CE	DOD-CTIP-2.0	07/31/2017	1 Days
INDV-MANAGING YOUR RISK	NETC-FSA-CF-CERT	03/21/2017	1 Days
THE ACTIVE SHOOTER	CPPD-ORM-MYR-1.0	03/15/2017	1 Days
FIRE PREVT & PORT EXTINGUISH	CNIC-TRTAS-1.1	01/13/2017	1 Days
THE ACTIVE SHOOTER	ESAMS-1024	01/05/2017	1 Days
INDV-MANAGING YOUR RISK	CNIC-TRTAS-1.1	02/22/2016	1 Days
FIRE PREVT & PORT EXTINGUISH	CPPD-ORM-MYR-1.0	02/01/2016	1 Days
PERSONALLY IDENT INFO - PII	ESAMS-1024	02/01/2016	1 Days
ANTITERRORISM LVL I AWARENES	DOD-PII-2.0	12/16/2015	1 Days
SEXUAL HEALTH/RESPONSIBILITY DOMESTIC VIOLENCE	CENSECFOR-AT-010-1.0	12/16/2015	1 Days
PERSONALLY IDENT INFO - PII	CPPD-GMT-SHR-1.0	12/09/2015	1 Days
INT NAVY FRATERNIZATION POLI	CPPD-GMT-DV-1.0	01/08/2015	1 Days
COMB TRFKNG IN PERS (CTIP) C	DOD-PII-2.0	01/08/2015	1 Days
FIRE PREVT & PORT EXTINGUISH	CPPD-GMT-INFP-1.0	01/08/2015	1 Days
OPERATIONAL RISK MANAGEMENT	DOD-CTIP-1.0	01/08/2015	1 Days
ANTITERRORISM LVL I AWARENES	ESAMS-1024	01/08/2015	1 Days
BYSTANDER INTERVENTION CERT	CPPD-GMT-ORMTC-1.0	01/08/2015	1 Days
INTEL SYS SEC AWARE IC-ISSA5	CENSECFOR-AT-010-1.0	01/08/2015	1 Days
DIVERSITY ALL-HANDS TRAINING	CPPD-BI2F-CF-CERT	01/07/2015	1 Days
DOMESTIC VIOLENCE	DOD-IC-ISSA-5.0	08/28/2014	1 Days
	CPPD-GMT-DAHT-1.0	02/28/2014	1 Days
	CPPD-GMT-DV-1.0	02/28/2014	1 Days

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USNR

NAVPERS 1070/881 (REV 8-2010)

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TRAINING EDUCATION AND QUALIFICATION HISTORY

INTRO TO ANGER MANAGEMENT	CPPD-GMT-IAM-1.0	02/28/2014	1	Days
SEXUAL HLTH PROM DECKPLATE S	CPPD-GMT-SHPDS-1.0	02/28/2014	1	Days
ANTITER LVI-MIL/CIV CONUS	CENSECFOR-AT-CONUS-2.0	02/28/2014	1	Days
RECORDS MANAGEMENT IN THE DO	DOR-RM-010-1.1	02/28/2014	1	Days
INTRO NAVYS DRUG ABUSE POLIC	CPPD-GMT-INDAP-1.0	02/28/2014	1	Days
INT NAVY FRATERNIZATION POLI	CPPD-GMT-INFP-1.0	02/28/2014	1	Days
INTRO TOBACCO CESSATION POLI	CPPD-GMT-INTCP-1.0	02/28/2014	1	Days
COMB TRFKNG IN PERS (CTIP) C	DOD-CTIP-1.0	02/28/2014	1	Days
OPERATIONAL RISK MANAGEMENT	CPPD-GMT-ORMTC-1.0	02/28/2014	1	Days
DOD IC CYBER AWARENESS	ERRORDOD-IC-IAA-V12.0	02/28/2014	1	Days
PERSONALLY IDENT INFO - PII	DOD-PII-2.0	02/27/2014	1	Days
UNCLE SAMS OPSEC	NIOC-USOPSEC-2.0	02/27/2014	1	Days
FIRE PREVT & PORT EXTINGUISH	ESAMS-1024	01/06/2014	1	Days
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT-DAHT-1.0	06/20/2013	1	Days
DOMESTIC VIOLENCE	CPPD-GMT-DV-1.0	06/20/2013	1	Days
INTRO TO NAVY POLICY ON HAZI	CPPD-GMT-INPH-1.0	06/20/2013	1	Days
UNCLE SAMS OPSEC	NIOC-USOPSEC-2.0	06/20/2013	1	Days
INT NAVY FRATERNIZATION POLI	CPPD-GMT-INFP-1.0	06/20/2013	1	Days
OPERATIONAL RISK MANAGEMENT	CPPD-GMT-ORMTC-1.0	06/20/2013	1	Days
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT-DAHT-1.0	05/16/2013	1	Days
INDV-MANAGING YOUR RISK	CPPD-ORM-MYR-1.0	05/16/2013	1	Days
OCCUP REPROD HAZ AWARE	ESAMS-1242	05/16/2013	1	Days
ATFP LVL1 AWR TRNG SMBRS CON	CANSF-ATFP-CONUS-1.0	05/09/2013	1	Days
DOD CYBER AWARENESS CHALLENG	DOD-IAA-V11.0	04/08/2013	1	Days
INTEL SYS SEC AWARE IC-ISSA5	DOD-IC-ISSA-5.0	03/22/2013	1	Days
TRAFF IN PERS GENL AWARE TRN	JKDDC-TIP-2.0	03/01/2013	1	Days
NAVY RES FUND ACTIVE DUTY CR	NAVRESFOR-NRF-3.0	02/07/2013	1	Days
PERSONALLY IDENT INFO - PII	DOD-PII-2.0	01/25/2013	1	Days
ERGONOMIC AWARENESS TRAINING	ESAMS-0371	12/26/2012	1	Days
FIRE PREVT & PORT EXTINGUISH	ESAMS-1024	12/26/2012	1	Days
HAZCOM INITIAL TRAINING	ESAMS-1169	12/26/2012	1	Days
SAF ORIEN SUPV CNR/CNRNE/CN	ESAMS-1077	12/17/2012	1	Days
NAVY FALL PROTECTION	ESAMS-1259	12/17/2012	1	Days
ALCOHOL&DRUG ABUSE MGRS/SUPV	S-501-0120	09/14/2012	1	Days
NAVY PRIDE AND PROFESSIONALI	CPPD-NPP-1.0	09/12/2012	1	Days
PO1 SELECTEE LEADERSHIP COUR	CPPD-LEAD09-003	09/05/2012	1	Days
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT-DAHT-1.0	08/10/2012	1	Days
TRAFF IN PERS GENL AWARE TRN	JKDDC-TIP-2.0	08/10/2012	1	Days
SUPV-MANAGING YOUR TEAMS RIS	CPPD-ORM-MYTR-1.0	02/23/2012	1	Days
DOD INFO ASSURANCE AWARENESS	DOD-IAA-V10.0	02/10/2012	1	Days
INDV-MANAGING YOUR RISK	CPPD-ORM-MYR-1.0	02/01/2012	1	Days
FY07 GMT UNIT 3.1 SEXUAL HAR	CPPD-GMT-EOSHGP-1.0	12/08/2011	1	Days
PERSONALLY IDENT INFO - PII	DOD-PII-V1	12/05/2011	1	Days
INTRO TO ANGER MANAGEMENT	CPPD-GMT-IAM-1.0	11/03/2011	1	Days
ATFP LVL1 AWR TRNG SMBRS	CANSF-ATFP-CONUS-1.0	10/19/2011	1	Days

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NAVPERS 1070/881 (REV 8-2010)

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CON				
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT-DAHT-1.0	09/30/2011	1	Days
SEXUAL ASSAULT VICTIM INTRVN	CPPD-GMT10-025	08/17/2011	1	Days
INTRO TO STRESS MANAGEMENT	CPPD-GMT-OSCNS-1.0	08/05/2011	1	Days
CODE OF CONDUCT - LEVEL A	CPPD-GMT-COCLA-1.0	07/18/2011	1	Days
PERS FIN MGT-MONEY	CPPD-GMT10-026	06/03/2011	1	Days
MANAGEMEN				
INDV-MANAGING YOUR RISK	CPPD-ORM-MYR-1.0	05/12/2011	1	Days
INTRO TO SUICIDE PREVENTION	CPPD-GMT08-013	03/04/2011	1	Days
ATFP LVL1 AWR TRNG SMBRS	CANSF-ATFP-CONUS-1.0	01/25/2011	1	Days
CON				
DOD INFO ASSURANCE	DOD-IAA-V9.0	01/19/2011	1	Days
AWARENESS				
PERS FIN MGT-MONEY	CPPD-GMT10-026	12/03/2010	1	Days
MANAGEMEN				
PERSONALLY IDENT INFO - PII	DOD-PII-V1	11/16/2010	1	Days
TRAFF IN PERS BASIC AWARE TR	JKDDC-TIP-1	11/16/2010	1	Days
FY07 GMT UNIT 3.1 SEXUAL HAR	CPD-GMT07-031	11/05/2010	1	Days
ALCOHOL MISUSE ENABLING	CPPD-GMT09-023	11/05/2010	1	Days
MSF MIL SPORTBIKE RIDER COUR	ESAMS-2359	11/04/2010	1	Days
MSF TRNG BASIC (BRC)OR EQUIV	ESAMS-0244	10/20/2010	1	Days
INTRO TO STRESS MANAGEMENT	CPPD-GMT-OSCNS-1.0	10/01/2010	1	Days
SEXUAL ASSAULT VICTIM INTRVN	CPPD-GMT10-025	10/01/2010	1	Days
ATFP LVL1 AWR TRNG SMBRS	CANSF-ATFP-CONUS-1.0	09/20/2010	1	Days
CON				
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT-DAHT-1.0	08/24/2010	1	Days
INTRO TO STRESS MANAGEMENT	CPPD-GMT-OSCNS-1.0	08/06/2010	1	Days
PERS FIN MGT-MONEY	CPPD-GMT10-026	08/06/2010	1	Days
MANAGEMEN				
CODE OF CONDUCT - LEVEL A	CPPD-GMT-COCLA-1.0	06/25/2010	1	Days
FY07 GMT UNIT 3.1 SEXUAL HAR	CPD-GMT07-031	06/15/2010	1	Days
FY07 GMT UNIT 3.1 SEXUAL HAR	CPD-GMT07-031	06/04/2010	1	Days
SEXUAL ASSAULT VICTIM INTRVN	CPPD-GMT10-025	06/04/2010	1	Days
ALCOHOL MISUSE ENABLING	CPPD-GMT09-023	04/23/2010	1	Days
DRIVING FOR LIFE	CPD-DFL-01	04/15/2010	1	Days
PERS FIN MGT-MONEY	CPPD-GMT10-026	03/01/2010	1	Days
MANAGEMEN				
ALCOHOL MISUSE ENABLING	CPPD-GMT09-023	02/09/2010	1	Days
PERSONALLY IDENT INFO - PII	DOD-PII-V1	01/14/2010	1	Days
FY07 GMT UNIT 3.1 SEXUAL HAR	CPD-GMT07-031	01/04/2010	1	Days
DOD INFO ASSURANCE	DOD-IAA-V8.0	12/04/2009	1	Days
AWARENESS				
INTRO TO SUICIDE PREVENTION	CPPD-GMT08-013	11/30/2009	1	Days
INTRO TO STRESS MANAGEMENT	CPPD-GMT09-009	11/04/2009	1	Days
INTRO TO SUICIDE PREVENTION	CPPD-GMT08-013	10/23/2009	1	Days
WHYS & HOWS SIGINT	RPTG1011	10/14/2009	8	Days
REPORTING				
ATFP LVL1 AWR TRNG SMBRS	CANSF-ATFP-CONUS-1.0	10/13/2009	1	Days
CON				
INTRO STRESS&SUICIDE	CPPD-GMT09-024	09/14/2009	1	Days
AWARENE				
DOD INFO ASSURANCE	DOD-IAA-V7.0	09/14/2009	1	Days
AWARENESS				
ATFP LVL1 AWR TRNG SMBRS	CANSF-ATFP-CONUS-1.0	09/14/2009	1	Days
CON				
ORM ALL NAVY ESSNTLS LDERS CR	CNET11969	09/14/2009	1	Days
ALCOHOL MISUSE ENABLING	CPPD-GMT09-023	09/14/2009	1	Days
INTRO TO NAVY POLICY ON HAZI	CPPD-GMT09-015	07/30/2009	1	Days
PERSONALLY IDENT INFO (PII)	DOD-PII-V1	07/30/2009	1	Days

NAME (Last first Middle)

ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

[REDACTED]

BRANCH AND CLASS

USNR

NAVPERS 1070/881 (REV 8-2010)

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TRAINING EDUCATION AND QUALIFICATION HISTORY

TRAFF IN PERS BASIC AWARE TR	JKDDC-TIP-1	07/30/2009	1	Days
UNPLANNED PREGNANCY PREVENTI	CPPD-GMT09-012	07/30/2009	1	Days
EO - RELIGIOUS ACCOMMODATION	CPPD-GMT09-014	07/30/2009	1	Days
LAW OF WAR	CPPD-GMT09-019	07/30/2009	1	Days
DIVERSITY ALL-HANDS TRAINING	CPPD-GMT07-001	07/29/2009	1	Days
CODE OF CONDUCT - LEVEL A	CPPD-GMT09-003	07/29/2009	1	Days
INTRO TO STRESS MANAGEMENT	CPPD-GMT09-009	07/29/2009	1	Days
INTRO TO ANGER MANAGEMENT	CPPD-GMT09-010	07/29/2009	1	Days
PERSONAL FINANCIAL MANAGEMEN	CPPD-GMT09-022	07/29/2009	1	Days
OPERATIONAL RISK MANAGEMENT	CPPD-GMT09-016	07/29/2009	1	Days
DOMESTIC VIOLENCE	CPPD-GMT09-020	07/29/2009	1	Days
DRIVING FOR LIFE	CPD-DFL-01	07/27/2009	1	Days
MSF TRNG BASIC (BRC)OR EQUIV	ESAMS-0244	03/13/2009	1	Days
FINAN MGT: INVENT CSTNG/DEPR	CNET11977	08/19/2008	1	Days
TRAFF IN PERS BASIC AWARE TR	JKDDC-TIP-1	08/15/2008	1	Days
INTRO SEXUAL CONDUCT POLICY	CPPD-GMT08-011	06/17/2008	1	Days
INTRO TO SUICIDE PREVENTION	CPPD-GMT08-013	06/17/2008	1	Days
OPS SECURITY NEXT GENERATION	CPPD-GMT08-017	06/17/2008	1	Days
PHYSICAL READINESS PREP PRT	CPPD-GMT08-018	06/17/2008	1	Days
SEXUAL ASSAULT RESP & PREV	CPPD-GMT08-021	06/17/2008	1	Days
INTRODUCTION TO UNIX	78920_ENG	05/26/2008	1	Days
LEVEL B - CODE OF CONDUCT	CPD-LEVELB-1.0	12/01/2007	1	Days
CPD-LVLB-1.0 LVL B- CD COND	CPD-LEVELB-1.0	12/01/2007	1	Days
CMD DELIVERED PO INDOC	CRS-526	09/16/2007	1	Days
LEVEL B - CODE OF CONDUCT	CPD-LEVELB-1.0	06/28/2007	1	Days
PREPARING A STANDARD NAVAL L	CNET11456	03/31/2007	1	Days
CMD ASSESSMENT TEAM INDOC CR	CNET9210	03/31/2007	1	Days
FORGING SHARED TEAM OP VALUE	CNET11456	03/31/2007	1	Days
UNIX: THE USER ENVIRONMENT	CNET9210	03/31/2007	1	Days
DOD INFO ASSURANCE AWARENESS	DOD-IAA-V2.0	02/27/2007	1	Days
ORM ALL NAVY FUNDAMENTALS	CNET11977	12/22/2006	1	Days
DOD INFO ASSURANCE AWARENESS	DOD-IAA-V2.0	08/31/2006	1	Days
DRIVING FOR LIFE	CPD-DFL-01	08/12/2006	1	Days
OPTIMIZ FILE SIZES W/IMAGRDY	CPD-DFL-01	08/12/2006	1	Days
LEVEL B - CODE OF CONDUCT	CPD-LEVELB-1.0	07/05/2006	1	Days

PQS

DATE	PQS TATION#	PQS TITLE
11/27/2008	43901 301	ENLISTED SURFACE WARFARE SPECIALIST (ESWS) COMMON CORE
11/27/2008	43901 4 301	ESWS UNIT SPECIFIC FOR LHD CLASS
11/12/2008	43397-D 306	PETTY OFFICER OF THE WATCH (POOW)
09/26/2008	43119-J 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS
09/26/2008	43119-J 302	BASIC FIRST AID
09/26/2008	43119-J 303	BASIC FIREFIGHTING
09/26/2008	43119-J 304	FIRE WATCH STANDER
09/26/2008	43119-J 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENSE
06/05/2008	43119-J 308	TEAM LEADER

NAME (Last first Middle)

ANDERSON,DANIEL

SOCIAL SECURITY NUMBER

[REDACTED]

BRANCH AND CLASS

USNR

NAVPERS 1070/881 (REV 8-2010)

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TRAINING EDUCATION AND QUALIFICATION HISTORY

05/30/2008	43119-J 307	ADVANCED DAMAGE CONTROL (DC)
03/14/2008	43397-D 305	MESSENGER OF THE WATCH (MOOW)
03/10/2008	43902-16 301	EAWS UNIT SPECIFIC FOR LPH/LHA/LHD/ MCS AVIATION CLASS
10/15/2007	43119-J 306	BASIC DAMAGE CONTROL (DC)
11/17/2006	43241-H 302	REPAIR PARTS/SUPPLY PETTY OFFICER
11/01/2006	43523-B 301	CRAFTSMAN
10/19/2006	43434-1C 305	TOWER OPERATOR
10/10/2006	43434-1C 307	SPOTTING DOLLY OPERATOR
07/31/2006	43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS
07/31/2006	43119-I 302	BASIC FIRST AID
07/31/2006	43119-I 303	BASIC FIREFIGHTING
07/31/2006	43119-I 304	FIRE WATCH STANDER
07/31/2006	43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENSE
07/31/2006	43119-I 306	BASIC DAMAGE CONTROL (DC)
07/30/2006	43119-I 301	BASIC DAMAGE CONTROL (DC) COMMUNICATIONS
07/30/2006	43119-I 302	BASIC FIRST AID
07/30/2006	43119-I 303	BASIC FIREFIGHTING
07/30/2006	43119-I 304	FIRE WATCH STANDER
07/30/2006	43119-I 305	BASIC CHEMICAL, BIOLOGICAL, AND RADIOLOGICAL (CBR) DEFENSE
07/30/2006	43119-I 306	BASIC DAMAGE CONTROL (DC)
06/11/2006	43241-H 301	MAINTENANCE PERSON
06/08/2006	43434-1C 304	AIRCRAFT ELEVATOR OPERATOR
05/23/2006	43434-1C 303	CONFLAGRATION STATION OPERATOR
05/20/2006	43434-1C 302	SOUND-POWERED TELEPHONE TALKER/OPERATOR
05/17/2006	43434-1C 301	CHOCK AND CHAIN HANDLER
05/14/2006	43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER
05/13/2006	43426-0A 302	LHA/LHD/MCS FLIGHT DECK OBSERVER

NAME (Last first Middle)

ANDERSON,DANIEL

NUMBER

BRANCH AND CLASS

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AWARDS RECORD

AWARD NAME	AWARD NUMBER	DATE OF AWARD	AUTHORITY	ADV POINTS
National Defense Service Medal	1st	11/01/2005 - 11/01/2005	SECNAV	0.00
GW-Terrorism Service Medal	1st	05/11/2006 - 05/11/2006	SECNAVINST 1650 H	0.00
Navy "E" Ribbon	1st	04/11/2006 - 12/31/2006	USS ESSEX	0.00
Navy/MC Overseas Svc Ribbon	1st	04/11/2006 - 04/10/2007	SECNAV	0.00
Sea Service Deployment Ribbon	1st	04/11/2006 - 04/10/2007	SE NAV	0.00
Good Conduct Medal Active	1st	11/01/2005 - 10/31/2008	SECNAVINST 1650.1H	2.00
Navy/MC Achievement Medal	1st	04/01/2005 - 04/13/2009	OTHER	2.00
Meritorious Unit Commendation	1st	09/01/2008 - 04/30/2010	S CNAVINST 1650.1H	0.00
Good Conduct Medal Active	2nd	11/01/2008 - 10/31/2011	SECNAVINST 1650.1H	2.00
Navy/MC Achievement Medal	2nd	03/01/2011 - 02/28/2 12	OTHER	2.00
Navy/MC Achievement Medal	3rd	07/01/2009 - 05/31 2012	OTHER	2.00
Good Conduct Medal Active	3rd	11/01/201 10/31/2014	SECNAVINST 1650.1H	2.00
Navy/MC Achievement Medal	4th	08/01 2012 - 08/ 6/2016	OTHER	2.00

NAME (LAST, FIRST MIDDLE)

ANDERSON, DANIEL

SOCIAL SECURITY NUMBER

[REDACTED]

BRANCH AND CLASS

USN

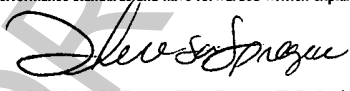

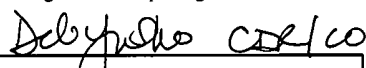

EVALUATION REPORT & COUNSELING RECORD (E1-E6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) ANDERSON, DANIEL D				2. Rate CTN2		3. Desig IW/SW		4. SSN [REDACTED]		
5. ACT <input checked="" type="checkbox"/> FTS <input type="checkbox"/> INACT <input type="checkbox"/> AT/ADSW/265		6. UIC 37700		7. Ship/Station CYBERSTRKACT 63			8. Promotion Status REGULAR		9. Date Reported 16SEP15	
Occasion for Report 10. Periodic <input type="checkbox"/> 11. of Individual <input checked="" type="checkbox"/> 12. Promotion/ Frocking <input type="checkbox"/> 13. Special <input type="checkbox"/>				Period of Report 14. From: 18MAR16 15. To: 18OCT19						
16. Not Observed Report <input type="checkbox"/>		Type of Report 17. Regular <input checked="" type="checkbox"/> 18. Concurrent <input type="checkbox"/>				20. Physical Readiness W		21. Billet Subcategory (if any) NA		
22. Reporting Senior (Last, FI MI) YUSKO, D B			23. Grade CDR		24. Desig 1810		25. Title CO		26. UIC 37700	
									27. SSN [REDACTED]	
28. Command employment and command achievements. Provide and deploy trained personnel, expertise, and equipment to conduct Offensive and Defensive Cyberspace Operations in support of U.S. Cyber Command (USCYBERCOM) and the Cyber National Mission Force (CNMF) Defend the Nation (DTN) missions.										
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) SUPPORT DIV COMMAND SUPPORT DIV-7. Provides support of grounds maintenance, building upkeep, and support to several highly visible Cryptologic Warfare Group SIX (CWG-6) and CSA-63 command programs and events. PFA: 18-1.										
For Mid-term Counseling Use. (When completing EVAL, enter 30 and 31 from counseling worksheet and sign 32.)				30. Date Counseled NOT REQ		31. Counselor		32. Signature of Individual Counseled <i>[Signature]</i>		
PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.										
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards					
33. PROFESSIONAL KNOWLEDGE: Technical knowledge and practical application. NOB <input type="checkbox"/>	-Marginal knowledge of rating, specialty or job. -Unable to apply knowledge to solve routine problems. -Fails to meet advancement/PQS requirements.	-	-Strong working knowledge of rating, specialty and job. -Reliably applies knowledge to accomplish tasks. -Meets advancement/PQS requirements on time.	-	-Recognized expert, sought out by all for technical knowledge. -Uses knowledge to solve complex technical problems. -Meets advancement/PQS requirements early/with distinction.					
34. QUALITY OF WORK: Standard of work; value of end product. NOB <input type="checkbox"/>	-Needs excessive supervision. -Product frequently needs rework. -Wasteful of resources.	-	-Needs little supervision. -Produces quality work. Few errors and resulting rework. -Uses resources efficiently.	-	-Needs no supervision. -Always produces exceptional work. No rework required. -Maximizes resources.					
35. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB <input type="checkbox"/>	-Actions counter to Navy's retention/reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	-	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	-	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.					
36. MILITARY BEARING/CHARACTER: Appearance, conduct physical fitness, adherence to Navy Core Values. NOB <input type="checkbox"/>	-Consistently unsatisfactory appearance. -Poor self-control; conduct resulting in disciplinary action. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Excellent personal appearance. -Excellent conduct conscientiously complies with regulations. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	-	-Exemplary personal appearance. -Model of conduct, on and off duty. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.					
37. PERSONAL JOB ACCOMPLISHMENT/INITIATIVE: Responsibility, quantity of work. NOB <input type="checkbox"/>	-Needs prodding to attain qualification or finish job. -Prioritizes poorly. -Avoids responsibility.	-	-Productive and motivated. Completes tasks and qualifications fully and on time. -Plans/prioritizes effectively. -Reliable, dependable, willingly accepts responsibility.	-	-Energetic self-starter. Completes tasks or qualifications early, far better than expected. -Plans/prioritizes wisely and with exceptional foresight. -Seeks extra responsibility and takes on the hardest jobs.					

EVALUATION REPORT & COUNSELING RECORD (E1-E6) (cont'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix) ANDERSON, DANIEL D		2. Rate CTN2		3. Design IW/SW		4. SSN [REDACTED]	
PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro- gressing	3.0 Meets Standards		4.0 Above Standards	5.0 Greatly Exceeds Standards	
38. TEAMWORK: Contributions to team building and team results. NOB <input type="checkbox"/>	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	<input type="checkbox"/>	-Reinforces others' efforts, meets commitments to team. -Understands goals, employs good teamwork techniques. -Accepts and offers team direction.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	- Team builder, inspires cooperation and progress. - Focuses goals and techniques for teams. - The best at accepting and offering team direction.
39. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB <input type="checkbox"/>	-Neglects growth/development or welfare of subordinates. -Fails to organize, creates problems for subordinates. -Does not set or achieve goals relevant to command mission and vision. -Lacks ability to cope with or tolerate stress. -Inadequate communicator. -Tolerates hazards or unsafe practices.	<input type="checkbox"/>	-Effectively stimulates growth/development in subordinates. -Organizes successfully, implementing process improvements and efficiencies. -Sets/achieves useful, realistic goals that support command mission. -Performs well in stressful situations. -Clear, timely communicator. -Ensures safety of personnel and equipment.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	-Inspiring motivator and trainer, subordinates reach highest level of growth and development. -Superb organizer, great foresight, develops process improvements and efficiencies. -Leadership achievements dramatically further command mission and vision. -Perseveres through the toughest challenges and inspires others. -Exceptional communicator. -Makes subordinates safety-conscious, maintains top safety record. -Constantly improves the personal and professional lives of others.
40. Individual Trait Avg. total of trait scores divided by number of graded traits. <input type="text" value="3.00"/>	41. I recommend this individual for (maximum of two): Assignment in Rating, Sea Special Programs, Shore Special Programs, Commissioning Programs, Special Warfare Programs, Rating Instructor Duty, Other. (Be specific) NONE		42. Signature of Rater (Typed Name & Rate): I have evaluated this member against the above performance standards and have forwarded written explanation of marks 1.0 and 5.0.  Date: 19 OCT 18 SPRAGUE, T L, ISC (IW/AW)				
43. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 35 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 point) only. Use upper and lower case. Submitted upon member's voluntary separation due to medical conditions. - SELFLESS MENTOR. Trained 13 Sailors for 26 hours on evaluation writing and formatting, reviewing and correcting evaluations before final processing to the chain of command. - DEDICATED INSTRUCTOR. Developed quarterly training plan for department to increase heritage and military advancement knowledge for 35 Sailors. Facilitated 12 hours of department General Military Training including Brilliant on the Basics topics, Trafficking in Persons, Anti-Terrorism/Force Protection, and Counter-Intelligence awareness. - WARFARE SME. Provided 23 hours of Enlisted Information Warfare Specialist (EIWS) training to 19 personnel contributing to the completion of EIWS books 1 and 2 Personnel Qualification Standards and testing.							
44. QUALIFICATIONS/ACHIEVEMENTS - Education, awards, community involvement, etc., during this period. COMPLETED: Transition, Goals, Plans, and Success program.							
Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	47. Retention: Not Recommended <input checked="" type="checkbox"/> Recommended <input type="checkbox"/>
45. INDIVIDUAL			X				48. Reporting Senior Address COMMANDING OFFICER CYBERSTRKACT 63 9800 SAVAGE RD, SUITE 6235 FT MEADE, MD 20755-6585
46. SUMMARY	<input checked="" type="checkbox"/>	0	1	0	0	0	
49. Signature of Senior Rater (Typed Name & Grade/Rate): I have reviewed the evaluation of this member against these performance standards and have provided written explanation to support the marks of 1.0 and 5.0.  Date: 19 OCT 18 HOWELL, D J, LT				50. Signature of Reporting Senior  Date: 18 OCT 18 Summary Group Average: <input type="text" value="3.00"/>			
51. Signature of Individual Evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement." I intend to submit a statement. <input type="checkbox"/> I do not intend to submit a statement. <input checked="" type="checkbox"/>  Date: 19 OCT 18				52. Type name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report Date:			

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>.
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I: INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible.)

1. NAME USED DURING SERVICE (last, first, full middle) Anderson, Daniel, Dennis	2. SOCIAL SECURITY # [REDACTED]	3. DATE OF BIRTH [REDACTED] 1985	4. PLACE OF BIRTH RIVERSIDE, CALIFORNIA
--	------------------------------------	-------------------------------------	--

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	USN-US Navy	11/01/05	10/19/18	<input type="checkbox"/>	<input checked="" type="checkbox"/>	UNKNOWN
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>	

6. IS THIS PERSON DECEASED? ☒ NO ☐ YES - MUST provide Date of Death if veteran is deceased:

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☒ NO ☐ YES

SECTION II: INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☒ DD Form 214 or equivalent. Year(s) in which form(s) issued to veteran: _____
This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. An UNDELETED DD214 is ordinarily required to determine eligibility for benefits. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a DELETED copy.

☒ Medical Records includes Service Treatment Records, Health (outpatient) and Dental Records. IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided: _____

☒ Other (Specify): Please include ALL documents in my OMPF; do NOT send an extract.

2. PURPOSE: (Providing information about the purpose of the request is strictly voluntary; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☒ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: benefits claim assistance

SECTION III: RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: DANIEL ANDERSON

2. ☒ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I. above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN (MUST submit Proof of Death. See item 2a on instruction sheet.)
(Relationship to deceased veteran)

☐ I am the VETERAN'S LEGAL GUARDIAN (MUST submit copy of Court Appointment) or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER
(Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)
National Veterans Legal Services Program
Name
1600 K Street NW, Suite 500
Street Apt.
Washington DC 20006
City State Zip Code

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)
[Signature]
Signature Required - Do not print Date

* This form is available at <http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf> on the National Archives and Records Administration (NARA) web site. *

Daytime phone _____ Fax Number _____
[REDACTED]@GMAIL.COM
Email address _____

RECEIVED DEC 13 2018

AR 3543

**NVLSP**

NATIONAL VETERANS LEGAL SERVICES PROGRAM

December 5, 2018

7017 3040 0001 1295 8082
Navy Personnel Command (PERS-313)
5720 Integrity Drive
Millington, TN 38055-3120

Reference: Daniel Anderson
Social Security Number: [REDACTED]

Subject: Request for Copy of Military Records (Personnel Records)

To Whom It May Concern:

This is a request for documents under the Privacy Act, 5 U.S.C. § 552a; and 38 C.F.R. §§ 1.577 (2015) on behalf of veteran Daniel Anderson. Please find enclosed a copy of a Privacy Act Waiver and a Standard Form 180 signed by Daniel Anderson. See Privacy Act Waiver, executed on 12/5/2018 and Standard Form 180, executed on 12/5/2018.

I hereby request a copy of all documents contained in Daniel Anderson's military records file inclusive of all documents specified in the attached Standard Form 180. The documentation should include the undeleted DD Form 214 and all miscellaneous documents in the OMPF. Daniel Anderson was separated from the Navy on 10/19/2018. Please do NOT send an extract of the records.

****PER THE SF-180, MEDICAL RECORDS HAVE BEEN REQUESTED AND SENT TO THE APPROPRIATE OFFICE; THIS IS A REQUEST FOR PERSONNEL RECORDS ONLY****

I prefer a paperless option; information sent via electronic delivery with login information or on a disc with password is encouraged. Please forward the requested information directly to me at the following address:
Lawyers Serving Warriors c/o NVLSP
Attn: Dorrie Popovski
1600 K Street, NW, Suite 500
Washington, DC 20006

I am requesting these documents in order for our organization to assist Daniel Anderson with an application for disability benefits.

Please respond to this request within twenty (20) business days. If fulfillment of this request will result in fees, please discontinue processing this request and send correspondence with the amount in advance. Please contact me at dorrie@nvlsp.org if there are any questions. Thank you very much for your assistance.

Sincerely,

Dorrie Popovski

Dorrie Popovski
Intake Specialist

Enclosures

RECEIVED DEC 13 2018

PRIVACY ACT WAIVER

In order to waive my rights under the Privacy Act, 5 U.S.C. 552a(b), and under any other federal or state law or regulation which controls access to my records, I give my prior written consent to the U.S. Department of Veterans Affairs (VA); U.S. Departments of Defense, Army, Navy, Marine Corps, and Air Force; and any other public or private custodian of (including, but not limited to, hospitals, clinics, and current and former treating physicians), or agency that possesses or controls, my military personnel, military medical, VA claims file, VA medical, mental health, drug or alcohol treatment, Discharge Review Board, Board for Correction of Military or Naval Records, or Physical Disability Board of Review records and files, to disclose fully and promptly to National Veterans Legal Services Program employee **Dorrie Popovski**, and/or attorneys **Rochelle Bobroff, Patrick Berkshire, Katy Clemens, Christine Cote, Jill Davenport, Jenna A. Goldberg, Alexis Ivory, Ray Kim, Esther N. Leibfarth, Erin Mee, Caitlin Milo, Paul Schwen, David Sonenshine, Richard V. Spataro, Barton F. Stichman, Stacy Tromble, and Bernadette Valdellon**, and any agents, attorneys, legal interns or law clerks working under their supervision or any other person or law firm designated by any of the attorneys named above, any and all records, documents, or files that pertain to me which they may request.

If these records include information protected under 38 U.S.C. § 7332 about drug abuse, infection with human immunodeficiency virus (HIV), alcoholism or alcohol abuse or sickle cell anemia, I specifically consent to that disclosure as well.

Name: Anderson, Daniel

(Last, First, Middle Initial)

Date of Birth: 1985

(YYYYMMDD)

Last 4 Digits of Social Security #:

VA Claims File # (if known):

Address:

Glen Burnie, MD

(Street, City, State and Zip Code)

Signature:

(Please provide a handwritten signature)

Today's Date: 20181205

(YYYYMMDD)

RECEIVED DEC 13 2018



DEPARTMENT OF THE NAVY
CYBER STRIKE ACTIVITY SIXTY THREE
FORT GEORGE G MEADE MARYLAND 20755-6585

1910
Ser N00L/098
24 Oct 18

From: Commanding Officer, Cyber Strike Activity SIXTY THREE
To: Commander, Navy Personnel Command (PERS-832)

Subj: CTN2 DANIEL ANDERSON, USN; REPORT OF ADMINISTRATIVE
SEPARATION

Ref: (a) MILPERSMAN 1910-600
(b) MILPERSMAN 1910-120
(c) CSA-63 ltr 1621 Ser N00L/008 of 2 Aug 17

Encl: (1) CTN2 Daniel Anderson ltr of 20 Aug 18
(2) NAVPERS 1070/613 of 29 Aug 18
(3) NAVPERS 1070/613 of 26 Mar 18
(4) DD-214 of 18 Oct 18

1. Per reference (a), the following information is submitted:

a. Reason for processing: Convenience of the Government – Physical or Mental Conditions, in accordance with reference (b).

b. Basic record data. Active duty start date: 1 Nov 05; date of current enlistment: 16 Oct 15; Soft EAOS: 15 Oct 21; Hard EAOS: 15 Oct 21; race/ethnicity: white; marital status and dependents: single, none; months on board: 25; is member pending orders: no; age: 33; total service: 12 years, 11 months active; participated in Montgomery GI Bill: yes; specialized training: Joint Network Attack Course

c. Involvement with civil authorities: None

d. Summary of military and civilian offenses: Commanding Officer's Nonjudicial Punishment (NJP) on 20 July 2017 for Violation of UCMJ Article 92 for Sexual Harassment. Reference (c) is the Report of NJP previously submitted to PERS-832.

e. Findings of the administrative board: N/A

f. Recommendations of administrative board: N/A

g. Type of discharge recommended by administrative board: N/A

h. MILPERSMAN 1910-702 Screening requirements.

FINISH FILE PERS 8352 FICHE

1910 OLT 2018
Hon
KFW

Subj: CTN2 DANIEL ANDERSON, USN; REPORT OF ADMINISTRATIVE SEPARATION

(1) Did member serve in an imminent danger zone in the 2-year period prior to notification of separation processing (If Yes, answer (2) and (3)): No

(2) Was member's record screened for PTSD/TBI as a contributing factor per MILPERSMAN 1910-702? N/A

(3) Was PTSD/TBI determined to be a contributing factor? N/A

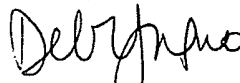
i. Psychiatric, medical and/or PTSD/TBI evaluation complete or not applicable (as required): N/A

j. Most recent NAVPERS 1070/613 (Rev. 07-06), Administrative Remarks Warning: Given on 26 March 2018, enclosure (3). Not related to reason for separation.

k. Comments of the Commanding Officer: Per Enclosure (1), CTN2 Anderson requested separation due to medical conditions that do not amount to a disability and obviates potential for continued naval service. His conditions included Irritable Bowel Syndrome-Diarrhea, Visceral Hypersensitivity, Major Depression Disorder, Generalized Anxiety Disorder, and Alcohol Use Disorder. These conditions were documented by his clinical psychologist, his gastroenterologist, and his counselor. These conditions, along with the recommendation for separation prior to the completion of his obligated service, were approved by his primary care manager and the Cryptologic Warfare Group SIX Authorized Medical Department Representative. At the time of his request, CTN2 Anderson was scheduled for a Physical Evaluation Board (PEB). He signed Enclosure (2), a Page 13 documenting that he understood that by making this request he was waiving this PEB and may not be eligible for any disability benefits. Based on the documentation and recommendations provided, his conditions, while not amounting to a disability, are incompatible with his duties and continued service as a Sailor in the United States Navy and necessitated his separation prior to the conclusion of his obligated service.

l. Date, Reason, and Characterization of Discharge: 19 October 2018; Condition, Not a Disability; Honorable. Enclosure (4) is the DD-214.

m. Point of contact: LT Michael Pellittiere, USN; Fort Meade, MD; (667) 812-2206 (COMM); E-Mail: mmpelli@nsa.gov.


D. B. YUSKO

20 Aug 18

From: CTN2 Anderson Daniel, USN, XXX-XX-XXXX
To: Commanding Officer, Cyber Strike Activity 63
Via: Authorized Medical Department Representative, Cryptologic Warfare Group Six

Subj: REQUEST FOR SEPARATION BASED ON PHYSICAL OR BEHAVIORAL
CONDITION(S) NOT AMOUNTING TO A DISABILITY

Ref: (a) MILPERSMAN 1910-120

Encl: (1) Primary Care Physician Memo, Walter Reed National Medical Center
(2) Behavior Health Memo and Diagnoses, Walter Reed National Medical Center
(3) Gastroenterology Memo, Capital Digestive Care
(4) Gastroenterology Diagnoses, Capital Digestive Care
(5) Addiction Treatment Service Memo, Walter Reed National Medical Center

1. Per reference (a), I request separation based on the medical condition which I and or my attending physician believe exists but does not amount to a disability per current Navy guidance. The medical condition is Irritable Bowel Syndrome – Diarrhea (IBS-D), Visceral hypersensitivity (VH), Major Depression Disorder(MDD), Generalized Anxiety Disorder (GAD) and Alcohol Use Disorder (AUD) and is supported by enclosures (1-5).

2. The following information is provided:

- a. Active Duty Start Date: 01NOV05
- b. Expiration of Service: 15OCT21
- c. Date Reported Current Command: 15SEP16
- d. Projected Rotation Date (PRD): 01SEP19
- e. This medical condition did not exist upon my entry into Navy.
- f. This medical condition was not the result of, or contributed to, my own misconduct.
- g. A mishap/safety investigation was not conducted regarding this medical injury/problem. If conducted, attach as enclosure (2).

3. Remarks:

I am unable to complete my service obligations physically and mentally; which will be demonstrated by the attached enclosures and these remarks. The attached enclosures include doctors and counselor recommendations. These remarks and enclosures represent the future based on doctor recommendations and condition status. All treatment avenues available by the military have been exhausted for each major diagnosis. In summary the following items prevent

me from completing my service obligations; Inability to participate in group PT and PRT. Mental health practitioners and command recommendations to hold my security clearance access. Non-deployable and not medically ready due to mental health, pain diagnoses and incontinence. Historical time out of work between March 2015 and June 2018 (a total of 845 business days) is approximately 150 full working days and 243 half-full days due to medical treatment. Additional time loss to the military is approximately 75 to 125 working days due to prolonged bathroom usage, late arrival and sitting in pain at my desk or work center.

IBS-D, VH, MDD, GAD and because of coping incorrectly with the above conditions AUD exist prior to 2015 but became exacerbated by additional stress, anxiety, inability to develop healthy coping, no continuity and inability to form proper social and personal relationships. IBS-D is primarily caused by anxiety, stress, food types and physical exertion. The daily life of the military adds layers of stress and anxiety; contributing to my irritable bowel syndrome being completely uncontrolled and unpredictable. The military Gastrointestinal Clinic (GI) has not been able to provide any effective treatments. It is difficult pretty much impossible to keep getting repeat authorization for civilian Gastrointestinal clinic follow ups. Tricare will not cover my pain medication prescription due to its formulary not including it; out of pocket cost is over 1200 USD. According to the VA medical examinations all conditions are not likely to improve in 12-36 months. Continued service will not only continue to exacerbate the conditions; but possibly result in death.

Daniel Ant 2 Aug 18

23 Aug 18

FIRST ENDORSEMENT on CTN2 Anderson ltr of 20 Aug 18

From: Authorized Medical Department Representative, Cryptologic Warfare Group Six
To: Commanding Officer, Cyber Strike Activity 63

Subj: REQUEST FOR SEPARATION BASED ON PHYSICAL or BEHAVIORAL
CONDITION(S) NOT AMOUNTING TO A DISABILITY

1. The purposes of this endorsement is to provide information for the Commanding Officer's decision concerning the service member's medical status and separation request.
2. From an Authorized Medical Department Representative (AMDR) perspective, although CTN2 Anderson was found fit for continued service, he has requested voluntary administrative separation due to his ongoing specialty care.
3. I have reviewed available records and information from CTN2 Anderson's Primary Care Manager and other specialists and concur with their recommendations to support his separation.



Caitlin Tallant, LT, USN, M.D.



DEPARTMENT OF THE NAVY
CYBER STRIKE ACTIVITY SIXTY THREE
FORT GEORGE G MEADE MARYLAND 20755-6585


1910
Ser N00L/071
6 Sep 18

SECOND ENDORSEMENT on CTN2 Anderson ltr of 20 Aug 18

From: Commanding Officer, Cyber Strike Activity SIXTY THREE
To: CTN2 Daniel D. Anderson, USN

Subj: REQUEST FOR SEPARATION BASED ON PHYSICAL OR BEHAVIORAL
CONDITION(S) NOT AMOUNTING TO A DISABILITY

1. In reference to your request received on 30 August 2018, I support your request to separate and find the information in your paragraph 2 to be accurate. After review of the information submitted in your request, I have determined that no mishap/safety investigation is required nor enclosed.
2. In accordance with your reference (a), I concur with the recommendations from the Authorized Medical Department Representative and those you included from your medical team. Based on submitted documentation, I find that your conditions, while not amounting to a disability, are incompatible with your duties and continued service as a Sailor in the United States Navy and necessitate your separation prior to the conclusion of your obligated service.
3. Under separate correspondence, I am directing your separation.


D. B. YUSKO



General Internal Medicine Service

Medical Home Team Bravo (301) 295-7815 office; (301) 319-4712 fax


21 Aug 18

From: Mr. Paul Cauchon, PA-C, Primary Care Physician, Walter Reed National Medical Center
To: Commanding Officer, Cyber Strike Activity 63

Subj: Administrative Separation ICO: CTN2 Anderson Daniel, USN, XXX-XX [REDACTED]

Ref: (a) MILPERSMAN 1910-120

1. Per reference (a), the purpose of this memorandum is to provide information concerning CTN2 Daniel Anderson's medical treatment. I am the service member's Primary Care Manager. I coordinate his care and see him for routine medical concerns.
2. From a primary care perspective, CTN2 Daniel Anderson is cleared for separation. He has been through the PEB→IDES process and was found fit for continued service but has requested voluntary administrative separation
3. Petty Officer Anderson requires ongoing specialty care for Irritable Bowel Syndrome – Diarrhea, Visceral hypersensitivity, Major Depression Disorder and Generalized Anxiety Disorder. He is eligible to pursue this care through the VA Medical System.
4. I reviewed available records, letters from Dr. William Stern, Gastroenterologist, and Dr. Sherin Paul, Psychologist, and discussed the matter at length with Petty Office Anderson. I concur with the specialist recommendations and support his separation.


Paul R. Cauchon, PA-C, CP
LCDR (ret) MSC USN
Team Bravo, Active Duty Clinic
General Internal Medicine, WRNMMC

(office 301-319-2348)

Walter Reed National Military Medical Center Bethesda
8901 Wisconsin Avenue Bethesda, MD 20889

Enclosure (1)

AR 3552



**Walter Reed
National Military
Medical Center**

Sherin Paul Psy.D.

Clinical Psychologist
Adult Behavioral Health Clinic - Outpatient
Walter Reed National Military Medical Center
(WRNMMC)
8901 Wisconsin Ave., Bethesda, MD 20889-5600

6 August 2018

TO: CTN2 Anderson, Daniel Dennis [REDACTED]

THRU: LCDR Rosa C. Grgurich, LCSW, Deputy Chief Adult Behavioral Health Clinic-
Outpatient Service, WRNMMC

SUBJECT: Administrative Separation

1. The purpose of this memorandum is to provide information concerning CTN2 Daniel Anderson's ability to continue to serve as a Cryptologic Networking Technician in the United States Navy from a behavioral health perspective.
2. CTN2 Anderson has received behavioral health services at the Adult Outpatient Behavioral Health Clinic at Walter Reed National Military Medical Center since 04 August 2014 and consistently on a weekly basis with this provider since 15 November 2016. CTN2 Anderson was initially treated in 2014 for a diagnosis of Anxiety Disorder Not Otherwise Specified which was then revised to a diagnosis of Generalized Anxiety Disorder (GAD) in 2015. CTN2 Anderson also has a concurrent diagnosis of Major Depressive Disorder (MDD). Additionally, per available records, CTN2 Anderson also completed a 28-day inpatient program in March 2015 for a diagnosis of Alcohol Use Disorder and has maintained follow up outpatient treatment on this issue.
3. Despite being found Fit for Duty and long term compliance with treatment recommendations CTN2 Anderson's GAD and MDD diagnoses cause him various symptoms that impair and limit his ability to serve in the military, including but not limited to the following: 1) consistent anxiety or depression affecting the ability to function independently, appropriately and effectively; 2) difficulty in adapting to stressful circumstances, including work or a work-like setting; 3) difficulty adapting to change; and 4) and difficulty developing healthy coping skills to manage life stressors.
4. The above limitations prevent CTN2 Anderson from performing both his basic military duties and the duties of his rating. As a Cryptologic Networking Technician, CTN2 Anderson works daily in a stressful position that requires him to maintain complex Information Technology (IT) networks containing secure, classified information. CTN2 Anderson's continued service would place at risk not only his mental health but also his sensitive work product, as his symptoms will likely continue to negatively interfere with his ability to efficiently, effectively, and accurately perform his duties.

This document may contain information covered under the Privacy Act, 5 USC522(a), and/or the Health Insurance Portability and Accountability Act (PL104-191) and the various implementing regulations and must be protected in accordance with those provisions.

Enclosure (2)



Walter Reed
National Military
Medical Center

5. In my professional medical opinion, CTN2 Anderson's GAD and MDD diagnoses, individually and when taken together, leave him unable to safely and reliably perform the duties required of a service member in the United States Navy. CTN2 Anderson is therefore unable to meet his obligated service requirement.
6. Questions regarding this memo can be directed to the undersigned at (301) 295-0500 and/or sherin.paul.ctr@mail.mil.

Psy.D.

Sherin Paul, Psy.D.
Clinical Psychologist
WRNMMC

This document may contain information covered under the Privacy Act, 5 USC522(a), and/or the Health Insurance Portability and Accountability Act (PL104-191) and the various implementing regulations and must be protected in accordance with those provisions.

Enclosure(2)



DEPARTMENT OF THE NAVY
WALTER REED NATIONAL MILITARY MEDICAL CENTER
8901 WISCONSIN AVENUE
BETHESDA MARYLAND 20889-5600

IN REPLY REFER TO

1 June 2018

From: Chief, Department of Addiction Treatment Services (ATS), Walter Reed National Military Medical Center (WRNMMC), 8901 Wisconsin Avenue, Bethesda, MD 20889

To: Whom It May Concern

SUBJECT: Statement of Program Progress for CT2 ANDERSON, Daniel (DOB: [REDACTED] 1985)

1. CT2 Anderson was a medical referral to Walter Reed National Military Medical Center (WRNMMC) Addiction Treatment Services (ATS) on 19 July 2017 due to disclosing to his behavioral health provider that he was using alcohol while taking prescribed psychotropic medications.
2. The psychosocial assessment was completed on 25 July 2017 and it was determined that CT2 Anderson meets criteria for Alcohol Use Disorder, Severe based on DSM V standards.
3. CT2 Anderson has been tested regularly for abstinence via breathalyzers and urinalysis testing. All tests have come back negative during his time in treatment.
4. CT2 Anderson was recommended to participate in a Level II (Intensive Outpatient) treatment which he successfully completed on 22 November 2017.
5. Following completion of Level II treatment, CT2 Anderson was recommended to participate in Level I treatment to include participation in Bill W. Group and Dialectical Behavioral Therapy (DBT) Skills and Process Groups.
6. CT2 Anderson is currently participating in DBT Process Group.
7. CT2 Anderson is recommended to attend community recovery meetings and prognosis is fair to good if CT2 Anderson attends those recovery meetings.
8. If you have any questions please contact Despina Hangemanole at (301) 400-1285 or the undersigned at 301-400-1298.
9. This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have

Enclosure (5)

AR 3555

SUBJECT: Statement of Program Progress for CT2 ANDERSON, Andrew (DOB [REDACTED])

received this correspondence in error, please notify the sender at once and destroy any copies you have made.



James Hardin LCSW-C, MAC
Chief, Addiction Treatment
By direction of the Director

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 08-2012) PREVIOUS EDITIONS ARE OBSOLETE

SUPPORTING DIRECTIVE MILPERSMAN 1070-320

SHIP OR STATION:

Cyber Strike Activity SIXTY THREE

SUBJECT:

☐ PERMANENT☒ TEMPORARY

REQUEST FOR SEPARATION


AUTHORITY (IF PERMANENT):

29 AUG 18:

1. I have submitted a request for Separation by Reason of Convenience of the Government - Physical or Mental Conditions, per MILPERSMAN 1910-120, based on medical conditions that do not amount to a disability.
2. I understand that I have a Physical Evaluation Board (PEB) scheduled in September 2018 and that by requesting this separation, I am waiving the PEB. I understand that, by waiving the PEB, I may not be eligible for any disability benefits.
3. I understand that this is considered a voluntary separation; therefore, there are no separation pay entitlements and selective reenlistment bonus (SRB) will be recouped.


 D. D. ANDERSON
 CTN2 USN

Witnessed:


 M. M. PELLITTIERE
 LT USN

ENTERED AND VERIFIED IN ELECTRONIC SERVICE RECORD:

VERIFYING OFFICIAL RANK OR GRADE/TITLE:

DATE:

SIGNATURE OF VERIFYING OFFICIAL:

NAME (LAST, FIRST, MIDDLE):

SOCIAL SECURITY NUMBER:

BRANCH AND CLASS:

ANDERSON, DANIEL D

XXX-XX-XXXX

USN

FOR OFFICIAL USE ONLY
 PRIVACY SENSITIVE

AR 3557

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 08-2012) PREVIOUS EDITIONS ARE OBSOLETE

SUPPORTING DIRECTIVE MILPERSMAN 1070-320

SHIP OR STATION:

Cyber Strike Activity SIXTY THREE

SUBJECT:

☒ PERMANENT☐ TEMPORARY

ADMINISTRATIVE COUNSELING/WARNING

AUTHORITY (IF PERMANENT):

MILPERSMAN 1910-202

26 MAR 18

1. The following deficiencies in your performance and/or conduct are identified: Violation of the UCMJ Article 92, Violation of a Lawful General Regulation as evidenced by CO's NJP on 20 July 2017.
2. The following are recommendations for corrective action:
Reduction to the next inferior paygrade (E-5)
Forfeiture of \$1,606 per month for two months
3. Assistance is available through: your chain of command, the command chaplain, and Fleet and Family Support Center.
4. Any further deficiencies in your performance and/or conduct will terminate the reasonable period of time for rehabilitation that this counseling/warning entry provides and may result in disciplinary action and processing for administrative separation. All deficiencies or misconduct during your current enlistment, occurring before and after the date of this action will be considered. Subsequent violation of UCMJ, conduct resulting in civilian conviction, or deficient conduct or performance of duty could result in an administrative separation under Other Than Honorable Conditions.
5. This counseling/warning is made to afford you an opportunity to undertake the recommended corrective action.
6. This counseling/warning entry is based upon known deficiencies or misconduct. If any misconduct, unknown to the Navy, is discovered after this counseling/warning is executed, further counseling or administrative action may result.

D. B. YUSKO
D. B. YUSKO

26 MAR 18: I hereby acknowledge the above NAVPERS 1070/613 entry and desire to (make a statement/not make a statement).

Daniel Anderson
D. D. ANDERSON

Witnessed:

M. M. PELLITTIERE
Legal Officer

ENTERED AND VERIFIED IN ELECTRONIC SERVICE RECORD:

VERIFYING OFFICIAL RANK OR GRADE/TITLE:

DATE:

SIGNATURE OF VERIFYING OFFICIAL:

NAME (LAST, FIRST, MIDDLE):

ANDERSON, Daniel D

SOCIAL SECURITY NUMBER:

XXX-XX

BRANCH AND CLASS:

USN

FOR OFFICIAL USE ONLY
PRIVACY SENSITIVE

AR 3558

CAUTION: NOT TO BE USED FOR
IDENTIFICATION PURPOSESTHIS IS AN IMPORTANT RECORD.
SAFEGUARD IT.ANY ALTERATIONS IN SHADED AREAS
RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

This Report Contains Information Subject to the Privacy Act of 1974, As Amended.

1. NAME (Last, First, Middle) ANDERSON, DANIEL "NMN"		2. DEPARTMENT, COMPONENT AND BRANCH NAVY-USN		3. SOCIAL SECURITY NUMBER [REDACTED]	
4a. GRADE, RATE OR RANK CTN2		b. PAY GRADE E5		5. DATE OF BIRTH (YYYYMMDD) 1985 [REDACTED]	
6. RESERVE OBLIGATION TERMINATION DATE (YYYYMMDD) NA					
7a. PLACE OF ENTRY INTO ACTIVE DUTY MECHANICSBURG PA		b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) [REDACTED] BETHLEHEM PA [REDACTED]			
8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND CYBER STRIKE ACTIVITY 63			b. STATION WHERE SEPARATED PERSUPDET MEMPHIS		
9. COMMAND TO WHICH TRANSFERRED NA				10. SGLI COVERAGE <input type="checkbox"/> NONE AMOUNT: \$400,000	
11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.) 0000 CTN - 0000 1YR 0MOS X			12. RECORD OF SERVICE		
			YEAR(S) MONTH(S) DAY(S)		
			a. DATE ENTERED AD THIS PERIOD 2005 11 01		
			b. SEPARATION DATE THIS PERIOD 2018 10 19		
			c. NET ACTIVE SERVICES THIS PERIOD 12 11 19		
			d. TOTAL PRIOR ACTIVE SERVICE 00 00 00		
			e. TOTAL PRIOR INACTIVE SERVICE 00 00 00		
			f. FOREIGN SERVICE 00 00 00		
			g. SEA SERVICE 00 00 00		
			h. INITIAL ENTRY TRAINING 00 02 06		
			i. EFFECTIVE DATE OF PAY GRADE 2017 07 20		
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) GW-TERRORISM SERVICE MEDAL (1);GOOD CONDUCT MEDAL ACTIVE (3);MERITORIOUS UNIT COMMENDATION (1);NATIONAL DEFENSE SERVICE MEDAL (1);NAVY "E" RIBBON (1);NAVY/MC ACHIEVEMENT MEDAL (4);NAVY/MC "SEE REMARKS"			14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed) RTC BMT. 8 WKS, DEC05; AVIATION FUNDAMENTALS. 1 WKS, JAN06; ABH A1. 4 WKS, MAR06; ABH REFR AMPHIB. 1 WKS, DEC06; CTN CLASS A SCHOOL. 4 WKS, JUN09; BASIC DIGITAL NETWORK ANALYSIS. 7 WKS, JUL09; JOINT NETWORK ATTACK "SEE REMARKS"		
15a. COMMISSIONED THROUGH SERVICE ACADEMY			YES <input checked="" type="checkbox"/> NO		
b. COMMISSIONED THROUGH ROTC SCHOLARSHIP (10 USC Sec. 2107b)			YES <input checked="" type="checkbox"/> NO		
c. ENLISTED UNDER LOAN REPAYMENT PROGRAM (10 USC Chap 109) (If Yes, year of commitment)			YES <input checked="" type="checkbox"/> NO		
16. DAYS ACCRUED LEAVE PAID 10.5		17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION			YES <input checked="" type="checkbox"/> NO
18. REMARKS SERIAL NUMBER: N2018102200062-0; TRANSACTION CODE: A; CONTACT INFORMATION AFTER SEPARATION: EMAIL [REDACTED]@GMAIL.COM PHONE [REDACTED] X X X X X BLK 13 CONT: OVERSEAS SVC RIBBON (1); SEA SERVICE DEPLOYMENT RIBBON (1); X X X BLK 14 CONT: COURSE, 4 WKS, NOV13; CMD TRN TEAM INDOCTRINATION, 1 WKS, APR11 X X X X X X X X X X X X X X X X The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.					
19a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code) [REDACTED] GLEN BURNIE MD [REDACTED]			b. NEAREST RELATIVE (Name and address - include ZIP Code) [REDACTED] LEXINGTON SC [REDACTED]		
20. MEMBER REQUESTS COPY 6 BE SENT TO (Specify state/locality) MD OFFICE OF VETERANS AFFAIRS			YES <input checked="" type="checkbox"/> NO		
a. MEMBER REQUESTS COPY 3 BE SENT TO THE CENTRAL OFFICE OF THE DEPARTMENT OF VETERANS AFFAIRS (WASHINGTON, DC)			YES <input checked="" type="checkbox"/> NO		
21a. MEMBER SIGNATURE Signature Unattainable		b. DATE (YYYYMMDD) 20181019		22a. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title, signature) WALDRON.MELISSA.BETH.118694883 Digitally signed by WALDRON.MELISSA.BETH.118694883 Date: 2018.10.22 15:33:36 -0500 GS7, Authorizing Official	
				b. DATE (YYYYMMDD) 20181022	

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION Discharged		24. CHARACTER OF SERVICE (Include upgrades) HONORABLE	
25. SEPARATION AUTHORITY MILPERSMAN 1910-120		26. SEPARATION CODE KFV	
27. REENTRY CODE RE-3G			
28. NARRATIVE REASON FOR SEPARATION CONDITION, NOT A DISABILITY			
29. DATES OF TIME LOST DURING THIS PERIOD (YYYYMMDD) TL - NONE		30. MEMBER REQUESTS COPY 4 (Initials) DDA	

DD FORM 214, AUG 2009

PREVIOUS EDITION IS OBSOLETE.

MEMBER - 4

AR 3559

Service_Request_Information (012)

10/14/191W

DD 214 Sent

Referral Request from:
NATIONAL PERSONNEL RECORDS CENTER
1 Archives Drive
St. Louis MO 63138

SERVICE REQUEST

SERVICE REQUEST #: 2-23394775265
HOW RECEIVED: Web
DESCRIPTION:

REQUESTER INFORMATION:

LAST NAME: ANDERSON
FIRST NAME: DANIEL
STREET: [REDACTED]
CITY: GLEN BURNIE
STATE: MD
POSTAL CODE: [REDACTED]
PHONE: [REDACTED]
FAX: [REDACTED]
EMAIL: [REDACTED]@gmail.com
COMPANY:

VETERAN INFORMATION:

LAST NAME: MERWIN
FIRST NAME: DANIEL
MIDDLE NAME: [REDACTED]
SSN: [REDACTED]
DATE OF BIRTH: [REDACTED] 1985
DATE OF DEATH: [REDACTED]
PLACE OF BIRTH: Riverside, Ca
BRANCH OF SERVICE: Navy

SERVICE DETAILS

QA.TC
10.15.2019

Service_Request_Information (012)

SERVICE DETAIL - 1

BRANCH: Navy

COMPONENT: Active

DATE RELEASED: 10/2018

OFFICER/ENLISTED: Enlisted

SERVICE NUMBER: [REDACTED]

SERVICE PERIOD:

DOCUMENTS REQUESTED

DOCUMENT REQUESTED - 1

BRANCH: Navy

COMMENT: UNDELETED

DOCUMENT REQUESTED: Separation Document

TYPE: Documents Requested

SERVICE REQUEST NOTES

NO NOTES FOUND

9/30/2019

Yes

Signature Verification

Monday, September 30, 2019 10:44:46 AM CDT

Service Request Number:

National Personnel Records Center

Military Personnel Records

1 Archives Drive

Saint Louis, MO 63138-1002



2-23394775265

Attention:

NPRC WEB

Service Request Number:

2-23394775265

I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information that I provided is true and correct.

Requester is: Veteran

Relationship: Not Applicable

(Signature Required)

DANIEL ANDERSON

(Print Name)

Please allow at least 90 days after you return the signature page before following-up on the status of your request. During that time, please do not resubmit your request as doing so will add further delay.

IN THE MATTER OF

Daniel Dennis Merwin

(your current name)

FOR CHANGE OF NAME TO

Daniel Anderson

(new name)

IN THE

CIRCUIT COURT

FOR

ANNE ARUNDEL COUNTY

Civil No. C-62-FM-17-825

ORDER FOR CHANGE OF NAME

1. BASIS

The provisions of this order are based upon

☐ An evidentiary hearing before a ☐ Judge ☐ Master.

☒ A ruling by the court without a hearing.

2. ORDER

UPON CONSIDERATION of the Petition to Change Name filed in this matter, it is hereby

ORDERED that the name of Daniel Dennis Merwin be and the same is changed to: Daniel Anderson

Signed 4/7/2017 11:29 AM

Date

JUDGE

Judge Alison L. Asst

I, Robert P. Duckworth, Clerk of the Circuit Court for Anne Arundel County, hereby certify that this is a true copy from the record in this court. Witness the hand and act of the undersigned this 17 day of April 2017

Robert P. Duckworth

Circuit Court for Anne Arundel County, Maryland

